THE ASK THE QUESTION PILOT PROJECT, 2023-25

EVALUATION

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Executive summary

About Ask the Question

People who have experienced sexual harm are significantly more likely to have poor mental health, misuse substances, or attempt suicide (WHO, 2001). Asking victims and survivors about experiences of sexual harm may help to identify and then address the root causes of some of their issues.

Barnsley Sexual Abuse and Rape Crisis Service (BSARCS), a long-established organisation supporting sexual harm survivors and professionals, knew that many survivors would like to be asked about prior experience of sexual harm but rarely are: in a survey to their users, 88% had never been asked and 92% wished that someone had. BSARCS also identified that local professionals often lacked the skills and confidence to identify and work effectively with people who have experienced sexual harm.

To address this, BSARCS launched the two-year Ask the Question (ATQ) project in 2023, funded by the Domestic Abuse Partnership at Barnsley Metropolitan Borough Council (BMBC). This innovative pilot aimed to equip local practitioner teams to routinely ask adult clients about sexual harm and to better support people post-disclosure, so victims and survivors would get timely access to appropriate support. This is believed to be the first example of such an initiative focused on a whole town.

This evaluation covers the ATQ pilot from 2023-25; funding has since been extended to 2026. The evaluation draws on data from interviews, desk research and analysis of BSARCS' own monitoring data.

Delivering Ask the Question

ATQ supported 48 organisations in its first two years. Of these, 17 had the full package of support: pre-training briefings; three half-day trainings; post-training support. In an effective collaboration with the Centre for Child Sexual Abuse (the CSA Centre), 18 practitioners also attended a six-day Practice Leads Programme (PLP) training course, led by the CSA Centre.

ATQ targeted organisations with high anticipated prevalence – mental health, criminal justice, substance misuse and homelessness. However, BSARCS welcomed all interested organisations, to catalyse interest in the work. This also allowed ATQ to get going with an initial cohort, while undertaking developmental work with organisations presenting more barriers to engagement. The downside was the inclusion of some organisations, not part of the target group, some of whom required high levels of support from ATQ. Their data also affected the overall prevalence rates (see below).

The majority of participants in the first two years were from the voluntary and community sector, although more statutory teams were coming onboard by the end of the pilot.

Participating organisations rated training and support from ATQ highly, with some describing it as powerful, accessible and honest. A few people requested more information before the courses; a few others wanted a greater focus on working with specific client groups.

Some organisations, especally statutory ones, took more support and time than anticipated to engage. Once engaged, while for some participation with ATQ was very easy, other organisations required considerable support to maintain engagement with the programme.

The ATQ team adapted their approach to meet participants' needs, offering flexible support; this helped sustain engagement. The expertise and credibility of BSARCS were crucial in managing training in a difficult subject, and supporting those who found the subject matter particularly hard.

Outcomes for clients

The ATQ pilot demonstrated a high prevalence of experience of sexual harm in the clients of the 15 organisations who shared data, in line with national statistics. Across all organisations and the whole pilot phase, disclosure rate was 12%; this rises to 20% in target organisations.

However, this data is likely to be an underestimate. Not all clients were asked, and not everyone may have disclosed on first ask – and subsequent disclosures were not always recorded. Conversely, some clients may have been counted by more than one participating organisation. BSARCS is aware of these limitations and is working with the participating organisations to address them. Although progress is fairly slow, the data is improving in accuracy over time.

Anecdotally, most clients responded well to being asked, while small numbers were very positive and a very few reacted negatively. Post-disclosure data is limited. Professionals told us that most clients didn't want support around their experience of sexual harm, or were happy with low-level emotional support, that acknowledges the trauma, from the asking organisation. Some had more immediate concerns like homelessness or active drug use to work on first. A relatively small number wanted a referral to specialist support, usually BSARCS.

Outcomes for professionals, organisations and systems

Most professionals reported increased confidence in asking the question as a result of ATQ; even some experienced professionals reported improvements. A very few people were still lacking in confidence post training, and there was some evidence that confidence decreased over time for a few, especially if they did not have to ask the question frequently.

Participants gained knowledge and understanding of sexual harm as a result of ATQ. Several reported that they and their teams had gained insight into how sexual harm may influence clients' behaviours. Some managers felt better able to support staff around sexual harm cases as a result of ATQ; other participants reported raising the issue more often within casework meetings.

Participating organisations changed their assessment and recording processes to incorporate ATQ. Most said that they would continue asking even if ATQ closed, provided they still had BSARCS to refer in to.

The ATQ theory of change identified significant systemic outcomes, including raising the profile of sexual harm and improving the way organisations work together. While some progress has been made in this area, it is limited to date. Partly this is because the ATQ team has prioritised delivery to participating organisations. It may also be that the original theory of change was overambitious for a two-year pilot.

Barriers and enablers to success

ATQ was easy to implement in organisations that: worked with clients long term; carried out in-depth assessment and had staff confident in asking difficult questions and working with trauma; had freedom around databases and reporting; had low staff turnover; had strong management buy in.

The local context has also been important. That ATQ was led by BSARCS – an organisation with longevity and credibility in the field – was supportive, as was the funding and championing of ATQ by Barnsley Metropolitan Borough Council. The project may also have benefitted from a focus on trauma-informed work more widely, and from external events like the #MeToo movement.

At the same time, there were significant barriers to participation for some organisations. ATQ tried to mitigate these where possible. Barriers were experienced in four main areas.

1. **Organisational barriers** included:
   - time required to change some IT systems – on occasion this took more than a year
   - lack of staff capacity to engage, even at the level of attending the initial training
   - staff turnover leading to loss of learning and/or momentum.
2. **The nature of the service** posed some difficulties, for example:
   - short-term services, and those not already working with trauma, struggled
   - the geographical focus of ATQ was logistically difficult for some cross-regional organisations
   - communication challenges with some client groups.
3. **A few participating professionals reported ongoing lack of confidence in asking the question,** possibly fearing harm to clients or due to their own personal experiences.
4. **The wider context** may have posed some barriers, for example:
   - a few professionals were concerned about the waiting list for BSARCS support
   - the existence of cultural taboos in discussing sex and sexual harm.

The future

BSARCS' ATQ project 2023-25 was a well-delivered, successful pilot, which has generated significant learning for the future, for ATQ in Barnsley and beyond.

Developing ATQ in Barnsley

To further develop ATQ within Barnsley, BSARCS should continue to:

- support current participants, including those that wish to extend ATQ within their own organisations
- work with participating organisations on improving data accuracy
- share aggregate data with participants
- work on wider systemic changes within Barnsley that will, in the long term, support ATQ
- widen the range of participating organisations, in particular to include more statutory organisations
- develop and improve the model, including finding less resource-intensive ways to support and motivate participants.

Expanding ATQ

BSARCS has ambitious plans to further expand ATQ, with the help of BMBC and other partners, with an ultimate aim of introducing routine enquiry about sexual harm to all referral and assessment processes in England and Wales. For any such roll out, BSARCS should:

- gather all relevant learning from previous related initiatives around routine enquiry
- develop, with partners and other stakeholders, a clear theory of change, including tactics for roll out
- build a stronger evidence base for asking the question
- engage national decision makers, alongside ongoing work with participating organisations.

1. Introduction

1.1 About Ask the Question

Established in 1987, Barnsley Sexual Abuse and Rape Crisis Service (BSARCS) offers a range of support services for people in Barnsley who have experienced sexual harm. The organisation also offers training and support for professionals working with people affected by sexual harm, for example in drug and alcohol or mental health services.

People who have experienced sexual harm are much more likely to have poor mental health, misuse substances, or attempt suicide;[1] there maybe also be far-reaching effects, for example into their sexual life, spiritual life, relationships and parenting.[2] Many victims and survivors of CSA do not report it at the time,[3] with common reasons being 'embarrassment, fear of not being believed, and fear of humiliation'.[4]

Asking victims and survivors about experiences of sexual harm may help to address the root causes of some of their issues. However, studies have shown that sexual abuse survivors are not often asked, but would welcome such enquiry, or were disbelieved when they disclosed.[5] This is supported by BSARCS' own data: in a survey to users, 88% of respondents had never been asked about their experiences of sexual harm and 92% wished that someone had asked them. BSARCS has also identified that local professionals, even those with considerable experience in their fields, may lack the skills and confidence to identify and work effectively with people who have experienced sexual harm.

To address this, BSARCS launched the two-year Ask the Question (ATQ) project in April 2023, funded by the Domestic Abuse Partnership at Barnsley Metropolitan Borough Council (BMBC). This innovative pilot aimed to skill up local practitioner teams to introduce a routine enquiry question into their referral and assessment processes with adult clients, and to better support people post-disclosure, so victims and survivors get timely access to appropriate support. We understand this to be the first example of such an initiative focused on a whole town. Project funding was subsequently extended to March 2026.

1.2 About this evaluation

Data for this evaluation was gathered via:

- Interviews with three BSARCS staff involved in ATQ (called 'the ATQ team' in this report).
- 20 interviews with local professionals, 17 of whom had taken part in ATQ and three who had not.
- An interview with a former BSARCS service user.
- A group interview with the ATQ steering group and individual interviews with stakeholders with a strategic view (local or national) on the programme. To protect anonymity, we refer to these eight respondents collectively as 'strategic interviewees'.
- Analysis of BSARCS' documents and data.
- Desk research.

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[1] WHO 2001

[2] Vera-Gray (2023) Key messages from research on the impacts of child sexual abuse. Child and Woman Abuse Studies Unit, London Metropolitan University

[3] Office for National Statistics, 2020, reported in https://www.csacentre.org.uk/

[4] Karsna and Kelly, 2021, The scale and nature of child sexual abuse: Review of evidence, CSA Centre

[5] See: www.iicsa.org.uk/index.html or https://learning.nspcc.org.uk/research-resources/2013/no-one-noticed-no-one-heard See: www.iicsa.org.uk/index.html or https://learning.nspcc.org.uk/research-resources/2013/no-one-noticed-no-one-heard

SECTION 1: DELIVERING THE ATQ PILOT

This section describes what BSARCS delivered through ATQ, what participants thought of the quality of ATQ, and what has been learned through the process. Outcomes of the work are described in section 2.

