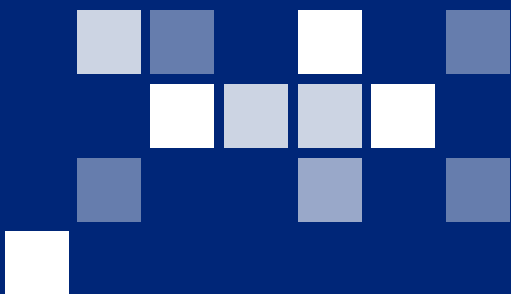




# Enquiring about Childhood Sexual Abuse: Obstacles and Potential Solutions

Aberdeen Foyer is a local charitable organisation working to prevent and alleviate youth homelessness and unemployment.



A pilot data collection project commissioned by the Scottish Government for the National Strategy for Survivors of Childhood Sexual Abuse.



# **Enquiring about Childhood Sexual Abuse: Obstacles and Potential Solutions**

## **The Experience at Aberdeen Foyer**

Aberdeen Foyer is a local charitable organisation working to prevent and alleviate youth homelessness and unemployment

Report and Recommendations

Alison J Lowit



## Acknowledgments

I would like to thank all Aberdeen Foyer staff who generously contributed interviews and background information for this study.

I would also like to thank the following people; Dr Andrew Moskowitz (academic advisor) for his advice and support throughout this project; Jennifer Upson for representing Aberdeen Foyer and contributing invaluable information for the report; Sarah Nelson for her guidance and counsel and Dr Linda Treliving for her help.

I would like to thank staff from the following outside agencies who spoke to me and told me about their organisations: The Corrieneuchin Project (Children 1st), Aberdeen Counselling and Information Service (Mental Health Aberdeen), Caledonia Youth, Rape & Abuse Support, the Psychotherapy Department (The Royal Cornhill Hospital) and The Richmond Fellowship.

I would like to express my gratitude to the Scottish Government for funding this research project.

# Contents

	<b>Page</b>
<b>Acknowledgements</b>	2
<b>Glossary</b>	5
<b>Executive Summary</b>	6
<b>1. Introduction</b>	
1.1 Origins and Background	12
1.2 Aims of Pilot	12
1.3 Origin of and Reasons for Project	12
1.4 Aberdeen Foyer as Pilot Site	12
<b>2. Literature Review. Why is it important for agencies to recognise and address CSA and its effects?</b>	
2.1 Background	17
2.2 Why Ask?	20
<b>3. Methods</b>	
3.1 Methodology	22
<b>4. Findings: Aberdeen Foyer</b>	
4.1 Assessment of Aberdeen Foyer's current information gathering and assessment procedures with regard to sexual abuse	23
4.2 Assessment of staff attitudes toward asking about abuse, and the impact on staff attitudes and confidence of targeted training sessions	30
4.3 Conclusion	42
4.4 Recommendations	44

<b>5. Findings: Specialist Support Outside Aberdeen Foyer</b>	
5.1. Assessment of potential specialist support available for survivors out with Aberdeen Foyer	49
5.2 Recommendations	50
<b>6. References</b>	52
<b>7. Appendices</b>	
A: Interview schedule	58
B: Training course details	65
<b>List of Tables</b>	
Table 1: Aberdeen Foyer Staff Interviews	23
Table 2: Current Rates of Asking About CSA	30
Table 3: Staff Views on Routinely Asking about CSA	31
Table 4: Staff Views on Current Level of Training to Ask About CSA	35

## Glossary

AF = Aberdeen Foyer

CSA = Childhood Sexual Abuse

ICDRS = Integrated Community Drug Rehabilitation Service

SLWG = Short Life Working Group

WHO = World Health Organisation

PTSD = Posttraumatic Stress Disorder

ACIS = Aberdeen Counselling and Information Service

SW = Support Worker

SSW = Senior Support Worker

CORE = Clinical Outcomes in Routine Evaluation

## Executive Summary

A pilot data collection project with Aberdeen Foyer (AF) was commissioned by the Scottish Government as part of the National Strategy for Survivors of Childhood Sexual Abuse (CSA), under the objective of improving responses to the needs of CSA survivors in Scotland.

It aimed to improve responses to the needs of CSA survivors using AF, through recommending improvements to current means of data collection; enhancing staff confidence in addressing CSA issues with service users; and assessing needs for general and specialised support.

The principal objectives were to assess:

- Current information gathering and assessment procedures at AF
- Staff attitudes towards asking about abuse both before and after attending a targeted training session
- The availability of potential specialist support for CSA survivors out with AF.

The methods utilised were:

- A review of the application and assessment forms used by the various departments within AF
- Face-to-face, semi-structured interviews with AF staff to record their views about asking and responding to CSA.

Frontline staff were interviewed both before and after attending a “Safe To Say” training course, to find out how it had impacted on their attitudes and their practices.

The principal findings of the project were:

1. None of the application forms used by AF contained any direct questions about CSA or any other form of childhood maltreatment. Generally staff do not routinely ask about CSA, and many staff have never asked their clients about CSA.
2. Both within individual departments and across the whole organisation there was no standardised method for recording CSA data, and no standardised location for storing such data.
3. Only the client and staff directly involved with the client had access to any CSA information that was collected. Information was only shared on a “need to know” basis, and only if the client wanted to be referred would it be passed to others within the organisation.
4. Staff accessed other colleagues’ skills, knowledge and expertise in dealing with CSA and surrounding issues, when appropriate. In particular, staff used the expertise of Foyer Health effectively. Supervision was also used to get help if an issue was troubling a support worker.

