



Embedding Safe to Say: supporting survivors of abuse

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The embedding of Safe to Say into the BSc pre-registration (mental health) nursing programme at University of the West of Scotland (UWS) is resonant with contemporary recovery-focused practice (Scottish Executive, 2006). This recognises that the survivor is an expert in their own experiences and seeks to build trust and develop a therapeutic alliance. The Nursing and Midwifery Council (2010) highlights that mental health nurses need to recognise the need for, and work effectively with survivors of childhood sexual abuse (CSA), as part of their recovery. This is necessary given the potential impact of abuse on people's development of mental health difficulties and their wellbeing (Spataro et al, 2004; Dube et al, 2005; Read and Bentall, 2012).

This evaluation focuses on the mental health students making up the September 2008 to February 2009 cohorts—from three of the UWS campuses. The plan had been for all four campuses to be involved, however, the training was delayed until Year 3 on one campus as a result of accommodation difficulties. Therefore our sample consisted of 94 Year 2 students. As this training was embedded into our pre-registration mental health nursing programme and we were not collecting any individually identifiable student information, it was decided by the University Ethics Committee that ethical approval was not required for this evaluation.

Data collection method

There were two forms of data collection which used both qualitative and quantitative methods. The first component gathered qualitative data which was drawn from the standard Safe to Say evaluation form which students completed at the end of the training. This form asks open questions seeking feedback on various elements including: the learning environment, each activity, the role of the facilitators, the time and pacing of the training. It also prompts students to provide feedback. The second component of the evaluation was a questionnaire of three questions on a likert scale. These were similar to the questions used in the work of Shaw et al (1978) on therapeutic commitment:

ABSTRACT

This is the second article relating to the embedding of Safe to Say into a BSc pre-registration course. The first article (McNay et al, 2012) outlined the format of Safe to Say and its rationale and indicated the need for evaluative research. This article reports on the first two student cohorts that were evaluated. Improvement in the self-perceived confidence and competence of participants was apparent at end of the training and on three-month follow-up as compared to pre-workshop assessment. Qualitative data supports and elucidates the quantitative findings and four clear themes are identified.

- To what extent do you believe that it is legitimate for you to discuss sexual abuse/disclosure in your professional role?
- To what extent do you feel competent to respond to someone who discloses CSA?
- I know where to get appropriate support if complications were to arise following a disclosure of sexual abuse?

Although these questions were similar to those of Shaw et al (1978) they were derived in this context from the key reasons cited by staff in studies for not working with disclosure. These being: lack of training, it not being part of their role and fear (Nelson and Hampson, 2008). Students were therefore requested to circle the number on the scale which they felt corresponded most

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to their view—from 1 (not at all) to 5 (completely).

Students were asked to complete this prior to the training, at the end of the training and at three months post-delivery of the training. Of the 94 students who undertook the training, 71 were available to complete the three-month evaluation. The difference in the numbers of students at three-month follow-up were as a result of a number of factors including: students on academic suspension (from Year 2 to Year 3 progression), interruption for personal reasons, maternity leave and students being absent from class when the questionnaire was re-administered. Significant improvements in the ratings for questions 2 and 3 were evident post-workshop and these were maintained at three-month follow up.

Method of data analysis

For component 1, the qualitative data, thematic analysis was used. The principle investigators read and re-read the data and discussed themes which best matched this data were parsimonious and comprehensive. Each group is made up of different individuals and therefore has its own unique dynamics and discussions although remarkable similarities could be found on analysis in terms of what each group valued about the processes involved.

For component 2, the quantitative data, analysis of variance (ANOVA) was used with each question representing the dependent variable and observation point being the independent variable at three levels. Consequently, three within-subject one-way ANOVA's were conducted. Following the observation of an overall statistically significant *F* value, post-hoc comparisons were conducted to determine where the significant differences were to be found at each combination of observation points. The Bonferroni correction procedure was used to adjust *p* to control potential type I error of multiple comparisons.

Results: component 1

Thematic analysis of the qualitative data from student evaluations is expressed in the following four themes. These themes elucidate how the barriers to staff responding to disclosure identified by Nelson and Hampson (2008) are addressed during the training. Illustrative extracts from the students' statements are included.

Safety and bonding

- 'Excellent I felt safe and supported the lecturers were open honest and accommodating regarding our reactions and comments'
- 'It was really useful to learn that the fears I had were the same as others'
- 'Learning about issues I would normally avoid'

- 'Made it all seem very real it was upsetting but I was glad I learned this in a safe environment rather than on placement.'