2. What ATQ delivered

2.1 The offer to participants

The ATQ offer to participant organisations comprised:

- An initial ATQ Briefing with managers.
- ATQ staff attending a team meeting with frontline staff to hear any concerns and alleviate anxieties.
- ATQ delivering three, three-hour training sessions (usually over a period of around a month). These sessions, delivered in person, comprised:
    1. Compassionate enquiry.
    2. Trauma informed responses and the impact of sexual harm.
    3. Understanding and working with the impact of vicarious and secondary trauma.
- ATQ staff meeting with management to discuss next steps and data collection.
- The participant organisation asking the question and sharing the results with BSARCS.
- Ongoing support from ATQ, if needed, to support implementation.

In addition, BSARCS collaborated with the Centre for Child Sexual Abuse (the CSA Centre) as part of the ATQ pilot, with the CSA Centre delivering a version of their six-day Practice Leads Programme (PLP) in Barnsley in 2024. The collaboration aimed to help BSARCS better embed the ATQ approach, by creating a cohort of sexual harm practice leads, within a range of local organisations, who would be able to support colleagues around sexual harm, where users' experience of sexual harm had been identified as a barrier to effective support. The leads would also be able to champion both sexual harm issues and ATQ internally. The course was led by CSA Centre staff, with ATQ trainers supporting, which made an effective bridge between the organisations.

2.2 How organisations engaged with ATQ

Engagement in ATQ training

Over the two years to end March 2025, 48 organisations received support through ATQ – 17 completed the full training, and of these 15 submitted at least some monthly data. The project almost met targets for training sessions and briefings. It is not known how many individuals were trained, but there were 1090 attendances at training sessions. Given that most people attended three sessions, it is not unreasonable to assume that around 350 individuals were trained.

ATQ engagement: April 2023-March 2025	Target (both years)	Actual
Training sessions delivered	120	112
Professional briefings held	64	63
Professionals trained	600 individuals	1090 attendances (unique individuals not known)

Who signed up

Participating teams came from a mix of primarily statutory and voluntary and community organisations (VCOs), although more VCOs had been involved at the time of writing.

BSARCS was keen to target ATQ at those professionals most likely to encounter those with experience of sexual harm, including substance misuse and mental health services. However, to get the project started and to 'create some noise', they chose to spread the net wide. This has resulted in a good spread of participant organisations, including some less obvious organisations who were keen to be involved, for example an organisation supporting unpaid carers.

This tactic also helpfully allowed ATQ to get the project going, while starting the longer-term developmental work with some of the organisations – primarily statutory – that presented more barriers to engagement. Over time, significant successes were made in statutory engagement.

- GP engagement proved difficult; given the time pressures on their roles this may be unsurprising. However, an ATQ pilot in a GP surgery started in early 2025. This development may have been also influenced by one of the PLP participants; as part of their role as an ICB commissioner they shared their PLP learning with GPs, in an attempt to increase ATQ engagement.
- Following a pilot in their transitions team, Adult Social Care made ATQ training mandatory for all frontline staff. ATQ will offer around six one-day courses, post-pilot. As yet collecting and reporting data on prevalence has not been agreed.
- The local ICB asked ATQ to start delivering the project in Children's Social Care.

Engagement in the Practice Leads Programme

The PLP training was completed by 18 people from a range of Barnsley organisations; some attended with colleagues, some solo. ATQ staff reflected that they were broadly happy with who they got onto the course, but reflected that in any second iteration they might be more strategic as to who was invited, to better embed ATQ into frontline practice. Ideally, they would also have had a greater overlap between ATQ and PLP: around half the participants came from organisations that also did the ATQ training.

Engagement with post-training support

ATQ offered post-training support to participating organisations, including in-person support (both reactively and proactively offered) and access to the BSARCS helpline and their website resources. The team also facilitated quarterly networking sessions for PLP attendees to share learning and concerns.

Evidence around the use of the helpline by ATQ participants is limited. Calls to the helpline increased during the ATQ pilot funding period, with 32 calls received in year 1 and 67 in year 2, but it is not known how many were ATQ participants. Additionally, no pre-ATQ baseline data exists. However, it must be noted that ATQ's emphasis was on skilling up organisations to be able to ask the question and support disclosures internally; staff were not expecting a significant uptake in demand of the helpline as a result of ATQ.

Why organisations wanted to engage with ATQ

The credibility and longevity of BSARCS, the expertise of their staff, the quality of their training (including being CPD accredited) and the support of BMBC all helped open doors for ATQ.

In interview, six participants stated they had signed up to ATQ as a result of a previous good relationship with BSARCS staff. Of these, two added that they had wanted to support BSARCS in the pilot. Seven

respondents said they joined the ATQ pilot because sexual harm is a significant issue for their clients and they wanted to ensure they got the right support:

> "A lot of our clients are deep seated in alcohol and substance misuse. And some have got sexual abuse in the past that's never been disclosed, it's never been managed, so they've jumped on to drugs and alcohol to try to block things. A lot of clients, they continue to get evicted, get into the wrong crowd, and it's like a revolving door. So if we can get to the root cause of the issue, we can start supporting with that and get the correct help. It helps us to understand their behaviours and why they act that way and why they are where they are, but it's even more helpful for the clients." (ATQ participant)

Others mentioned that ATQ was a good learning opportunity for staff, or that ATQ would help support their efforts to become more trauma informed. A respondent in a criminal justice organisation explained why they wanted to be involved:

> "It's an area of our business that we're not proficient at. When ATQ approached me, I took it upon myself to do a little bit of research within our organisation. As you can imagine, we do a huge assessment of any new client, and then a very, very thorough risk of harm section that covers every conceivable thing that you could imagine. And not anywhere in that document does it ask the question. Then when we start working with an individual, we have huge induction packs. Nowhere in that pack does it ask that question."

3. Participant feedback on the quality of ATQ support

This section describes participants' views on quality of support received through ATQ and PLP. Outcomes as a result of this work are described in section 2, below.

3.1 Feedback on ATQ training

Of the ATQ participants we interviewed for this evaluation, all reported attending training as a team, with most team-mates attending. They felt that attending as a team was helpful because: everyone needed the same, consistent understanding of the subject; there was a danger of diluting training if it was cascaded internally; it was a chance to chat through any difficulties in person.

All interviewees who had attended ATQ training said it was good, variously describing the training as 'powerful', 'fantastic', or 'brilliant'. A number of people also used words like 'honest' or 'real' to describe the training. Most respondents also noted that the quality of training delivery was high, praising the ATQ teams' knowledge, skills and experience, and delivery style. They appreciated that the trainers made the topic real, interactive, accessible and at times used humour to make the subject less heavy.

> "The ATQ team were there to support during the PLP training and they were brilliant, very approachable people. Whether you needed them inside or outside of the course, they're very knowledgeable. I already knew that, though, having worked with them previously; knowledgeable, helpful people who, even if they don't know – which they usually do – they'll find out for you." (ATQ participant)

Feedback in ATQ's own surveys was also very positive, with almost all respondents from each course rating it as excellent or very good, and several unsolicited comments about the quality of the trainers.

Interviewees particularly praised the final ATQ training session on vicarious trauma. They found this helpful for them and their teams, with application to much of their work, not just sexual harm.

Suggestions for improvement

Few recommendations for improvements to ATQ training were made in surveys or interviews. Individual respondents suggested that BSARCS might consider the following:

- More preparation of participants around this challenging material, in advance of the training.
- Send paperwork about ATQ requirements and implications further in advance of the training.
- Consider reducing some of the content for teams who already work in sexual harm and/or domestic abuse.
- More clarity from the outset as to when disclosing clients should be referred to specialists and when they should be supported in house.
- More on how to work with perpetrators around asking the question.
- More on working with people with learning disabilities.
- More sharing of the aggregate prevalence data collected by ATQ.

3.2 The Practice Leads Programme

We interviewed nine organisations who had sent staff on the PLP course. All rated it highly, and several praised the course leader. PLP attendees particularly appreciated the other participants in the group, finding them supportive and really willing to share and 'give it 110%'. They found networking and learning about other organisations valuable.

Attendees also liked the afternoon sessions devoted to case studies, with participants sharing their own examples for feedback, and learning from each other's. One explained that it made them feel less alone in the difficulties faced in their roles – they realised that other organisations in Barnsley had similarly complex cases.

The CSA Centre's own evaluation of the training also showed it to be very well received by participants.

Recommendations for improvement

As with ATQ training, few recommendations for improvement were made. However, five PLP attendees felt strongly that the in-person sessions were better than online. This was not about learning outcomes, rather it was about the nature of the experience, particularly because of the 'heaviness' of the topic:

> "Some topics are OK online, aren't they? But PLP wasn't as easy online. Did that impact on my learning? Probably not, but I didn't feel as looked after. So for example, there were one particular session online that were really, really difficult to hear. And for all we had all the health warnings that you would expect, not having that support of people around, I felt that were challenging." (ATQ participant)

3.3 Participant feedback on the quality of ATQ post-training support

Some interviewees also received follow-up support from ATQ, post training. For most, this comprised either a bespoke follow up session, or a repeat of the training for new staff; the latter was particularly appreciated. Some commented that ATQ staff had helpfully dealt with any follow up enquiries; some said that it was reassuring just to know the team was there if needed. One person reported having used the BSARCS helpline, and finding it useful.

After the end of the PLP training, ATQ staff ran meetings for PLP participants every few months. Views on these varied. Some people found them helpful, and very much appreciated being able to meet up with fellow participants again. Two noted that they had turned up and there were insufficient people attending to make it worthwhile. Several found the sessions hard to fit in, particularly in person. One suggested that shorter, online sessions, with dates planned far in advance, might help.

4. Learning from delivery

4.1 The time required for new projects

Some staff and strategic respondents expressed some disappointment or frustration at the time taken to set ATQ up, although there was no suggestion that BSARCS could have done anything differently. For some this set up phase was inevitable, others were surprised at the amount of behind-the-scenes work required to get some organisations, particularly statutory ones, on board. However, an ATQ respondent felt that the momentum now behind the project had led to a 'balance flip: now organisations are starting to come to us. We're not going to them'.

Conversely, some staff and strategic interviewees said they thought that, in retrospect, more time spent planning the project, and engaging external stakeholders – to get buy in and help shape the project – might have been useful. One felt this may have led to better engagement of at least one organisation. However, one of these respondents did note that BSARCS understandably needed to get the project moving fast when funding was agreed.

4.2 How delivery changed over time

The ATQ team was responsive to the emerging needs of participating organisations and developed ways of working to address these.

Encouraging signups, minimising barriers

While some Barnsley organisations found it easy to take part in ATQ, others experienced a number of barriers to engagement in (see chapter 11 for a discussion of these). To proactively address some of the barriers, the ATQ team adopted a range of tactics. As a result of some significant learning early on, the team developed pre-training support – for example briefing sessions – to try to identify and address concerns prior to training.