5. The different programmes within AF were examined to consider whether it would be appropriate to insert questions addressing sexual abuse in their existing interview forms:

- The Training for Work and Prince's Trust programmes and the Learning Houses have a focus on helping clients acquire skills in employability, learning and teamwork. This makes the addition of questions on CSA in their current forms neither appropriate or relevant. However, after the other changes have been piloted, the need for the CSA question in skills and employment programmes may be reassessed.
- Foyer Housing and the ICDRS, Lifeshapers and Progress2Work programmes work with clients who frequently have healthcare and lifestyle issues that may be a consequence of CSA. The application forms on these programmes already include a section on abusive relationships and it would be appropriate to enquire about CSA on these programmes as well. These forms should be expanded to include specific questions about CSA.
- The Clinical Outcomes in Routine Evaluation (CORE) therapy assessment form already used by Foyer Health's counsellors presents an opportunity to explore 'trauma and abuse', and recently it has been decided that routinely asking sensitively about CSA during the assessment is going to be the general practice for all counsellors working at AF.

These changes to interview forms would help standardise procedures relating to gathering and recording information about CSA, and make early recognition of CSA more likely.

6. Prior to attending the training course, staff were asked whether they felt that the routine assessment of their clients should include questions about CSA. The results are detailed below:

- Twenty-nine percent (29%) of staff felt they should always ask about CSA, because a history of CSA could impact on all aspects of the client's needs, and having this information early on could greatly increase the likelihood of best outcome for the client.
- Thirty-eight percent (38%) of staff felt they should sometimes ask about CSA provided the client gave some indication that they wanted to disclose.
- Thirty-three percent (33%) of staff felt they should never ask about CSA. This response was generally from staff that were part of Foyer Learning who felt asking about an abusive past was not appropriate in the context of the service provided to their clients.

7. Staff attitudes towards asking and responding to CSA before and after the training courses were explored. The results are below:

- Before the training course, eighty percent (80%) of interviewees were concerned that they lacked the skills and expertise to judge when to ask, how to ask and how to respond to a client's disclosure in an appropriate supportive way.
- After the training course, eighty-seven percent (87%) of interviewees felt they had benefited from the training, that their awareness of the issues had increased and their confidence was significantly enhanced. Sixty percent (60%) of interviewees thought they now had sufficient training to be able to ask a client about a CSA history; twenty-seven percent (27%) of interviewees, all from the first training course, felt they needed further training on how to ask a client about CSA. This further training, in the form of role-play, was included in a second presentation of the training course.

8. The only specialist support identified specifically for CSA in Aberdeen and the surrounding area is the Children 1st's Corrieneuchin project; no dedicated service for CSA survivors over the age of 18 was identified in the area. A number of services were found which offered counselling and advice on a variety of issues, including CSA: Aberdeen Counselling and Information Service (ACIS), Caledonia Youth, The Royal Cornhill Hospital, and Rape and Abuse Support.

# Recommendations

## For Aberdeen Foyer:

1. The assessment form for Lifeshapers and Progress2Work should include appropriate questions about CSA, and other types of childhood maltreatment.
2. Foyer Housing should gather information about CSA, and other types of childhood maltreatment, during the 1-month induction period.
3. The Integrated Community Drugs Rehabilitation Service (ICDRS) should routinely ask about CSA.
4. Staff should consider asking questions about CSA more than once, if it seems appropriate, to ensure there are further opportunities to disclose when the person is ready.
5. Aberdeen Foyer should move towards developing a single shared assessment form for all appropriate services.
6. If a client spontaneously discloses, or tells a support worker about their abuse history, this information should be recorded in the client's file (with their knowledge and agreement).
7. There should be procedures in place, and funding for the appropriate staff, so a central database can be developed to gather and store anonymous CSA data from all of Aberdeen Foyer's services.
8. If a client is referred to the in-house counselling service, questions related to CSA should be asked at the initial assessment.
9. A CSA specialist based within Aberdeen Foyer's Health Team should be established, along with appropriate funding for the post.
10. Due attention and consideration should be given to the way questions about CSA are developed and used.
11. Staff need to be aware of resources for specialist counselling and support should their clients require referral outside of Aberdeen Foyer.
12. All staff working with clients at Aberdeen Foyer, and staff working in services with a high prevalence of survivors, should have access to CSA training.

13. Targeted training courses should include more information about how to sensitively ask about CSA.
14. Organisational policy should include procedures that will be effective in providing support to someone when they disclose CSA and guidelines so support workers know what to do with the information disclosed.
15. Training needs to be backed up by education to promote a general awareness of CSA.
16. Funders need to provide extra resources for support workers and managers to enable staff to meet the needs of clients more fully.

## **For Outside Services:**

1. A specialist service for male and female CSA survivors, including an outreach service, should be established in Aberdeen.
2. Existing services need more dedicated funding to employ more skilled specialists, to bring down waiting lists and to continue doing the valuable work they already do.
3. Closer communication between different services, clear referral routes, and information sharing protocols need to be established in order to provide the best service for clients that are being referred from one service to another.
4. A supported and well-resourced self-help group for survivors of CSA should be established in Aberdeen.
5. A service for survivors of CSA in the mental health system should be established at The Royal Cornhill Hospital. This should be a multi-disciplinary team focusing on childhood trauma origins as well as working to alleviate the post-traumatic symptoms brought on by CSA.

# 1. Introduction

## 1.1 Aims of Pilot

To improve responses to the needs of CSA survivors using Aberdeen Foyer (AF), through recommending improvements to current means of data collection; through enhancing staff confidence in addressing CSA issues with service users; and through assessing needs for general and specialised support. This pilot study could potentially offer guidance to other organisations working with vulnerable people with high risk of childhood sexual trauma.

## 1.2 Objectives

1. Assessment of Aberdeen Foyer's current information gathering and assessment procedures with regard to sexual abuse, with recommendations for modifications if needed.
2. Assessment of staff attitudes toward asking about abuse, and the impact on staff attitudes and confidence of targeted training sessions.
3. Assessment of potential specialist support available for survivors out with Aberdeen Foyer.