Further discussion and context

The design and process of the course is deliberately set up to mirror the establishment of a safe relationship for worker and survivor who discloses. It begins with the setting out of agreed ways of working for safety that are essential at the start. The process is then followed throughout, naturally placing more potentially exposing exercises once the group has gelled and completing with how we look after ourselves as workers. Two lecturers are involved in Safe to Say training which allows for full support. It is not uncommon for participants to disclose within the groups and it is vital to role model effective responses. Whenever possible we strive to ensure that both genders are represented in the training pairs.

Space to think and feel

- 'Gave plenty of time for reflection'
- 'Found the pace very helpful, I was comfortable, which I felt I needed due to the nature of the training course'
- 'Excellent use of silence I felt we had enough time to decide if/what we wanted to discuss'
- 'Small groups and format very helpful-so different to large classes and lectures'

Further discussion and context

Again we are mirroring the way of working that enables survivors to disclose. By giving the group members' space to talk and reflect, the space is theirs—and they fill it. If there were more exercises then we would be filling the space and taking the focus away from them. By giving the group space, we demonstrate that we have faith in their ability to do this. Survivors want someone who will give them time and space to speak. A minority of evaluations did indicate, however, that some students found the pacing to be too slow.

Feeling enabled

- 'I feel better equipped to deal with it and I know who to return to for support'
- 'To know this is a subject which should be approached'
- 'I now feel able to work with people disclosing sexual abuse whereas before the course I did not want to pursue that type of work.'

Further discussion and context

During the training participants are facilitated to realise that they do have the skills and knowledge required to support people who want to disclose and that this is a legitimate part of their role as mental



health nurses.

Hidden curriculum

- ‘I feel this course will influence all my practice and has made me more self-aware and less judgmental, aware of others’ needs’
- ‘Have learned about many transferable skills too and have increased in self-awareness’
- ‘I massively value this overall experience and will value the very deep conversations and the insight it has given me has further reinforced my beliefs about how mental health nurses should approach their work.’

Further discussion and context

Although this training is about working with adult survivors who disclose CSA the skills of engagement, the ability for workers to reflect on themselves and what issues may get in the way of good practice, the ability to stay with survivors in their pain and requisite values transfer widely in the role of the mental health nurse in recovery focused practice.

Results: component 2

The mean scores and standard deviations for each question at each observation point are in *Table 1*. A graphical representation of descriptive mean score data for each question is shown in *Figure 1* which reveals an increase in each score following training and a relatively modest decline, though still above baseline, at observation point 3. A highly significant effect of the training programme was observed for question 1, $F(2,140) = 6.55, p = 0.002$, question 2, $F(2,140) = 87.08, p < 0.001$ and question 3, $F(2,140) = 120.49, p < 0.001$, respectively. Post-hoc comparisons were conducted on all three questions (*Table 2*) and revealed that, with exception of question 1, scores remained significantly higher at the third observation point compared to the first. However, in relation to question 1, though the training had a significant impact on this score when assessed at observation point two, this was not maintained at the three-month observation point. It is also noteworthy to highlight that scores all fell significantly following completion of training from observation point 2 and the final observation point.

The qualitative data shows the value placed in the training by mental health student nurses. It succeeds in providing a narrative of how the three aims of: legitimacy, competence and appropriate support were achieved. Participants appreciate that they gain transferable skills and knowledge which can be applied to other aspects of mental health nursing which are based around relationship building and concordance. Concordance being a process of collaboration, based on shared expertise, mutual respect and perseverance towards agreed outcomes (Marland et al, 2012).