> "We realised that the frontline staff needed an opportunity to raise their concerns before the training delivery, they needed to know that their senior people were buying into this. So at the briefing with the manager or the lead of an agency, we would try and troubleshoot a little bit and hear what their issues were and then we would go and speak at a team meeting, where possible, and just speak to the team: 'what are your views? How do you feel about this? What are your concerns?'" (ATQ team member)

Other approaches to encourage engagement included:
- Being flexible as to training format, for example offering the training as a one-day event rather than three half days.
- Training managers and frontline staff together, so managers can both troubleshoot and motivate.
- Routine enquiry is still the long-term aim of the project, but the team recognised that, at least initially, targeted compassionate enquiry is more acceptable to some organisations.

- Developing materials like posters for professionals to put up in their premises, to reduce the chance of clients being surprised when asked about sexual harm.

Support beyond training

At six months post-training ATQ sent a survey to the staff of participating teams, about what's working or what's challenging. This survey helped the team identify new needs within participating organisations, for example new starter staff who had missed the initial training.

It became apparent that some participants were concerned about lack of resources to support people who disclose, especially as BSARCS had a waiting list for support. The ATQ team developed additional adult wellbeing resources on their website, designed to be used by professionals and victims and survivors, separately or together. Launched in February 2025, uptake of this new resource was limited by the time of writing, with 154 people registered, but it is anticipated this will grow.

Ongoing contact with participating organisations enabled the ATQ team to identify and then share good practice. For example, one of the managers of a participating organisation shared that they put ATQ on every team meeting agenda to keep it live. The ATQ team began recommending this to all participating organisations and some took this up.

The nature of the question

BSARCS purposely kept the question very simple, to increase the likelihood of organisations participating. The team also allowed participating organisations to adapt the question to make it as comfortable as possible for staff and clients.

The team also started to develop the nature of the data collected in some organisations, to make it more useful both to the participants and the ATQ. For example, two of the participating organisations chose to add an additional question about whether the sexual harm is historic or recent.

4.3 Training in a difficult subject

The importance of trainers' expertise

ATQ staff reported that it is quite common for people participating in ATQ training to disclose their own experience of sexual harm, and trainers needed to be able to manage this effectively. They also reflected on the importance of trainers having frontline expertise to give credibility and so they can share their experience as to what works. A member of staff explained:

> "Having that experience is vital because you draw on that a lot. When you're facilitating, it's not just about the content. The content is there as a guide on what we need to cover and it brings in the key points of research. But I find that the building of someone's confidence comes from my own experience. How could I deliver a training session on asking the question about sexual abuse, if that's not a conversation I've already had, because I'd probably be feeling just like they are feeling in that group session, thinking 'it's too much, I can't, I don't see the benefit of it'. So I think it's important that trainers have that experience and continue to utilise the stabilisation stuff in the day-to-day because I'm not going to tell you something that doesn't work." (ATQ staff member)

Effect of the training on participants

Many of the ATQ training participants interviewed reflected on the challenging nature of the training topic. Some found it challenging, and needed to take time out during the training. However respondents noted that the ATQ team was very supportive of participants and held the space well.

PLP participants also found some of the content tough going. However, the presence of the ATQ staff at PLP contributed to participants feeling supported though tough material. One respondent, who thought the PLP training was excellent, described the effect the content had had on them:

> "The PLP training is very hard and in-your-face. There's a lot of personal experience videos. There was one particular lesson that we did around institutional sexual harm, and it was focused partly on a type of service where I used to work. And I really, really struggled. I had to leave early, because I questioned myself as to whether I'd done enough to ask and support the clients that I was working with. It raised questions for me, questioning the staff team that I'd worked with, and had anybody got the potential to sexually harm and had I noticed anything. Had I acted on anything. But I met with an ATQ staff member after, and the CSA Centre trainer rang me to check in. I find it hard now talking about it actually. They were very good, very supportive." (ATQ participant)

Several interviewees noted that their staff team included people with lived experience of sexual harm, and in a few cases, staff chose not to attend ATQ training. BSARCS staff were keen to acknowledge the personal experience that professionals bring to training, and to support any disclosures. However, they were concerned that non-attendance at sexual harm training might present a barrier for staff in effectively supporting their clients. They reflected that such non-attendance at training due to personal experience is not usually seen in other training content.

5. Working with others

5.1 The ATQ Steering Group

BSARCS convened the ATQ Steering Group very early in in the programme – ATQ staff noted that the support of its members and their respective organisations was valuable in creating interest in, and credibility for, the programme. Staff commented on the value of enhanced connections and learning brought by the group, and one added that they valued having the group members scrutinise work, as it made them feel 'safer'. The ATQ Steering Group members interviewed were positive about the group, describing it as well chaired and friendly.

The steering group was set up to help inform practice, but the delay in getting the project going meant this role was limited at the start. BSARCS staff and some Steering Group members felt that, with hindsight, members might perhaps have been better utilised, particularly at the beginning. For example, some reflected that meetings were, on occasion, mostly about staff giving updates. One Group member felt that while the Group's input had been sought, this was more about implementation than strategy, with the latter already appearing largely settled. Others said they weren't fully clear on their own role or what they brought to the group, and some said they didn't really know everyone in the room.

Staff reflected that things were improving after they had introduced more structure to the meetings and a greater focus on the 'asks' from the steering group.

To help BSARCS make best use of the ATQ Steering Group in future, some suggestions were made.

- Group membership might be widened in future, to include more senior people from key organisations, to help cultivate buy in for future ATQ developments locally or nationally.
- It would be good to involve the Steering Group more with strategic direction, particularly around ATQ roll out to other areas.
- Some team building would help members get to know each other.
- Regular, brief project summaries or recaps would help members keep up to speed, given that for some of them their contact with ATQ is relatively minimal.
- Group members would appreciate as much notice in advance of meeting dates – ideally 4-6 months.
- Papers as far in advance as possible would be appreciated – though respondents recognised the difficulty within a small organisation of doing this.

5.2 The CSA Centre partnership

Through the ATQ pilot, BSARCS developed a closer partnership with the CSA Centre. Alongside work together on PLP, a senior member of CSA Centre staff is also member of the ATQ Steering Group and CSA Centre staff also helped BSARCS create the ATQ theory of change.

Both ATQ and CSA Centre staff reported that the collaboration was very positive, noting the strong alignment between the goals and approaches of the two organisations, and the skills and expertise of each other's staff. Both organisations supported the PLP training, financially or in terms of staff time.

ATQ staff felt that BSARCS benefitted from the collaboration in terms of access to learning and expertise, and a close working relationship with a key national organisation. As had been hoped, ATQ staff reported that, through the PLP participants, ATQ staff had been invited to larger meetings with a greater audience to deliver briefings about ATQ. An ATQ staff member explained that the involvement of the CSA centre gave their work added 'kudos' and 'weight':

> "The CSA Centre continues to be the voice of talking about sexual harm, alongside us. I think there's a lot of weight in the fact that you're not alone if other organisations within that area are supporting you; it's not just you shouting about it." (ATQ staff member)

The collaboration helped the CSA Centre add to its growing knowledge base around PLP, and created a new, potentially replicable model of working with a local VCS sexual harm service.

5.3 Service user input

BSARCS facilitates a monthly support group for service users post support; on a quarterly basis this group was asked to give input on ATQ. Such input included:

- Designing the ATQ logo.
- Sharing thoughts and feelings about the importance of asking the question, and on the impact of not asking. This input was used in ATQ training and other materials.
- Helping shape the content of the adult wellbeing resources online.
- Helping shape a social media and marketing campaign.

SECTION 2: THE ACHIEVEMENTS OF THE ATQ PILOT

This section describes what changed for service users and for participating professionals and their organisations, as a result of ATQ. Change beyond individual organisations is also discussed. Barriers and enablers to these changes is described in section 3 below.

6. Outcomes for service users

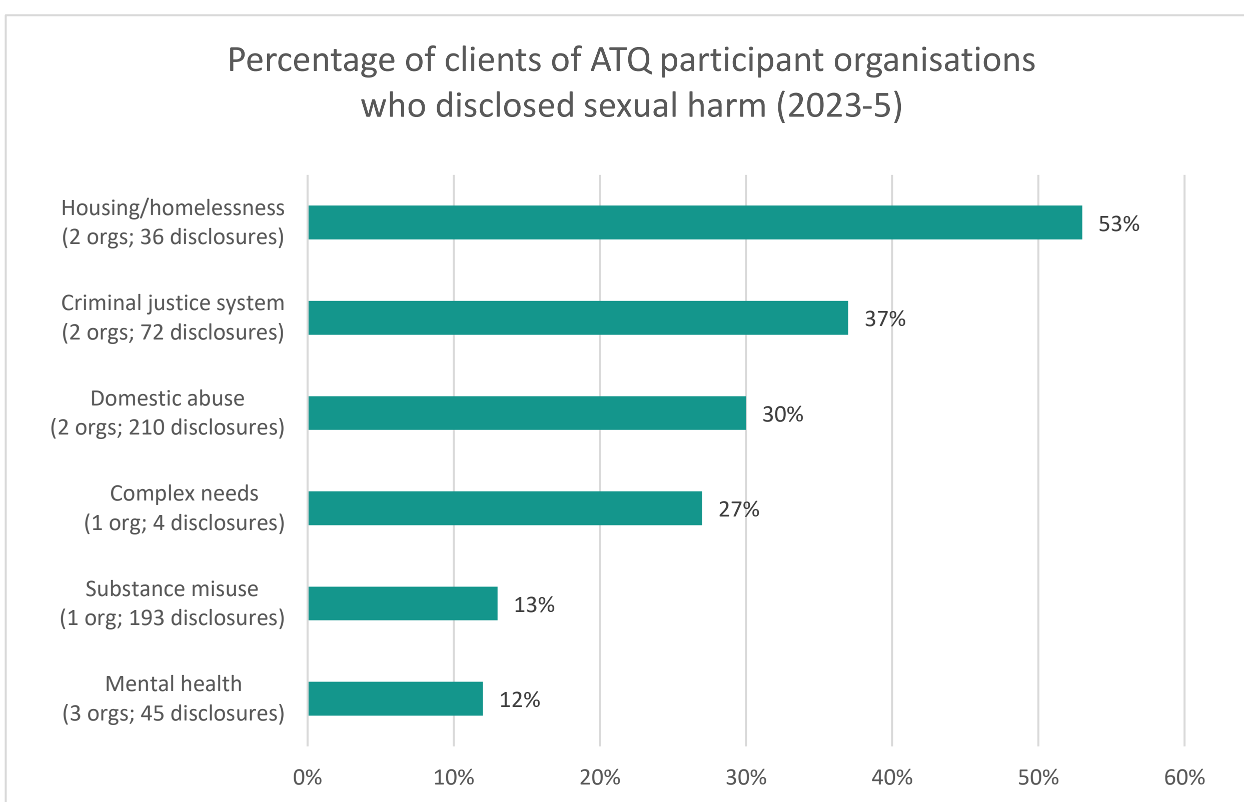
6.1 Identifying victims and survivors

Prevalence and disclosures

Notwithstanding some significant limitations to the data (see below), the ATQ pilot is demonstrating a high prevalence of experience of sexual harm in the clients of participating organisations, based on disclosures. From April '24 to March '25, 15 organisations reported 5835 new referrals. Of these, 683 (12%) disclosed previous experience of sexual harm. Across the 15, the percentage of clients disclosing ranged from 0 to 100%, although the highest and lowest figures are based on very small numbers.