## 1.3 Outcomes

1. Improve recording systems for CSA by suggesting more standardised, yet sympathetic, ways in which a CSA background can be explored.
2. Improve staff skills, knowledge and confidence in relation to supporting survivors.
3. Identify agencies out with AF that can provide the specialist skills or services appropriate to the needs of survivors, such that stronger links can be developed in the longer term.

## 1.4 Origin of and Reasons for Project

This data collection project was commissioned and funded by the Scottish Government (Health Department, Adult Care and Support Division) as a key part of the National Strategy for Survivors of Childhood Sexual Abuse. The Strategy was launched in 2005, and arose through the long-term efforts of many groups and individuals including the Scottish Parliament's Cross-Party Group for Adult Survivors of CSA. In 2003 the then Scottish Health Minister Malcolm Chisholm set up a Short Life Working Group (SLWG) to consider the care needs of people who had survived childhood sexual abuse. This SLWG identified needs and gaps in the current provision of services, and its report led directly to the launch of the National Strategy by the then Health Minister Lewis Macdonald.

Among the gaps in knowledge and provision which the SLWG report had identified was an absence of recorded data about survivors' needs and problems, which could provide an evidence base for new or better services for a group of people who were often socially excluded. When the National Strategy document (1) was published better data collection became one of the priorities for the first years of implementation.

The National Strategy noted that:

- Only an estimated one percent (1%) of sexual abuse histories were recorded in health records, even though CSA was a risk factor for a wide range of physical and mental ill health.
- There was no clear requirement on services to identify those affected.
- CSA was not widely enough recognised as contributing to major issues such as self-harm, substance misuse and homelessness. The emphasis by health services was on treating symptoms, often ineffectively at a large cost to resources, without addressing the underlying issues.

Research such as that conducted by Nelson (2) also highlighted that many staff felt inadequate, unsafe or anxious about enquiring for sexual abuse histories in patients or clients, seeing it as opening "a can of worms". In contrast, most survivors interviewed appreciated being asked about their abuse histories and felt frustrated that no one had previously done this and linked CSA to problems they had been having. It was concluded that finding better ways of gaining information sensitively from CSA survivors, in order to better assess their needs, would have to involve confidence-building work with staff.

Extensive discussions were held with AF with a view to this data collection pilot project. The National Strategy team were interested in pursuing a project with AF for a number of reasons including:

- Its established standing and reputation as a quality organisation working with a wide range of young people.
- The likelihood that its population – young people with difficulties such as mental health problems, substance misuse, homelessness and family upheaval – would have a high frequency of childhood trauma.
- Aberdeen Foyer's working links with a wide range of organisations and services in Aberdeen and elsewhere.

## Aberdeen Foyer: Aims

Aberdeen Foyer (AF) is a charitable organisation working to alleviate and prevent youth homelessness and unemployment in Aberdeen and Aberdeenshire. They provide supported accommodation and access to a range of education, training and employment opportunities and community health services for young people and their communities.

AF recognises that supporting homeless and disadvantaged people requires addressing many of the underlying causes of homelessness and disadvantage, which includes providing programmes to develop life skills, address addiction problems, provide learning opportunities and enhance employment prospects. This integrated approach provides the best opportunity for clients to take the next steps toward independent living, learning and work.

Foyer Housing is open to clients aged 16-25 and includes single parents, care leavers, ex-offenders and those who have or have had substance misuse issues, learning difficulties or mental health issues. In addition learning and training opportunities are provided to all age groups in disadvantaged communities in the Grampian area.

## Aberdeen Foyer: Services and Programmes

Here follows a brief description of the programmes run by Aberdeen Foyer.

### Foyer Housing

AF has six accommodation sites throughout Aberdeen City and Aberdeenshire providing eighty (80) tenancies for 16 – 25 year olds who have been homeless or at risk of homelessness. Each site has a balanced community – substance misuse issues, mental health issues, young offenders, care leavers, single parents and those with mild learning difficulties. Each tenant works with a support worker (SW) to develop an action plan to address presenting needs. For example: health, training, benefits and education.

### Foyer Learning

The programmes run by Foyer Learning have up to 1,000 participants each year in Aberdeen City and Aberdeenshire.

**Lifeshapers** is a 12-week programme aimed at those with a history of substance misuse. The programme consists of various components to enable participants to work toward a healthier, happier future. Lifeshapers is based on an equal division of work, rest and play and includes a focus at the end of the programme on the next steps to education, training and employment.

There are 9 programmes each year, three in Aberdeen City, three in both Peterhead and Fraserburgh, with approximately 10 programme participants. Age range: 16 – 34.

**Progress2Work** is a work support service to help individuals with a history of substance misuse to overcome barriers and to enter into employment, mainstream education and training projects. There is up to 100 clients registered per year. Age range: 18 plus.

**Prince's Trust** is a 12-week personal development programme. The aim of the programme is to boost confidence, motivation and build a healthy team spirit to prepare individuals for moving into further education, training or employment. Aberdeen Foyer currently operates six programmes per year in two different locations. Age range 16 – 25.

**Learning Houses.** There are five Learning Houses, 3 in Aberdeen City and one each in Fraserburgh and Peterhead. They are sited in areas deemed to be deprived areas and local people attend the Learning Houses as they see fit to work on IT skills, adult literacy / numeracy and help with job searches / CV preparation, confidence building, interview skills and health and financial advice. Age range 16+.

**Training For Work** consists of seven separate training strands: Construction, Oil & Gas Industry, Care, Hospitality, Retail, Warehousing and Administration work. These programmes are designed to assist individuals to realise their job aspirations in their chosen field through a combination of training and work placements to allow assessment by employer and potential employee. Age range 16+.