In relation to the non-significance of the

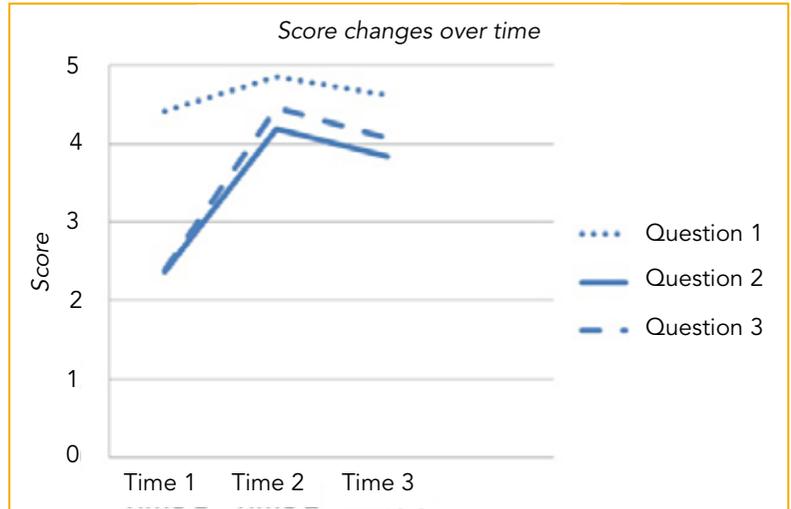


Figure 1. Mean scores for each question as a function of each observation point

improvement from observation point 2 compared to point 1 for role legitimacy, it needs to be taken into account that compared to aims 2 and 3 that aim 1 had a much higher starting score. An important consideration arising from the quantitative data overall is to understand why the impact of training was not maintained to the same level at point 3 compared to point 2. It may be that exposure to the clinical environment may have not reinforced the learning from training. This may arise naturally from mental health student nurse practice placements which still have staff who exhibit the attitudes and fears towards working with disclosure as found by Nelson and Hampson (2008) which led to the need

	Time 1 Mean (SD)	Time 2 Mean (SD)	Time 3 Mean (SD)
Question 1	4.44 (0.80)	4.83 (0.45)	4.62 (0.62)
Question 2	2.38 (1.09)	4.17 (0.61)	3.84 (0.69)
Question 3	2.35 (1.06)	4.45 (0.65)	4.07 (0.78)

		P value
Question 1	Time 1 < Time 2	0.002*
Question 1	Time 1 < Time 3	0.434
Question 1	Time 2 > Time 3	0.05*
Question 2	Time 1 < Time 2	0.001*
Question 2	Time 1 < Time 3	0.001*
Question 2	Time 2 > Time 3	0.009*
Question 3	Time 1 < Time 2	0.001*
Question 3	Time 1 < Time 3	0.001*
Question 3	Time 2 > Time 3	0.003*

Significance is denoted by *



KEY POINTS

- Safe to Say training led to significant improvements in self-perceived competence in dealing with disclosure when evaluated immediately post training and on three-month follow-up
- Training led to students reporting significantly more confidence in how to seek help if problems arose in dealing with disclosure
- Safe to Say training led to students becoming more affirmative in their legitimacy in dealing with disclosure when evaluated immediately post training and on three-month follow up but the change was not to significant levels at three-month follow up
- Qualitative evaluative data suggests that the safe space created by the training is highly valued by students and is congruent with their role in responding to disclosure
- Quantitative evaluative data highlights the desire for more methodologically sophisticated longitudinal mixed-methods research in this area

for the training in the first place. This is in spite of the Scottish Government's *CEL_41 Gender-Based Violence Guidelines for Implementation* which among many aspects set out that mental health services should introduce routine enquiry for CSA, supported by staff training and reviewed documentation by 2010 (Scottish Government, 2009). Although this should have been attained by 2010 anecdotal accounts reflect that progress has been inconsistent nationally. It may be therefore that when embedding Safe to Say more cognisance should have been given to the need to offer on-going support to mental student nurses who may have found themselves out of step with normative contemporary practice. Further evidence for the provision of ongoing support is the observation at the third time point of a non-significant decline in scores (on two questions), a characteristic which is not uncommon in competency training without post-training refresher intervention. This indicates a need for liaison between those who provide education to mental health workers and providers of services.

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Further developments

There is a need to extend the longitudinal research to include how newly qualified practitioners who have completed the training influence practice. We propose that this takes place by mixed methods of questionnaire and focus groups at end of year 1 and again at end of year 5. A limitation of the present study is the short time frame for training evaluation, future studies may usefully examine the impact of training over a longer period. This will be valuable to determine the integration of the underlying philosophical tenets of Safe to Say within the context of everyday practice. A further limitation of the study was implicit to the methodology itself, which necessarily circumscribed a simple and unsophisticated approach to the collection of key quantitative data. Reflecting on the significant differences observed during the course of the study a compelling rationale now exists to develop the evaluative framework with more robust, standardised and validated measures.

Further research to address these issues is required to truly determine the potential scope and impact of the training as a potential core component of mental health practice provision beyond the current context. It would also be useful in the qualitative arm of this future study to explore helping and hindering factors encountered by newly qualified practitioners. As Routine Enquiry (Scottish Government, 2009) influences practice, there may be room for some optimism in this regard as taboos in this area become eroded.

Conclusion

Both the qualitative and quantitative data confirm that Safe to Say training with under graduate pre-registration mental health student nurses successfully addresses the needs identified by Nelson and Hampson (2008). It remains to be seen, however, if these gains will be sustained once these student cohorts graduate and take up post. A further longitudinal study will be conducted and the reporting of the results will form Part 3 of this series. **BJMHN**

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