Two of the organisations had a large number of referrals, but low disclosures. Neither of these was from the target group of organisations originally anticipated for ATQ where the highest prevalence might be expected – one was a social prescribing organisation; the other gave support to carers. If we exclude these organisations, the percentage of clients disclosing rises to 20%.

If we group the ten organisations that are from key target organisation types, we see the prevalence ranged from 12% of clients in the three mental health services, to 53% of clients in the two housing/homelessness organisations (see chart below).



Understanding this data

Stakeholder perceptions of the prevalence findings

There is evidence that stakeholders thought prevalence would be higher:

- The ATQ team, while pleased to have demonstrated a relatively significant prevalence, was still surprised that this was not higher in some organisations, based on their own experience and intelligence from participating organisations.
- Prior to ATQ training, participants were asked to estimate prevalence in their client group: 166 were able to give an estimate. Of these, 52% estimated prevalence at over 31%.
- In interview, three organisations felt that their prevalence was too low.

Limitations to the data

ATQ staff and interview respondents noted some limitations to the data so far. Some of these mean the data is likely to be an underestimate in terms of prevalence:

- Not all organisations were able to say how many clients had actually been asked the question; they submitted to BSARCS the number of new clients in the quarter, and the number of positive disclosures. Only two participating organisations replied confidently in interview that *all* their clients were being asked the question, with most being less sure. Of these, several said they were asking most of the time (some also shared that these issues were not unique to ATQ). Given that it is unlikely that everyone has been asked, this will underestimate prevalence.
- Participants explained that some of their clients didn't disclose at the start of a professional relationship, but went on to make a later disclosure. In some of these cases – but not all – the organisations recorded the subsequent disclosure.

BSARCS was aware of these issues, and the ATQ team was working on them with participating organisations, although they reported that progress is slow. It was difficult for them to fully investigate with services the extent to which all their staff were asking the question. ATQ staff reflected that, in retrospect, they would set up the reporting process differently at the start, to clarify who is being asked, and to allow for disclosures at any point in the clients' work with the participating organisations.

Conversely, there may have been at least some double counting within these figures that might lead to an overestimation of prevalence, albeit likely relatively small. Some of the people within the prevalence statistics may have accessed more than one service, and may have disclosed at more than one service too. Without tracking individuals through services we cannot know how many people were counted more than once in either those being asked or those disclosing.

Finally, we cannot say whether participating organisations identified more people with lived experience of sexual harm than prior to implementing ATQ. No participating organisation was able to give pre-ATQ baseline data on numbers of disclosures. Some said they thought they were, or might be, getting more than before. In addition, we do not know how many of those disclosing did so for the first time.

Comparison to other data

Estimates of experiences of sexual harm in the UK population vary according to study methodologies, definitions and framing, but are almost invariably high. In their 2021 meta-analysis of the evidence, Karsna and Kelly conclude that, as a conservative estimate, one in 10 children experience sexual abuse

before age 16.[6] Rape Crisis similarly state that 1 in 4 women (25%), and 1 in 18 men (6%), have been raped or sexually assaulted since age 16.[7] The ATQ pilot in Barnsley was consistent with these figures.

6.2 How clients responded to being asked

Interview respondents described a wide range of reactions from their clients to being asked the question. Most respondents reported that their clients were, generally, fine about being asked – some clients answered easily. A few professionals recounted positive responses, with clients reflecting that no one had asked them before.

> "Some service users, they've sat there and they've said 'I've never talked about this before' or they'll cry and they'll say 'I don't cry, I don't show my vulnerabilities. Why am I crying?' And they're shocked at themselves for letting somebody in and asking that question, but they feel validated and heard or believed." (ATQ participant)

In BSARCS' survey to participating organisations six months after ATQ training, 20 of 32 respondents reported no issues in asking the question, and some positive responses:

> "The experience has been positive, for the people I have spoken to who have disclosed sexual harm it was almost like they were relieved to be asked in a 'normal' way and it opened a discussion up if they were comfortable for further questioning/support."

Nine of the 32 survey respondents reported that some clients were initially surprised or confused or, on occasion, negative about being asked. But professionals said this was temporary and surmountable:

> "Usually people answer with no complications but a few people have raised an eyebrow regarding the question. Overall, I feel comfortable asking the question and comfortable answering any resistance I receive."

Clients were given the option not to answer, and some chose not to. In interview, a few organisations reported a small number of negative reactions; one described some 'backlash' which had upset staff. Two organisations reported a few clients disengaging after disclosure. It is worth noting that we cannot be sure of reasons for disengagement; another agency explained that, in their sector, there was high drop out after assessment, regardless of any disclosure about sexual harm.

Why clients might not disclose

Some participants noted that on occasion clients were wary of disclosing, and suspected that not everyone with experience of sexual harm chose to disclose. We do not have evidence from service users as to why this may have been the case. However, professionals suggested a range of reasons:

- Clients may have felt ashamed about what has happened to them.
- Their clients may have come to them for other, more immediate issues, like support with homelessness or substance misuse.
- Clients might have felt wary of being judged.
- People involved in the criminal justice system may have worried about 'having something else pinned on them'.
- Clients may have feared having more professionals intervening in their lives.

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[6] Karsna and Kelly, 2021 (ibid)
[7] https://rapecrisis.org.uk/

- One respondent commented that some of their clients almost accepted sexual abuse as the norm, given their lifestyles: ‘they tend to brush it off’ because it’s become normalised. But by asking the question, ‘it's like actually we're noticing you and it isn't right. So let's get you the support.’
- It may take time to trust staff:

> “A lot of clients have trusted a professional along the way and they've been let down. I've got a person I’m working with now and she doesn’t trust, and to be fair, she doesn't know me. So why do I expect her just to be able to blurt it all out? You need to build that trust. And when that person does trust you, then they share.” (ATQ participant)

6.3 What happened after disclosure

Immediately after

Some professionals expressed surprise that a significant proportion of their clients didn’t want support following a disclosure, but the workers suspected that for some clients, just being heard was sufficient. Other clients had already had support for their experiences.

Some clients opted for a referral to BSARCS for specialist support, or to the GP for generic mental health support. One respondent noted the importance of giving the client as much control over referrals as possible, including where they might meet with another professional.

Other clients were happy to have emotional support from the team doing the asking. Some professionals felt able to do this, sometimes making it clear that while they were happy to listen and provide emotional support, they were not counsellors. A worker in a substance misuse organisation commented that, while their team was not specialist in supporting around sexual harm, they were very comfortable providing emotional support in house where appropriate:

> “We are used to doing bits of work that others might specialise in, like mental health, because we have to, that’s part of the job – because these clients trust us and might not trust other services. We don't just deal with substances in isolation, do we?” (ATQ participant)

One respondent explained that, through ATQ, they learned that offering support didn’t always mean needing to do a lot of deep work:

> “One of the things that we've learned during the ATQ training [is that] sometimes because of experiences people might not have the confidence, the self-esteem, the motivation to do what they need to do. And then it's not our role to unpick that, but to help with that developing confidence and self-esteem and motivation. And I think that's a really big thing to have learned, because I think naturally what you do is go: ‘tell me about that. What was that like for you?’ And people don't need that all the time. Some people do, but not everybody does. And sometimes it's another thing that they need to work on now, that's connected but isn't going back to what happened. (ATQ participant)

Several respondents explained that, even though clients may have made a disclosure around sexual harm, some preferred to focus on more immediate concerns.

> “They need to be in the right frame of mind to deal with past trauma. Some of our clients might have quite erratic drug use, and not be mentally ready or stable in themselves to deal with that. So we'd work on the drug use. You’re better off to try and stabilise them

> on the drug use or alcohol use. Get that reduced because then that'll give them a clearer mind for when they do go in for counselling." (ATQ participant)

> "We've got a lot of women who are over 40 where it's happened in childhood and they've never spoken about it before and they don't really know where to start with it. So that they kind of push that back and they want to do the current work at the moment, rather than look revisit of what's gone off in the past." (ATQ participant)

Most respondents commented that asking the question did not cause them any significant extra work; one pointed out that if BSARCS ended up supporting the client it might result in less work. Another said that asking had sometimes led to more work supporting disclosures, but that it had been worth it:

> "Sometimes the increased complexity leads to clients being open for that bit longer. And as a service, we're supposed to be time limited. But in the long term, the impact is that we shouldn't develop a revolving door client because we're addressing the issue that's underpinning the behaviour." (ATQ participant)

Longer-term outcomes for clients

There is limited data on what happened to clients as a result of disclosure. However, interview respondents shared a range of examples.