**Build & Train** is a programme that will offer New Deal participants the chance to achieve job aspirations within the construction industry. The programme runs for 13 weeks. Age range 18+.

**Platform2Work** is a programme offering participants the chance to achieve job aspirations within the Oil & Gas industry. The programme is available to a wide range of participants although specifically target people who have been unemployed from 0-24 months and who are from a wide range of backgrounds. Platform 2 Work is available throughout the Grampian area to people who have expressed an interest in the industry. Age range 18-25.

**Integrated Community Drug Rehabilitation Service (ICDRS)** is a partnership between four voluntary sector organisations, Aberdeen Foyer, Aberdeen Cyrenians, Phoenix Futures and Drugs Action and Aberdeen City's substance misuse service. ICDRS aims to support people in Aberdeen who have already taken steps to change their drug use and want to work towards changing their lives in other ways. It is open to anyone who is prescribed an opiate substitute, e.g. methadone, and who wants to move away from drugs and who feels they would benefit from an overall package of rehabilitation support to help them with a range of issues. It provides drug counselling, involvement in physical activity, advice and support on accommodation, budgeting, debt and other social issues and support to access education, training and employment. Age range 16–65.

Some AF clients may just participate in one programme, but others may go through a number of programmes on the road to independent living, education and employment.

## Foyer Health

Aberdeen Foyer's health team, Foyer Health, provides a wide range of community health services for clients and staff which cover mental health and wellbeing, lifestyle, substance misuse (drugs and alcohol) and sexual health. Aberdeen Foyer also works in partnership with NHS Grampian, with seconded health visitors at the housing sites offering improved access to primary care services.

Some examples of what Foyer Health provides are: lifestyle and wellbeing assessments, awareness raising workshops, art workshops, groupwork, support with healthy eating, access to physical activities, access to complementary therapies, smoking and cannabis cessation, counselling and relapse prevention and staff training and consultancy.

## **2. Literature Review. Why is it Important for Agencies to Recognise and Address CSA and its Effects?**

### **2.1 Background**

#### **Prevalence of CSA**

Epidemiological findings indicate that CSA occurs across most cultures, countries and social classes and CSA is recognised as a major cause of morbidity and mortality. The World Health Organisation (WHO) reports that CSA is common in both females (20-25%) and males (5-10%) (3), and is even more prevalent in substance misuse (4, 5), homeless (6, 7) and psychiatric populations (4, 5, 8, 9). Prevalence rates range from 20-62% for women, and 5-31% for men (the higher prevalence rates tend to be found in studies of specific groups, for example psychiatric or substance misuse populations).

#### **Long-term Outcomes of CSA**

Experiencing CSA often has a negative impact on health and well being. CSA is a risk factor for a wide range of profound life issues, including mental health problems, substance misuse, sexual difficulties and relationship difficulties (10, 11). Also the betrayal of trust, which is often a characteristic of CSA, can affect survivors' abilities to form stable personal and professional relationships (12). Self-punishing and avoidance behaviours such as eating disorders, self-mutilation, substance misuse and risky sexual activities are common and risk-taking behaviours make survivors vulnerable to revictimisation (13).

Survivors have varying degrees of resilience; differences in severity, frequency and type of sexual act, differences in the relationship with the perpetrator, and levels of family support all influence the effects of CSA.

#### **Mental Health Outcomes**

Survivors of CSA may experience a wide range of mental health problems including depression (14, 15), post-traumatic stress disorder (PTSD) (16, 17), personality disorder (18, 19), psychosis (20, 21), anxiety (22, 23), and substance misuse (24, 25). The literature also demonstrates clear evidence of the self-destructive effects that CSA can have for some survivors: self-mutilation (26), eating disorders (27) and suicidality (28, 29, 30). Furthermore, psychiatric patients with a history of CSA often have earlier first admissions, longer and more frequent hospitalisations are more likely to self-harm, receive more medication and have higher symptom profiles (31, 32, 33). The relationship between childhood abuse and mental health problems remains strong even after controlling for potential mediating factors such as socioeconomic status, current relationship violence, parental substance misuse and psychiatric history, and other childhood traumas, for example, the death of a parent, (3, 4, 33).

## Consequences of Non-Recognition

There is growing evidence that the experience of childhood abuse affects the way adult patients respond to treatment for various mental health disorders (34). This is especially so for patients with depressive disorders. Research has documented a much higher prevalence of survivors of childhood abuse in groups of people with treatment-resistant depression, (34). Research into the impact of child abuse on the clinical course of bipolar disorder has found that a history of child abuse is linked to a more complex and adverse course of the disorder, with higher suicide rates, (35). There is also substantial evidence that a history of abuse is associated with more complex psychopathology, because of higher co-morbid substance misuse and suicidality, which complicates all types of psychiatric illness, (36, 4).

Many survivors who seek mental health treatment have a “disguised presentation” (37). Professionals may fail to recognise the link between the presenting problems and a history of childhood abuse, and make a diagnosis without acknowledging this important contributory factor (2, 37). The complex needs of many survivors with a diagnosis of “personality disorder” means some survivors are given treatment that is fragmented or incomplete due to the lack of specialist services (38). Recognition of an abuse history is crucial for successful treatment or lifestyle change. Unless the underlying difficulties relating to CSA are addressed, treatment is unlikely to be effective.

## Physical Health Outcomes

Physical medical problems are often over represented among individuals who have experienced CSA. For example, studies have found CSA to be associated with the experience of generalized pain (39), pain in the pelvic and genital area (40), gastrointestinal problems (41), obesity (42), gynaecological problems (43), bowel disease (44), and medically unexplained symptoms (45).