For respondents working in substance misuse or the criminal justice system, it could be powerful for clients to make the connection between their past experiences and current behaviour. Sometimes this was a very positive experience. For others this could be very difficult:

> "Sometimes it can be very triggering. Sometimes when we make a breakthrough, that's when the clients start to disengage, and then they start to step back then because they probably don't know what to do with that information or they don't know how to cope with it." (ATQ participant)

One respondent described a case where a client's disclosure resulted in positive longer-term outcomes:

> "I have an experience myself where we were really struggling with a client. I agreed to go out on a joint visit and this lady was very clearly struggling with a mental health, significantly, very distracted, disjointed conversation, flitting from subject to subject, couldn't sit down, moving around lots. And she said something about a family member and not wanting her children to go there. And I said, 'why is that? Why don't you want them to go there?' And she went 'No, no, I don't trust them'. And I said … (just because it was fresh in my mind) 'I hope you don't mind me asking…'. And she said 'Yeah, that's exactly what happened to me. I'm nervous of him now. I don't like being around him' and then we did what was needed to be done from there. But my understanding, post our intervention, is she is doing a lot better, talking therapy in place and really good contact with children now and much better relationships. I like to think that was the start of that journey, as difficult it was it was." (ATQ participant)

A local carers' service was a keen adopter of ATQ, despite not being one of the immediate target organisations for the pilot. They described how previous experience of sexual harm was of direct and significant relevance to some clients in their caring role. Some carers were caring for their perpetrators; others were caring for their non-abusing parent, which sometimes led to resentment:

> "So even though they've got to care for them, there's still that animosity. They battle with themselves all the time because they think well, really should I care for them because they don't deserve it for what they allowed to happen to me. They didn't keep me safe, but if I don't do it, who's going to do it? And then they have carers guilt." (ATQ participant)

One respondent reflected that, although after disclosing some people didn't wish to do anything about it immediately, it might be that they come back to the issue later when they feel able:

> "You plant a seed that in six years' time they might think: somebody once mentioned there was a service to help me with this and then they might go back. Adding tools to the toolbox for if they ever need it or want it." (ATQ participant)

7. Outcomes for participating professionals

7.1 Changes in confidence

Some professionals began ATQ courses with concerns about asking the question. Before the course, ATQ surveyed participants about their perceptions of barriers to asking the question. Of 169 people making comments, almost 40% (66) mentioned concerns about not being able to ask the question well, or not being able to manage the response adequately; there were fears of 'opening a can of worms'. Thirteen percent (22) had concerns about the potentially negative impact on the client, of 'opening wounds that the person might have learnt to live with and doesn't want to discuss.'

Following training, almost all interview respondents reported improved confidence in themselves and/or their teams in asking the question. One explained:

> "You can see my team blossom when they learn this new stuff, and they know that they can deal with it. I mean, if the for the first time, they come across somebody who's really been damaged by that, you might be opening up a can of worms. It can be a bit daunting when it first happens to you, but it's just being sensible, being calm, understanding what they're going through and then at the end of it, when they've got it all off their chest, talking about BSARCS and what help they can offer." (ATQ participant)

A comparison of the pre- and post-ATQ training survey data showed a significant increase in participants' confidence in discussing sexual harm following the training (see table below). Some explained that they had learned 'that there are ways of asking the question without re-traumatising'.

How confident do you feel in your work currently discussing sexual harm?	Before (n=210[8])		After (n=154)	
Confident	37	18%	85	55%
Fairly confident	122	58%	66	43%
Not confident at all	51	24%	3	2%

[8] 210 people completed the pre-training forms, at a meeting prior to the training. On the day, only 189 people attended. As a result of this, ATQ started asking for pre-training data on the day at the start of the course.

In the table above, BSARCS followed up the three people who, even after attending ATQ training, were not at all confident about asking the question. All three were in roles where they did not carry out client assessments, so they felt that asking the question was less relevant to their work and expertise.

7.2 Changes in knowledge and understanding

Most interview respondents reported improved knowledge and understanding of sexual harm, in themselves and/or their teams. Those who were already very experienced in the field reported that the process was still valuable as a refresher, or as validation for their own approach.

Case study: Improved understanding for staff

One respondent, despite being a highly experienced professional, described significant learning outcomes as a result of taking part in ATQ. They described how they had grown in confidence asking the question:

> "To me, before the training, it was such a taboo subject. But then doing the training, it was like, it's so important that people talk about it. Now it's real trauma that people are going through and it's so important that you have an understanding of different forms of abuse. It was eye opening and it did make me feel more confident that it is important to talk about it and people should talk about it."

Although they reflected that the training had helped them spot the signs of sexual harm better, they also learned that victims and survivors might not display 'obvious' signs. They gave an example of a disclosure that surprised them.

> "I've seen this woman multiple times. She's always been happy, never gave me any hint, any inkling whatsoever. But it just so happened that, on the way to see me, she bumped into a friend who said something and it just totally triggered her. She'd never told anyone before. This happy, professional woman. So relaxed, you would never have suspected it. So that's when I thought I really do need to start asking the question now with people because there was no signs. I would never, ever have expected that at all. That made me realise, don't judge a book by its cover. You know, this could happen to anybody at any time."

Finally, the respondent explained that ATQ had changed their attitude to victims and survivors.

> "I can understand it better. I was never ignorant or arrogant about it to begin with, but they also made me realise that if I was to go back five years I'd just be like, 'oh, what, why don't they just leave them?' or 'why did they let it happen?' And I'm ashamed that I used to think that way, whereas this training made me think it's not as black and white as that."

7.3 Changes in personal experience

For one respondent, asking the question helped make their work more satisfying:

> "Asking the question makes our work more fulfilling. I think if you reach someone who otherwise wouldn't have disclosed, or wouldn't have sought help, for me that is why I do this job. That is amazing. If just one person benefits from that question, then for me that says it all really. Especially men. Maybe your alpha male, and he's been carrying this

> burden around and is now 60 years old. He never could really understand why relationships didn't work for him, sexual relationships in particular. For that one time to feel comfortable enough to be able to let that go. That is so powerful." (ATQ participant)

One respondent shared that taking part in ATQ helped them better understand their own lived experience of sexual harm; another explained that, following the training, a colleague had felt able to share their own personal experiences.

8. Outcomes for participating organisations

8.1 Asking the question

Fifteen organisations trained by ATQ submitted data to BSARCS, some for every month, others just a few times. Two of the fully-trained organisations did not give data to BSARCS; they hope to in future but have process issues to address first. Of these organisations, some staff were still asking the question but not all.

Most organisations that were asking the question had changed their assessment and/or recording processes, and were also recording data and sharing it with BSARCS on a quarterly basis. It is likely these changes will sustain in at least some organisations. Almost all participants said they would continue asking the question even if the ATQ project ended, as long as they still had BSARCS to refer in to.

Four organisations said they hoped to roll ATQ out further into their organisations, beyond the initial participating teams (for an example, see below).

Case study: Rolling out ATQ within GROW

GROW's team of 15 supports women and girls in Barnsley and Rotherham. Given the nature of their work, and the history of the geographical area they cover, they felt it was important that they take part in the ATQ pilot. They have three main service areas and at the time of writing were keen to roll ATQ out through these.

The four members of GROW's **Women's Justice Service (WJS)** did the ATQ training in 2024; two of the team also did PLP. They found the ATQ training well delivered. It was especially useful for newer team members, but the more experienced staff also found it a useful refresher and it helped build team confidence. Doing the training as a team helped ensure they were 'all on the same page'.

The WJS assessment forms are in-depth and contain questions on related topics, so it was easy to add in the sexual harm question. The service is holistic and trauma informed so asking the question felt quite normal to staff. Two staff are Rotherham based and so did not implement ATQ through the pilot; the Barnsley team did, and reported data to BSARCS.

Staff in GROW's domestic abuse team, **Hear Her Voice**, were initially trained at the same time as WJS, but ATQ had to be put on hold after some staff turnover. The team were trained again near the end of the pilot and were planning to implement soon after; their assessment forms had been amended to capture the data.

In future, the GROW CEO would like to expand ATQ into Rotherham, and into their third service area, their Post Abuse Service.

8.2 Using learning to support others

Six interviewees, mostly managers, observed that ATQ increased their ability to support their team or colleagues around sexual harm. One organisation has created an internal role for a sexual harm representative. Two respondents described bringing their learning to casework meetings:

> "Sometimes we talk about clients that are open across the management team and it's something I'll quite frequently say: 'have you have you thought about sexual harm, or could this be a possibility? Is it worth exploring? How would you explore that?' It can be a bit more difficult to make such suggestions with peers, so being able to offer statistical information or evidential information from ATQ, around behaviour and what you might see, is helpful." (ATQ participant)

> "In my role I sit on the Panel that reviews drug-related deaths in Barnsley. Following the PLP, I have asked the professionals involved about asking the question.'"(ATQ participant)

8.3 Better understanding of clients' coping strategies

Several respondents reflected that taking part in ATQ helped improve their service, by helping staff better understand their clients' behaviour; some were actively using this in their work with clients. For some organisations, ATQ was a helpful addition to their development of trauma informed working.

> "There is a drive in the service to understand people's drivers for their behaviour and to help resolve that experience for them a little bit more and help them understand why they feel the way they do – because that's more resilient in the long term. It's not just about applying a label; it's about getting the right support in place so that they can manage their feelings and their thoughts. And the behaviours that they've developed to cope, and be more adaptive to life." (ATQ participant)

> "The bits of training we've done along those lines are slowly getting people to be 'professionally nosy'. So, if someone says that they're really struggling, asking them 'why, what's caused that?' And I think ATQ was a big part of that." (ATQ participant)

One respondent described how a client's behaviour – which had been concerning – made sense when the client described their past experiences of sexual harm. In this case, this understanding may have prevented a safeguarding escalation. Another respondent explained how an understanding of a client's past experiences helped reframe their behaviour:

> "Having sexual harm uppermost in my mind as a result of the course has been really useful. It helped me with one particular case, whose behaviour and experiences were very much labelled and it was like, 'oh, that's an individual illness.' But something – almost like the solidarity of the people on the training – emboldened me to talk about it more clearly with this person. To help them make the links between their behaviour and their past experiences. It's like, 'no, you're having an understandable reaction to your experiences.' There's got to be a respect for people's ways of surviving. Because it all makes sense when you know what's happened to someone, even if it's confusing at first. And the course really reawakened that in me. And made me feel more passionate about it again."(ATQ participant)

9. Outcomes in Barnsley

The ATQ pilot theory of change identified a number of intended Barnsley-wide outcomes, around interagency working, use of the ATQ prevalence data, and the creation of a sexual abuse strategy for Barnsley.[9] The theory also described ATQ undertaking a public awareness campaign to increase community understanding of sexual harm and reduce stigma.

There is limited evidence of these more systemic changes in Barnsley as yet; we present what data we have below. However, although some staff and strategic respondents expressed a little frustration at the pace of this change, no one said that ATQ could have done or achieved much more by this point. It may be that the theory of change was overambitious, and/or focused more on the systemic than was required at this stage in the pilot. Staff also prioritised delivery to participating organisations.

9.1 Raising the profile of sexual harm and of ATQ

Activities to raise awareness

BSARCS staff attended local and regional forums, and the ATQ team spoke about the project at the 2024 one-day South Yorkshire conference on domestic violence and the South Yorkshire sexual violence conference – the first of its kind – in February 2025.