There have been numerous reasons suggested for the high proportion of physical health problems suffered by CSA survivors (46). For example, some survivors’ poor physical health is the result of direct physical injury or infection that happened at the time of the abuse, or as a result of early pregnancy, miscarriage or abortion (45). Another factor that could be related to survivors’ poor health is inadequate personal health care. Survivors often have coping mechanisms such as substance misuse that contribute to ill health, and clinical depression and low self-esteem can result in poor diet, lack of exercise or inadequate self-care that also impact on health (45).

Many survivors use medical services more frequently than average, often with unproductive results, which results in increased health care costs (47).

## Social Outcomes

The social consequences of CSA have also been documented. There is good evidence that CSA can lead to problems in education (48, 49, 50), homelessness (6, 51), revictimisation (52), and antisocial (53) and high-risk sexual behaviours (52). As noted previously, CSA also increases drug and alcohol use. Many of these problems are interrelated: early substance misuse affects school attendance and performance, and increases the likelihood of risky sexual behaviours, such as unprotected sex and multiple partners. It also increases the risk of antisocial behaviour, revictimisation and homelessness. However, other factors associated with CSA also impact on all of these social consequences. Low self-esteem, flashbacks, dissociation, and panic attacks all have a negative impact on life chances. These factors contribute to interpersonal conflict, which is a key catalyst for homelessness (54, 55).

CSA may also be a factor leading people to land in prison. Research has found high rates of CSA in prison populations, both for men and women (56, 57). Briere et al. (14) described individuals who have experienced CSA as more likely than non-abused or physically abused individuals to commit violence against others, and Brodsky et al's. research, (58), concluded that abuse in childhood could be a risk factor for the development of trait impulsivity and aggression. CSA contributes significantly to substance abuse and violent behaviours that can often lead to criminality.

## Resilience

Most research into the long-term effects of CSA has concentrated on the negative outcomes that survivors often experience. Some survivors of CSA appear to have few symptoms or mental health problems. Understanding why this is the case may help to identify resilience factors.

Resilient factors can be grouped into two categories: those that are associated with the child's own abilities, and those that are associated with the child's environment. Variables associated with resilience in adult survivors of CSA are: above average cognitive abilities, high self-esteem, a strong sense of being in control of life events, (internal locus of control), blaming the perpetrator rather than themselves, healthy ego development (59), female gender and non white ethnicity (60). Variables associated with protective environmental factors are: a stable living situation (60) a high level of parental care, good interpersonal relationships, fewer relationships with delinquent and substance misusing peers (61), and a positive school experience (62). Factors found to promote resilience in the survivors adult life are: having support from a sympathetic and understanding partner and supportive relatives and friends who promote the survivor's self worth while assuring them they are not to blame (12).

## 2.2 Why Ask?

### Difficulties in Disclosure

Although many forms of child maltreatment can have dire consequences, the person sexually abused in childhood carries the additional burden of the “guilty secret”. Secrecy surrounds the CSA survivor. Societal taboos against talking about sexual subjects are often reinforced by survivors’ own feelings of shame, guilt, fear and betrayal, generated by the sexual abuse (10). Perpetrators’ threats of violence, promises to stop loving a child, or telling a child that they will get into trouble if they tell, can hold a child to secrecy.

Clients who have experienced CSA can be slow to trust and may take some time to engage in a relationship or make the most of what is being offered to them (63). Research shows that if a survivor does disclose, the average time before disclosure is between 9.5 – 16 years (64).

Childhood maltreatment is associated with so many important mental, physical and social problems that unless we routinely ask about childhood experiences in projects trying to address these problems, we obscure the role abuse plays in certain illnesses and behaviours. Consequently help or treatment given to a client may focus too much on one aspect of their problem, while ignoring another of fundamental importance.

In all areas of statutory and non-statutory sectors where professionals are working with problems related to mental, physical and social care, some of the clients will have been abused. Asking questions relating to CSA helps survivors recognise that talking about their experiences is important. Organisations asking about many aspects of a client’s life, but not asking about CSA, may convey to the client that CSA is unimportant.

Research in the last few years has strongly recommended that CSA and other forms of child abuse should routinely be asked about in appropriate settings (63, 64, 65). However, research also shows that these recommendations are not currently being implemented (33, 63, 64). This is true even when a section about abuse is included on the organisation’s client evaluation form (33, 63, 64).

## Barriers to Asking

Several studies have looked at the reasons why professionals do not ask about CSA (63, 64, 33). These include:

- Fear of upsetting or offending the client.
- Fear of opening a “can of worms” whose result they may be unable to control
- Fear of inducing “false memories”.
- Beliefs that CSA is “too rare” to ask about or that clients have too many other more immediate needs.
- The client being male.
- Lack of training in how to ask and how to respond.

## What Survivors Value

Qualities that staff possess that survivors find extremely helpful, or even life changing, are summarised in Sarah Nelson’s 2001 (2) report exploring the care needs of women survivors of CSA:

- Being secure and firm about boundaries, but relating to the client with warmth and kindness.
- Being informed or aware about the main effects of CSA trauma, or keen to become so, and examining their own personal issues around working with sexual abuse.
- Working non-hierarchically, consulting respectively with survivors about what their main needs were and what services could offer – trying to reach joint decisions about whether the service would be helpful, or about the work they could do together. Allowing survivors to talk about their abuse history whenever they wished, but not pressurising them into doing so.
- Being skilful, flexible, imaginative and eclectic, and sometimes “breaking the rules” of their service in the client’s interest.
- Neither hiding behind confidentiality nor breaking it insensitively. Consulting with the client about what information ought to be shared and what need not be.
- Not fearing to persist in asking tactfully if a client had experienced CSA and having the courage to stay with clients through distressing, frightening symptoms or behaviours.
- Being prepared to work consistently over a period of time – although brief contacts had sometimes proved a dramatic catalyst to survivors changing their lives. (S. Nelson, Beyond Trauma, p116)

## 3. Methods

### Review of Assessment Forms

Blank application and assessment forms were collected from the various departments of AF. The forms were examined to find out what type of information was collected for the different programmes, and whether information about CSA or other types of childhood trauma was investigated. AF staff were interviewed and documents about the different programmes were reviewed to get information about AF's programmes and services. The information gathered was assessed to find out what type of service was provided and whether it was appropriate to ask about CSA in that programme. Forms were examined to assess whether questions about CSA could be developed sensitively into existing sections of the forms where asking routinely would be appropriate.

### Semi-Structured Interviews

The research was conducted by carrying out face-to-face interviews that followed the format of a semi-structured questionnaire. The questionnaire was based on a previously reported questionnaire investigating health care professionals' attitudes towards asking about childhood abuse (65) and was re-developed to include the specific information needed for this research, (Appendix A).

Face-to-face, semi-structured interviews were carried out with staff from Foyer Housing, Foyer Learning and Foyer Health to record their views about asking and responding to CSA. All geographical regions covered by AF were included - Aberdeen, Peterhead, Fraserburgh, Banchory and Stonehaven. The researcher went to the sites and interviewed the member of staff in private. All interviews were confidential and no names appeared on the interview scripts.

Analysis consisted of reading and rereading the transcripts to identify the main themes of the research. Quantitative data was summarised in percentages.

### Training Courses

Three "Safe to Say" training courses covering working with adult survivors of CSA were held at AF (See Appendix B for details of the courses); two for frontline workers and one for supervising staff of frontline workers. The two frontline workers' courses ran for two and half days, the supervisors course for two days. These courses were planned on the assumption, based on prior research and subsequently borne out by the findings of this study, that many staff would be reluctant to enquire about abuse in their clients' histories for a variety of reasons, and that a specialised training course would impact on these perceived obstacles. To this end, frontline staff were interviewed a couple of weeks after the course to find out how it had impacted on them and their practice.

## 4. Findings

### 4.1 Assessment of Aberdeen Foyer's Current Information Gathering and Assessment Procedures With Regard to Sexual Abuse.

Aberdeen Foyer Staff Interviews

Foyer Service	Staff Positions	Number of Employees	Number of Employees Interviewed per Foyer Service (%)
Foyer Housing	Senior Support Worker	5	24 (53%)
	Support Worker	12	
	Assistant Support Worker	8	
Foyer Learning	Senior Support Worker	5	17 (38%)
	Support Worker	12	
Foyer Health	Counsellor	2	4 (9%)
	Health Visitor	2	
Total Interviewed			45

Table 1

### Information Gathering and Assessment Procedures

None of the application forms for any of the projects contained any direct questions about CSA, or any other form of childhood maltreatment. A consequence of having no questions about CSA on the application forms is that staff do not routinely ask about CSA and many staff have never asked their clients about CSA.

## Recording CSA Information

There was no standardised method for recording CSA data, either within individual departments or across the whole organisation. Information about CSA was recorded informally in a variety of formats and in a variety of locations. Some support workers (SW's) would record it in the client's paper file, others on a database, if one existed in their department and some in both. Some would record verbatim what the client had said, whereas others would not specifically mention CSA, but recorded that "issues relating to childhood had been discussed". Some staff thought it was inappropriate to record CSA information anywhere, as it would be a betrayal of the client's trust in the SW. These were normally SW's who would not ask outright, and would only have the CSA information if the client chose to disclose to them. Some staff would record in detail on the database and just mention it in the client's paper file. Other staff would record in detail on the paper file, and just refer to it generally on the client's file on the database. The client was typically made aware that the information was going to be recorded in their file.

## Storing CSA Information

A direct consequence of having no standardised method for recording CSA data was that there was no standardised location for storing such data. CSA information was stored by some staff on both the database and the client's paper file, some staff just stored it on the database and others stored it only on the paper file.

It should be noted that at the time of writing, not all AF's services had access to a database system to record their information. The supported accommodation service had a database for recording information, whereas the employment and training service did not. At the time of writing the employment and training service were designing a database system for recording client information.

## Accessing CSA Information

The general consensus was that only staff directly involved with the client and the clients themselves would have access to the CSA information. Paper files were only accessed by the client's support workers and senior support worker. However, locked filing cabinets could be accessed by all staff within a department (i.e., all who work in a particular housing office) so appropriate access was done on a trust basis. Database access was password protected, so only SW's with permission to use the database and their senior support workers (SSW) were able to access the information.

## Sharing CSA Information with Others Within Aberdeen Foyer to Assist the Client

There was a high priority put on confidentiality by staff and all were concerned about the confidentiality of their clients. Information was only shared on a “need to know” basis. The client’s SW and SSW could access the information, and only if the client wanted to be referred would it be passed to others in AF. CSA information was only shared with counsellors from Foyer Health or the client’s health visitor if the client wanted to be referred or have that information shared.

## Summary Statistics about CSA

Statistics about CSA within Aberdeen Foyer’s user group were not compiled or held by AF.

## Using Existing Knowledge about CSA Within Departments

The staff accessed other colleagues’ skills, knowledge and expertise in dealing with CSA and surrounding issues when appropriate. The staff used the expertise of Foyer Health effectively. Many staff reported that they would get advice from the Foyer Health if they were experiencing problems relating to issues surrounding CSA. This would be done with their client’s permission or anonymously by asking for advice without disclosing the name of the client concerned. Staff also reported that they would ask a colleague if they thought they had more knowledge about a certain issue. However, staff also felt that preserving anonymity could be difficult when working in small teams, as it would be obvious whom they were referring to since the team would know who each other’s clients were. Supervision was also used to get help if an issue was troubling a support worker, and talking things through during supervision was found to be helpful for all staff.