The ATQ project had an official launch event in November 2024, aiming to gather support from strategic leads and councillors. Following this, BSARCS received additional funding for marketing from BMBC to promote all of their work, including ATQ, and to raise awareness of sexual harm in Barnsley. Activities will include: posters in GP surgeries and other services; social media posts; interviews and videos; an ATQ pledge campaign.

Evidence of change

During the ATQ pilot, BSARCS social media activity increased significantly. Following a three-fold increase in posts on X, Facebook and Instagram, the number of unique users on all platforms increased substantially, particularly for Facebook, where the number of users in 23/24 was 1387, and in 24/25 was 6843. A decrease in posts on LinkedIn resulted in a reduction in unique users on that platform.

We have limited data on the uptake of ATQ-specific messages. We have one year of data on the ATQ website, which at the time of writing had low uptake, with 51 unique users. Among interviewees, there were mixed views on the profile of ATQ locally, with a few participant and strategic interviewees saying it was talked about a lot, a few saying they had heard very little.

ATQ staff reported a strong sense that ATQ had helped contribute to their profile as a specialist organisation, with an increasing number of invitations to events and to join relevant local agency boards.

[9] This is listed as an activity in the theory, but we'd argue that this would represent a significant local outcome.

9.2 Interagency working

ATQ staff ran meetings every few months for the individuals involved in PLP, to refresh learning and motivation, share updates, and discuss cases. There was some very early evidence that these, combined with PLP itself, may have contributed in some way to cross-organisational working. A few participants on that course reported having created better working relationships with other organisations that have continued post training. One commented:

> "Those reflective practice sessions with the other professionals were really useful to see what other teams do. And not just from a sexual harm perspective, also to see what other agencies are out there in Barnsley. It was such a good opportunity for 10 or 12 services in Barnsley to all come together a full day a month and talk about what services they offer because sometimes you can get a little bit in your own world and you don't explore other avenues. But it was really, really good to get in a room and build relationships with other services. Not just for the purposes of reducing sexual harm, but also just to build relationships for day-to-day work." (ATQ participant)

9.3 Use of the data

There was no evidence, at the time of writing, of organisations other than BSARCS using or sharing the data on prevalence, within their organisations or across Barnsley. One participant said they hoped to; another had reported the data back to their commissioner to keep them aware. Another participant requested more regular, two-way sharing of the prevalence data from BSARCS, so they can use the data themselves.

9.4 Local strategies and structures

There was, by the end of the pilot period, no sexual abuse strategy for Barnsley, but at that point local strategies and structures appeared to be reflecting a greater focus on sexual harm and/or sexual violence:

- The Safer Barnsley Partnership plan 2025 contained an increased focus on sexual violence and a pledge to further develop their sexual violence work strand.
- The BMBC domestic abuse strategy, 2022-27, didn't mention sexual harm or abuse specifically, but did focus on domestic abuse and violence against women and girls (VAWG).
- South Yorkshire Mayoral Combined Authority's Police & Crime Plan 2025 – 2029 priority 2 contained reference to wanting to prevent and reduce VAWG and child sexual abuse and exploitation.
- The local domestic abuse partnership was setting up a sexual violence and VAWG subgroup, with BSARCS cochairing.

SECTION 3: BARRIERS AND ENABLERS TO SUCCESS

BSARCS implemented the ATQ pilot within a wider context that affected what the project could achieve, both positively and negatively; for example the nature of participating organisations. This section describes learning about these barriers and enablers, to support future iterations of ATQ.

10. Enablers to asking the question

Alongside ATQ training and other support from the team, respondents described a range of factors that fostered implementation of ATQ, in terms of the nature of the participating organisations, the local and cultural context, and staff learning the best ways to ask the question.

10.1 The nature of the participating organisation

In interview, few organisations reported significant difficulties implementing ATQ. Over half of participating teams described it as easy to implement.

ATQ was easier when the implementing team or organisation:
- was already working in domestic abuse or sexual harm, or in some related field where supporting clients with trauma is a central part of the work
- did long term work with clients
- had in-depth assessments including sensitive questions
- had a staff team that felt confident in asking, felt able to deal with disclosures, and was supported in handling vicarious trauma
- had low staff turnover
- had freedom over their data collection and IT systems and changing these. This was often – but not always – true of smaller, voluntary sector organisations.

Similarly, the CSA Centre respondents shared their own learning from implementing PLP in other areas, as to what worked to sustain organisational change around addressing sexual harm:
- strong senior management buy in
- thinking about buy in, dissemination and embedding change from the outset
- support post training to keep people going.

Case study: When implementing ATQ was relatively straightforward

When BSARCS approached **Barnsley Independent Domestic Abuse Service (IDAS)** to get involved in ATQ, BSARCS was 'knocking at an open door', according to IDAS' local area manager. The two organisations already work closely together, and have similar client groups.

Most of IDAS' team of 25 attended ATQ training; BSARCS also provided an additional bespoke follow-up session on the impact of sexual harm on domestic abuse survivors' recovery. While some participants found the content of the training personally difficult, generally staff enjoyed the training and found it useful to hear from local specialists. Due to some staff turnover at IDAS, BSARCS are going to deliver the training again for the new cohort of staff.

IDAS already had an in-depth client assessment that includes sensitive questions, so adding in one about sexual harm was not difficult. Staff asked the question of most clients, with the main exception being if someone was in immediate crisis.

IDAS commented that the prevalence was lower than they would expect. They thought this may be at least in part due to how it was being recorded, and they were discussing this with BSARCS. They reflected there may also be some ongoing work to increase the percentage of clients being asked.

Rotherham and Barnsley Mind was also keen to be involved in ATQ, not least because the organisation had a longstanding, strong working relationship with BSARCS and wanted to support the new initiative. All their client-focused staff and students attended the training, which the clinical lead described as fantastic. Newer staff in particular got a lot out of it, and experienced staff found it helpful as a refresher and to hear about new developments in the field.

Once they had permission from their CEO and board, it was a simple process for Mind staff to change their assessment paperwork, and Lamplight, the database they use. They found that asking the question 'naturally fits into the work that we do' and there were no drawbacks for them in taking part.

10.2 Contextual enablers

In this Barnsley pilot, the good relationship between BSARCS and BMBC was key. In addition to BMBC funding ATQ, BSARCS reported that this relationship, and the overt backing of the Council, helped ATQ get access to wider group of organisations locally. Stakeholders described the work as 'a brave bit of commissioning'.

Several respondents noted that the ATQ pilot may have benefited from a wider focus on trauma informed work, and others noted that achievements in the domestic abuse sector, and the #MeToo movement, may have had some enabling effect. Staff and strategic interviewees also noted the importance of passionate, driven and skilled individuals, both within BSARCS and BMBC.

10.3 Learning how to ask the question

BSARCS was clear with organisations participating in ATQ that it was okay to be flexible in how they asked the question. Several respondents described learning different ways to ask their clients about their experiences of sexual harm. They shared their ideas.

- Grouping sensitive questions together was helpful, and then giving a gentle preface, like:

  > "Here are some sensitive questions we ask everybody. If you need any support around them just let us know. And if you don't feel comfortable answering that's fine – you don't have to."

- Professionals shouldn't feel the need to apologise for asking.
- Asking directly was fine for some clients; with others, professionals described working up to it by, for example, asking them about their relationships and whether these felt healthy.
- One organisation attached a crib sheet to the assessment to support staff in asking the question.
- Some teams used timelines to talk to people about their past, and found that this could be a useful tool within which to ask the question.
- If clients didn't want to answer, that was fine, professionals just recorded that in the client notes.

11. Barriers to asking the question

Taking part in ATQ was not easy for all organisations or all professionals. Barriers were identified in four areas:

- organisational
- the nature of the service and its clients
- individual professionals
- the wider context.

11.1 Organisational issues

Managing data

Two organisations, both statutory and both keen on implementing ATQ, were frustrated in their attempts to implement due to problems getting their IT systems changed; the question was not being asked of their clients because the organisation had nowhere to record it. VCS organisations reported having more control over their systems, so they were more able to adapt to the requirements of ATQ.

For one organisation, concerns around data protection held up the implementation of ATQ. The respondent reflected that, with hindsight, it would have been helpful to have more clarity from BSARCS about the requirements of ATQ, and for it to have come earlier in the process. However, ATQ had a contract that outlined mutual expectations, so the source of this lack of clarity is not clear. The respondent added that their own internal processes may also have contributed to some lack of clarity, including the inability of the relevant manager to attend a key briefing session.

Capacity

Some participants struggled to keep a focus on ATQ in the face of competing priorities. One explained how, despite being very committed to ATQ, their plans for expanding the pilot hadn't yet come to fruition by the point of interview. They described having an email in their drafts folder for six months about this:

> "You finish a course and then you have all these amazing intentions of doing so much with it. And then with such a busy, overstretched service that it doesn't then become a priority, and I feel that's what's probably happened." (ATQ participant)

This respondent suggested that regular prompts/reminders from ATQ would help, like an email or a quick phone call. This person noted that contact from ATQ tended to go to their manager, as the data provider, but additional contact with them as lead would help. It is worth noting that at the time of writing the ATQ team was working on this feedback, with one development being their attending participants' team meetings to give regular ATQ updates.

Some stakeholders noted that statutory staff in particular had significant amounts of mandatory training – ATQ is not mandatory for most. One NHS respondent explained that their mandatory training, plus 'essential to job role' training, amounted to around 100 hours per year for frontline clinicians.

> "There can be pressures in ensuring all staff in scope attend training in a timely manner due to the requirement to ensure adequate staffing cover for service delivery."

The requirements of other initiatives were an issue for some. For example, an NHS team was approached by ATQ staff to take part. The team was interested but had recently introduced routine enquiry for domestic abuse and felt unable to take ATQ on. One of the team reflected that 'it was never a "no" from

the beginning, more "not the right time". Nothing us or BSARCS could have done about it'. They explained that the domestic abuse work had involved significant staff training and resources to implement; with hindsight they felt they might have benefited from even more. Developments such as ATQ need internal buy in, staff training, changes to systems and processes, and work with external partners who might be affected by increased referrals.

> "It's the behind-the-scenes work that would have to be done to introduce something that might seem, on the face of it, quite a simple initiative, something that our staff would want to be involved in."