## Forms Used by Different Programmes and Services

In order to consider whether and where questions addressing sexual abuse could be inserted into interview forms already used by AF, it would be useful to summarise what the various forms in the different Foyer programmes address.

All the forms ask for general demographic details.

The **Training for Work** programmes are intended to help people realise their job ambitions in a particular field, through a mixture of training and work placements. These programmes allow the employer and potential employee to assess their suitability for that type of employment.

For example, **“Build and Train”** and **“Platform 2 Work”**, are geared towards giving clients the necessary skills to gain employment in the Construction and Oil & Gas industries, and they work in partnership with employers. These and the other training for work programmes are directly focused

on helping clients with learning skills, IT skills and specialist training, with a view to helping them gain employment. The interview forms for these programmes ask questions directly related to the employment potential of the client, such as qualifications and past work experience. There is a small section asking the client to identify the barriers they may have to gaining employment that a future employer would need to know (and that staff will be able to advise on). These have a specific focus on health and criminality. The only prerequisite for these programmes is being unemployed. A couple also have age restrictions.

The **Learning Houses** offer learning opportunities in disadvantaged communities. They are drop-in centres providing free and flexible learning support for a wide range of needs. Some clients may just come in once to access the Internet, whilst others attend regularly to get help with literacy and IT skills. When a client first arrives at the Learning House they are asked to fill in a short questionnaire asking about the type of help they require. Most of the questions are associated with finding out what type of help the client wants from the service. For example, preferred learning style (computer, paper/book study, tutor, etc.), type of help (essay writing, spelling, word processing, etc.), or help with certain skills (presentation, interview, job hunting). The questionnaire also asks if the client needs information on where to access extra help to enable them to get the most from the Learning House, for example childcare, benefit advice or welfare issues. The client can then be signposted to the relevant agency.

The Learning Houses run a **Family Project** that aims to assist a client with IT and literacy skills in the client's own home. A client is referred to this project, typically through the Social Work department, and then they have a brief assessment to check their eligibility for the project. The assessment includes information from the referring agency and asks questions about previous education, qualifications, employment history and hobbies. It also investigates the areas of learning the client is interested in, and what they would like to have achieved in six months time. There are also places on the assessment form that are used if a child is going to get some help from the project (e.g. best and least favourite subjects at school). The client, in consultation with the SW, develops an individual learning action plan for their use. The SW is there to assist the client in their learning action plan. They often work quite closely with the client and build up a good relationship with them.

Aberdeen Foyer works in partnership with Aberdeen College to deliver the **Prince's Trust** programme. The Prince's trust is a 12-week programme that offers challenges that help build young peoples' confidence and motivation while providing new skills and qualifications. The young people, (all from varied backgrounds, both unemployed and employed), work in a team of 15. Skills such as communication, problem-solving and teamwork are developed during the course. The team goes on a residential week and get two weeks' work experience. They also do voluntary work in the community. The work and activities The Prince's Trust members do is all centred around working as part of a team.

The Prince's Trust application form asks about education, qualifications, current/past employment, hobbies and any previous voluntary work. It asks about any relevant health issues or illnesses that the trust needs to be aware of, giving examples of what they would need to know (e.g., drug/alcohol addiction, diabetes, mental health problems). It asks about any criminality and whether the applicant has ever been charged with fire-raising, sex offences or schedule 1 offences. It also has a section on

legal issues, pending court cases and whether they have a social/support worker. Finally, questions on why they want to join the team and how they heard about the team programme are included.

All the above programmes have a focus on helping clients acquire skills in employability, learning and teamwork. The programmes' forms are geared toward gathering information that will assist their support workers in these activities; questions about CSA might seem jarring or out of place were they to be inserted in the current forms. However CSA does have an impact on survivors' ability to learn and maintain constant employment, so having well informed support staff who have participated in CSA training would be beneficial to clients on these programmes. After the other changes have been piloted, the need for the CSA question in skills and employment programmes may be reassessed.

**ICDRS** is a service that Aberdeen Foyer delivers in partnership with Aberdeen Cyrenians, (a voluntary sector organisation for homeless people), Drugs Action (an organisation which provides services to drug users, ex-users and their families), and Phoenix Futures (which provides care and rehabilitation for people with drug and alcohol problems). The ICDRS partners also work very closely with the Substance Misuse Service (NHS). ICDRS is a service for anyone who is prescribed an opiate substitute, such as methadone. They provide an overall package of rehabilitation support, including drug counselling, involvement in physical activity, advice and support on a variety of social issues, along with access to education, training and employment.

Clients are referred by their GP. AF provides specific support for these clients with an emphasis on education, training and employment. The ICDRS partnership agencies use a detailed single shared assessment form that can be shared by the partners so clients are not continually asked the same questions as they move through the different ICDRS services.

The form includes many questions related to the client's past and present drug and alcohol use, including questions about injecting practices, virus knowledge and any overdose history. There are also questions related to physical and mental health, social history, relationship issues, employment history, financial issues, and legal/offending issues. The form records the clients and assessors perception of the main problems/issues needing to be addressed, with a view of prioritising the client's needs to get the most out of the services on offer.

There are three sections within this form that could, without too much difficulty, potentially be amended to address CSA. The section on mental health issues addressed many of the common effects of CSA, including low self-esteem, self-harm, anxiety and depression. This is followed by a section on social history asking the client to describe their life history, including details about their schooling, parenting and any major life events that are relevant to their substance misuse. The next section addresses relationship issues, including individual family relationships and also domestic abuse.