Lack of capacity and resources, particularly during times of crisis, were a barrier for some. One organisation really wanted to take part but couldn't due to their internal difficulties at that time:

> "We had to be ruthless and it was absolutely essential core business only. At the time that ATQ approached me, it would have required me to send a practitioner on a three-day course. And literally we just couldn't afford that. I know it sounds silly at just three days. But we couldn't afford to send someone out for something that was not considered core business; it was literally all hands on deck. We were on a weekly, daily basis just trying to cover the basics."

Staff turnover

Staff turnover is a significant issue in both statutory and voluntary organisations, and may lead to loss of learning and/or momentum. Staffing consistency also supports change.

Several participants noted that staff turnover had hampered the ATQ pilot in their organisations. Some had lost the staff trained on PLP. BSARCS staff reflected that they hadn't anticipated how high staff turnover is, and how this might impact on ATQ.

When participating teams had several new starters, the ATQ team delivered a repeat of the ATQ training, or a condensed version of it, for new starters, and this was really appreciated. However, due to the limitations of funding, BSARCS is not in a position to be able to repeat training indefinitely to address this.

Not wanting to implement routine enquiry

One respondent reflected that one of the barriers to ATQ within their organisation was a concern over routine enquiry. They were supportive of ATQ and the need to ask about past experiences, but explained that they wanted to be able to exercise clinical judgement about the right time to ask a question. They were not clear as to how strict ATQ would be on this, but felt it had put off some of their staff. As a response to feedback like this, the ATQ team changed the focus from 'routine' to 'compassionate' enquiry, that allowed a more flexible approach, and less pressure on frontline services to ask everyone.

11.2 The nature of the service and its clients

Nature of the service

The nature of the service provided presented barriers to engagement in ATQ, at times:

- The small geographical focus of ATQ was both a strength and a weakness. For teams covering several areas the restriction to people from Barnsley posed some issues, for example within one team where some members were asking the question and others not.
- Occasionally lack of confidential space in organisational premises limited professionals' ability to ask.

- The length of time a service worked with clients was a barrier for some organisations. When support is time limited, it's harder to build up a trusting relationship to enable people to disclose, and there is less time to do any follow up support, if needed.
- Some participants in ATQ found the pilot harder to engage with as their team did not see emotional support as part of its remit. This was particularly the case for some triage teams (see below) or teams whose main focus was on supporting access to other services.

Case study: Implementing ATQ in a triage team

The Barnsley Housing Options team was keen to be involved in ATQ because they knew that a lot of their clients have experienced past trauma, including sexual harm. Most of the team of 40 attended the training, which the team lead described as brilliant. One member of the team attended PLP, too.

However, the triage team manager shared that some members of their team had concerns about asking the question at initial assessment. Some reflected that the question could feel a little 'shoehorned in' to assessments that were primarily around immediate housing need. The ATQ training did help build their confidence, but some also felt unsure how to handle a disclosure when they only worked with the client for a week or two. They wondered if BSARCS might add more into the ATQ training on how to incorporate the question into different work settings.

Due to some IT issues, the team hadn't fully implemented ATQ by the time of writing, but they hoped to do so soon. One of the options they planned to explore was asking the question after clients had been through triage and were referred on to longer-term support with housing advisers.

One team described how, because their work was a short-term service not focused on supporting trauma, some staff struggled with asking everyone routinely. With BSARCS support, the team experimented with a targeted approach, just asking the question of patients from certain priority groups (including substance misuse and mental health). However, they learned that a drawback of this approach was that, because numbers of people in target groups were not high, targeted asking could lead to a further loss of confidence in staff who were not getting to ask the question sufficiently often.

Needs of the client group

Participants explained that there might be times when they didn't ask, for example if the person was in immediate crisis or was accompanied by a family member. The needs of the client group also affected implementation, for example where clients had dementia, or with some disabilities (see below).

Case study: The challenge of discussing sexual harm with some disabled young people

Barnsley Council's Preparation for Adulthood Team supports young people aged 14-25 with social care needs as they transition to adulthood. The team was keen to be involved in ATQ, in part due to the vulnerability of their client group. The team of five did the ATQ course in 2024; one also attended PLP. They loved the training and found it built their confidence and knowledge.

At the time of writing, the team was asking the question of some of their 18+ clients. However, they also have a significant cohort of clients with learning disabilities, some of whom are nonverbal. Many live with their parents, and parents are often present during meetings, which brought additional issues around consent and confidentiality. Communicating about sexual harm with these people was complex and sensitive.

The team was therefore not yet asking the question of all their 18+ clients by the end of the pilot. They were waiting to get support from a local specialist service with expertise in working with this group of people. However, the team remained keen and reported that the subject of ATQ was regularly on team meeting agendas.

> "This is something that needs to be out there. We need to be doing it. It has been frustrating at times that actually we've not moved forward as quickly as I would have liked us to. But I know why. It's not something we can rush into and mess up. We need to make sure that we get it right."

11.3 Individual professionals

Even after ATQ training, some staff still lacked confidence to ask the question. Exact reasons why are not known, but interview respondents suggested it might be a combination of:

- fear of how the client might respond
- fear of the answer being triggering to the questioner if they themselves have lived experience
- fear of 'opening a pandora's box' and harming the client
- fear of not being able to support the client adequately
- where disclosures are infrequent, perhaps as not all clients are being asked, staff can start to feel deskilled
- discomfort in asking people of the opposite gender; anecdotally, men in particular reported to ATQ staff that asking women was more uncomfortable than asking men
- the age of questioners, with some younger people possibly more able to discuss sexual harm
- concerns about waiting lists for specialist support (see below).

Perhaps surprisingly, even some senior and experienced staff expressed concern that they were nervous to address this tricky topic with their clients, perhaps because, as one strategic interviewee put it, 'everyone thinks someone else is the expert.' The ATQ team worked to demonstrate to professionals that for many of them the skills needed to ask the question were skills they already had.

It's possible that confidence to discuss sexual harm may have gone down slightly some months after the training. The data was on small samples and using different questions, but at the end of the compassionate enquiry training, 98% of 154 participants said they felt confident (55%) or fairly confident (43%) in their work discussing sexual harm. By contrast, six months after the end of the training package, 81% of 32 respondents said they felt confident in their work discussing sexual harm, and 19% (6) did not feel confident. That a significant number said that follow up support or training from BSARCS might be useful seems to support this. As part of their response to this, ATQ is working on developing short online refresher resources.

11.4 Contextual barriers

Breaking taboos

Respondents noted that a significant barrier to change may be the cultural context for ATQ, and taboos surroundings discussion of sex and abuse.

> "There's still a big taboo about sexual abuse and professionals still not wanting to think it happens. We've got there with domestic abuse. It took a long time. I don't think we're anywhere near it with sexual abuse. Nobody wants to think about it and they don't want

> to ask about it and vocalise it. And so there is culture to change and there are barriers to break down." (Strategic interviewee)

Availability of specialist support

A few participants had concerns about access to specialist support for clients who disclose. Some mentioned the waiting time for 1:1 support at BSARCS – which at the time could be many months – as a cause for concern for their staff. This was more the case for organisations that did not see themselves as able to provide emotional support for those on the BSARCS waiting list. It was also reported by some that service users were not supposed to be on waiting lists for both BSARCS and mental health support.

Case study: Availability of post disclosure support

Barnsley Advanced Healthcare Federation CIC has a team of 24 link workers, plus a team lead, in their Barnsley social prescribing team. The team was keen to support ATQ and took part in the training in late 2023; they enjoyed this and found it useful.

While some team members found implementing ATQ relatively easy, others struggled with asking the question. In part this was because the team's work doesn't naturally focus on trauma – it is focused on signposting and helping people access services. Also, some link workers had concerns about post disclosure support. BSARCS suggested that the team might offer emotional support to patients who disclose, while they waited for BSARCS support to become available. However this was an issue for the team for several reasons.

- Although they could offer some emotional support, the social prescribing team do not consider themselves counsellors or therapists.
- The service is short term – up to 12 weeks. Following a disclosure of sexual harm, one link worker supported the patient longer than the 12 weeks, as they were worried about patient safety. However, this was not a sustainable option for them long term.
- The team had had a clear steer from their clinical directors that they are not there to offer support that other services should be addressing. The team lead explained:

> "I've got the clinical directors guiding me – not just around ATQ and that service, it's around a lot of other things like mental health or finance or benefits where we have been asked to plug gaps – and they're saying 'we don't do that. Other services are funded to do that. That's not what we're trained in.' So, [we'd like BSARCS to understand] that we're not being difficult, but we have to also stick to our policies as well. And we can't always provide support that we're not trained to deliver."

Despite the difficulties, the team lead was still supportive of ATQ and wanted to continue asking the question. They had, through the process, identified some people who had not previously disclosed, and who wanted support, which was an important outcome.

SECTION 4: THE FUTURE

BSARCS' ATQ project 2023-25 was a well-delivered, successful pilot. Despite significant barriers to involvement for some organisations, ATQ engaged a good range of Barnsley's professionals in asking new adult clients about their experiences of sexual harm, then recording the results and sharing the data. The ATQ team developed their support package responsively and training and support were well regarded. Participating professionals, in general, gained confidence in asking the question and in their understanding of sexual harm. Participating organisations changed their assessment and recording processes, and it is likely that most will continue to ask the question beyond the pilot.

The pilot demonstrated significant prevalence of sexual harm within Barnsley, in line with national figures, and the data improved in accuracy through the pilot. Beyond individual organisations, wider systemic change in Barnsley around sexual harm had not happened in any significant way by the end of the pilot, but continue to be a work in progress.

The ATQ pilot generated significant learning as to how to change organisational practice around identifying experience of sexual harm and supporting disclosures. There are implications for BSARCS, ATQ in Barnsley and any future roll out of ATQ. BSARCS is aware of, and working on, many of these recommendations, but we list them all here for completeness.

12. Developing ATQ within Barnsley

ATQ's 2023-25 participants wished to continue post-pilot. However, respondents across the evaluation referred to the need to continue to support participating organisations to embed change; evidence from the CSA Centre's own evaluations of previous iterations of PLP also supports this.[10] Ongoing support helps organisations to:

- maintain their focus on, and momentum around, sexual harm work
- maintain confidence during times when professionals have less chance to practice
- effectively manage ongoing casework
- keep learning current and abreast of changes in the external environment
- deal with the questioners' own trauma, either vicarious or from personal experience
- manage staff turnover
- reduce reliance on the cascading of learning by staff internally, which may dilute messaging.

To further develop ATQ within Barnsley, BSARCS should also continue to:

- support existing participants to expand ATQ within their own organisations, rolling it out to other teams or regions
- work with participating organisations to increase the accuracy of the data from participating organisations
- increase the number of participating teams, with a focus on statutory organisations
- seek the buy in of senior staff within target organisations
- further raise local awareness of sexual harm, in collaboration with BMBC
- work with local commissioners to get asking the question written into new funding agreements
- consider repeating the PLP programme in Barnsley to further embed change
- find ways to best work with, and utilise the skills of, the ATQ steering group.

[10] For example: Parkinson, D (2020) Piloting the CSA Practice Leads Programme in social work: Evaluation report; Berni Graham (2020) Piloting the CSA Practice Leads Programme in adult substance misuse services: Evaluation report.

BSARCS should also:

- Work with the Steering Group to reconsider the systemic goals of ATQ as set out in the current theory of change, to decide which are still fit for purpose.
- Find ways to share the aggregate ATQ data with participants on an ongoing basis.
- Consider the location of ATQ data longer term, to reduce reliance on BSARCS. BMBC commissioners suggested they might host the prevalence data, perhaps sharing it on their website.
- Consider whether the evaluation data indicates potential interest in support and training beyond ATQ, in particular helping other organisations to better support their own staff around trauma.

13. Developing the ATQ model

To further develop and improve the ATQ model in Barnsley and beyond, BSARCS should continue to:

- Find ways to further encourage the attendance at ATQ training by professionals with lived experience.
- Find less resource-intensive ways to support and train ATQ participants, without diluting the core messages.
- Find ways to maintain participant engagement and motivation post training.
- Consider how to minimise those IT issues that cause barriers to engagement, particularly within statutory organisations.
- Find ways to address ongoing lack of confidence in some participants, post-training. One respondent suggested that a communications campaign targeted at professionals might be effective here.

14. Expanding Ask the Question

Staff and strategic interviewees were all keen on rolling out ATQ – or a version of it – beyond Barnsley, ideally with BSARCS playing a significant role. There is evidence of interest: ATQ staff reported expressions of interest in ATQ from other South Yorkshire areas and in places as far as Cornwall. Having trialled ATQ locally, BSARCS has a good basis for rolling out ATQ more widely. When considering expansion, BSARCS should consider the following.

14.1 Learn from what has gone before

Stakeholders suggested BSARCS might find helpful learning from related initiatives, including:

- the experience of introducing routine enquiry around domestic abuse
- the roll out of routine enquiry about peoples' experience of violence and abuse, as part of adult mental health assessments in England
- the 2016 Ask and Act policy around routine enquiry about domestic abuse, in Wales.

14.2 Develop a clear approach

To direct any roll out it would be helpful for BSARCS and partners to develop clear goals and an associated approach for the roll out, perhaps via a simple theory of change. This process would include stakeholders considering the following questions:

- Does ATQ need further piloting?
    - One stakeholder felt that ATQ could still benefit from an expanded pilot, using and building on the learning from the Barnsley initiative. This would allow further testing of the approach in a range of areas, for example rural and urban.

- **What are the aims of roll out?**
  - This will help identify the appropriate approach. For example, if the goal of roll out is system change, then roll out may need to be driven by large, national/regional organisations. If the programme just wishes to build capacity in individual organisations, then this might be led by local organisations.
- **Who are the target organisations for ATQ?**
  - The ATQ pilot has shown there are pros and cons of an open access approach.
- **What is the best level of roll out?**
  - Some respondents felt a regional, South Yorkshire roll out would be desirable. This makes some sense, as BSARCS already has good connections within the region, and is the lead partner in the South Yorkshire ISVA service, delivered in partnership across the region. A roll out regionally may also be more feasible than going straight to a national focus. However, some stakeholders with a regional view were uncertain whether all areas within South Yorkshire would be sufficiently receptive.
  - Others suggested that a thematic or profession-wide approach might be effective. For example, in a separate initiative, the CSA Centre is about to start work with midwives and health visitors. A similar approach would mean BSARCS might target professions that stand to gain most from the initiative.
  - While the aim may be for national adoption of routine enquiry, stakeholders generally felt that further work would be needed before an expansion at this level.
- **What might be a realistic timescale for change**, at both organisational and systemic levels, given the learning from ATQ? What might be expected in future?
- **To what extent is it necessary that ATQ-type training is delivered by experts?**
  - One of the strengths of the ATQ pilot was the experience and expertise of trainers; the longevity and credibility of BSARCS was also a factor in some local organisations deciding to participate in ATQ. Stakeholders felt that, in an ideal world, any ATQ-type training would be led by sexual harm experts with local knowledge and credibility. However, not all areas have such organisations, and not all such organisations would be in a position to take on such a project. This may mean that training needs to be done by people with less experience than the ATQ team, if delivered locally. A staff member summarised the issue here: 'Does it matter who does it? Or does it matter that it's done?'

14.3 Making a stronger case of the value of asking the question

Several strategic interviewees noted the importance of making a good case, probably in economic terms, as to the benefits of asking the question. While work has been done on the socioeconomic costs of sexual harm and domestic violence,[11] respondents were not aware of work having been done specifically on the economic case for asking the question around sexual harm. The extent to which this additional step is necessary merits further debate.

Part of demonstrating the value of ATQ may be collecting better data on the client journey post disclosure, for example with a longitudinal study, to show the extent to which disclosure affects subsequent behaviour and service use. This could potentially be done within Barnsley.

[11] See: Radakin, F., Scholes, A., Soloman, K., Thomas-Lacroix, C. and Davies. A. (2021) The Economic and Social Cost of Contact Child Sexual Abuse. London: Home Office; Devine, Angela & Spencer, Anne & Eldridge, Sandra & Norman, Richard & Feder, Gene. (2012). Cost-effectiveness of Identification and Referral to Improve Safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial. BMJ. https://www.ncbi.nlm.nih.gov/pubmed/22730555; The economic and social costs of domestic abuse Research Report 107 Rhys Oliver, Barnaby Alexander, Stephen Roe and Miriam Wlasny. Home office, January 2019

Respondents noted that any roll out of ATQ – at whatever level – would take time. It was suggested that work on building an economic case might be done at the same time as a regional roll out.

14.4 The train-the-trainer model

BSARCS has created a train-the-trainer package in anticipation of future roll out, and respondents thought there could be interest in this. For example, Survivors Trust has member agencies across the country and their CEO felt many would be interested in running a similar project, with BSARCS support. She felt that their members' involvement may be helpful, as any increase in awareness locally may result in increased referrals to their organisations.

Despite this, several strategic interviewees felt that it was unlikely that voluntary organisations would be able to pay for a train-the-trainer package. Some felt that local authorities might, if it were marketed with a very clear outline of the benefits, and evidence that other councils were coming on board.

14.5 Engaging national decision-makers

Strategic interviewees stressed the importance of a top down and bottom-up approach, including engaging national decision makers. Respondents from national organisations offered support to facilitate conversations with, for example, the Home Office and Ministry of Justice. Local strategic interviewees also suggested working via local MPs to raise the issue in Parliament.

14.6 Funding and sustainability

All staff and strategic interviewees noted the necessity of making ATQ financially sustainable in the longer term. At the time of writing, talks were under way about a partnership funding bid for some form of national roll out, perhaps via a train-the-trainer model and possibly including both PLP and ATQ training.

A BMBC commissioner suggested that ATQ's current funding was insufficient to develop a model for roll out, and that BSARCS should go back to the Council to request additional funding to develop ATQ's plans. That this would be to support a national roll out of a Barnsley-born project would be an attractive offer.

Stakeholders also talked of the importance of continuing to grow the voice of sexual harm in Barnsley, to reduce reliance on BSARCS, and on particular individuals within that organisation and within BMBC.

Appendix: Ask the Question theory of change

Context/problem
Overall aim
Strategic aims
Long-term outcomes
Short-term outcomes
Activities
Assumptions

The "Ask the question" initiative

That all individuals who have been sexually abused are offered appropriate support at the earliest opportunity which will lead to better life outcomes

All professionals understand that asking about sexual abuse is the right thing to do and know how to do this and respond appropriately

- Professionals feel better supported in asking about and responding to sexual abuse
- Professionals feel more confident to ask about sexual abuse
- Professionals are more able to take appropriate action in responding to sexual abuse

All relevant agencies enable their staff to proactively and routinely ask about sexual abuse and respond appropriately

- Agencies improve their service delivery policies and procedures
- Agencies ensure staff and volunteers are appropriate inducted and trained in asking about and responding to sexual abuse
- Agencies improve their data recording around sexual abuse

A sense of collective responsibility across agencies for sexual abuse issues

- Improved cross-agency understanding and communication in relation to sexual abuse
- Increased and meaningful joint working
- Combined data/reports from across agencies in relation to sexual abuse

Increased community support for the initiative

- Local stakeholders understand that increased numbers is not a bad thing
- Less stigma for those who have been sexually abused

Professionals are clearer about the legalities surrounding safeguarding, duty to report etc

Professionals have a greater understanding of the importance of asking about sexual abuse

Professionals have a better understanding of how to respond to sexual abuse

Agencies know how to improve their policies, procedures

Agencies commit to addressing sexual abuse in their work and support their staff to do so

Agencies understand the impact on their own work

Agencies develop information-sharing protocols to support cross-agency working which is client-centred

Greater public empathy and understanding

Increased public understanding that this is an important community issue

Professionals know more knowledge about sexual abuse

Professionals have a greater awareness of their existing skills and abilities

Professionals know more about where they can get support for themselves and for their clients

Agencies support their staff to attend training

Agencies include working with sexual abuse as part of induction

Agencies know how to improve their data recording

Agencies see the value of working together to offer joined-up response

Better mutual recognition of agencies' professionalism to support streamlined referrals

Increased public understanding that anyone can have been sexually abused

Increased public understanding that support can make all the difference

- Training for professionals in relevant services
- Resources for professionals
- Advice line for professionals
- Advising on agencies' policies, procedures, induction and training
- Support with data collection
- Creating a steering group for agencies
- Liaising and communicating with local stakeholders and participating in relevant boards/partnerships
- Developing a sexual abuse strategy for Barnsley
- Public awareness campaigns

This Theory of Change is based on our assumptions that:
- professionals are willing to engage
- agencies are willing to support the initiative and make changes
- locally and nationally we are ready to open our minds
- training to be effective e.g. people ask question skilfully
- that not everyone will want/need specialist support
- that funding is available for specialist support
- this is new ground and we are taking risks
- that support will be available for children who sexually harm