Any of these sections could be adapted to sensitively include questions about childhood abuse. However, it may make sense to change the last two sections around so that information could be gathered about mental health and relationships and then social history, including questions about abusive childhood experiences. Being asked about mental health and relationships issues, followed by an exploration of social history, especially in relation to substance misuse, would set the context for asking about CSA. This would be appropriate because CSA could be the root cause of many of

the problems the client is or has experienced.

**Lifeshapers** is a twelve-week programme for 16-25 year olds who have a history of substance misuse and are currently on a Methadone programme, and want to get their life back on track. These clients get help to put structure and routine into their lives, build their confidence and develop new skills and interests. Sometimes these clients move on to Progress 2 Work after completing the course.

**Progress 2 Work** aims to help people, over the age of 18, who have a history of substance misuse, gain employment, training or education. Everyone is assessed and provided with an individual action plan that targets employability and overcoming barriers that may hinder the clients' long-term prospects of employment.

The Lifeshapers and Progress 2 Work programmes in Aberdeen City use the same interview form. The form is normally completed over three sessions. Questions are asked about the client's financial situation, housing issues, qualifications/training/employment, involvement with other support agencies, past/current drug and alcohol use, offending behaviour, health, dependents, relationships with others and risk assessment of harm to self or towards others. The sections on health include questions about self-harm, mental health and anger management; the section on relationship issues includes a question on abusive relationships (past and present). The Lifeshapers assessment form for Aberdeenshire North has a different layout to the Aberdeen form, but essentially it includes the same types of questions about the same issues.

These forms ask about common effects of CSA (e.g., self-harm and mental health problems), and then address supportive and abusive relationships. Some SW's said that if a client answered 'yes' to the question about abusive relationships, they would then ask for more details of the abusive relationships, which they would record on the form. However, not all SW's did this. It would be beneficial to expand this section of these forms to include specific questions about abusive relationships, including questions about CSA. This would standardise procedures and help to ensure that support workers in these programmes adopt a more consistent approach to gathering and recording information about CSA. Having this information will be beneficial to the clients, make early recognition of CSA more likely, and likely have a positive effect on the general outcomes of these programmes.

**Foyer Housing** provides a two-year supported tenancy where an allocated SW helps the tenant to move towards social and economic independence in a variety of ways. The application form asks about present housing circumstances, housing background, family background, health and well-being, drug/alcohol use, legal issues, education/qualifications, communication skills, other support providers and housekeeping skills. It also includes questions on why the client thinks the service is suitable for them and what the client wants from the service. The section on family background includes a question on family relationships and breakdown, and the section on health and well-being asks about mental health and self-harm. The interview is carried out to decide whether a potential client is suitable for the supported accommodation service provided.

In addition, AF are currently running a pilot project where a client referred for supported accommodation is immediately placed in accommodation for a 28 day assessment period. During that time, their allocated SW goes through the induction process with them, explaining what AF has to offer and

what is expected of the client. During that time, the SW and new client develop an action plan for the client to work on during their two years' support. At the end of the month, a decision is made about whether the client is suitable for a tenancy with AF and whether the client wants the support provided.

The section about family relationships could be adapted to include questions about other types of relationships and different types of childhood abuse, so this information could be recorded during the one-month assessment. Again, this would standardise procedures relating to gathering and recording information about CSA, and make early recognition of CSA more likely.

**Foyer Health.** Foyer Health's counselling service uses the Clinical Outcomes in Routine Evaluation (CORE) therapy assessment form. CORE is a routine evaluation tool used to evaluate psychological therapy and counselling services. Foyer clients can either self-refer or ask their SW to refer them to the counselling service if they are experiencing problems and want additional help. The client fills out a referral form where they write down their main concerns and how they think counselling might be helpful to them.

At the beginning of the counselling the CORE assessment form is filled out by the counsellor and client together. One identified concern noted in the CORE assessment form is 'Trauma and Abuse'. Thus there is a clear opportunity for the counsellor to enquire about childhood abuse at this point. The CORE assessment form has a manual that gives the clinician codes for various psychological disorders (F codes) and codes for non-illness features relevant to health care (Z codes), for example, unemployment, being the victim of crime or different types of childhood trauma. The Z codes include codes for "problems related to alleged sexual abuse of child by someone in primary support group" and "problems related to alleged sexual abuse of child by someone outside primary support group". This information can be directly recorded onto the form after the assessment. The severity and duration of problems related to this issue is recorded while the client is with the counsellor. This would give the client confidence to address this issue in therapy, if they were experiencing problems relating to the past abuse, which they were ready to address.

The client also has a personal file where more details can be recorded if necessary. Although there are codes for CSA in the CORE manual, in the past if the client has identified trauma/abuse as a problem, the counsellor has asked the client to expand on that information, rather than ask directly if CSA is one of the areas of trauma/abuse experienced. However, this practice is changing and, during this assessment period, one of the counsellors routinely asked all clients about CSA. Following a counsellors' team meeting, it has been decided that routinely asking about CSA is going to be the general practice for all counsellors working at AF. This will be done sensitively and in the context of asking about the client's history during the initial assessment.

## 4.2 Assessment of Staff Attitudes Toward Asking About Abuse, and the Impact on Staff Attitudes and Confidence of Targeted Training Sessions

### Asking About CSA

Staff were asked how often they currently asked about CSA. Their responses are summarised below.

Current Rates of Asking About CSA

Foyer Service	Staff Response						Total
	Always	50% of the time	25% of the time	Less than 25% of	Never	N/A	
<b>Foyer Housing</b>	1*	2	4	1	8	8**	24
<b>Foyer Learning</b>	1*	-	-	-	16	-	17
<b>Foyer Health</b>	-	-	-	1	3	-	4
<b>Total</b>	2	2	4	2	27	8	45

Table 2

\*These support workers said they always asked, but not specifically about CSA, about childhood abuse in general.

\*\* These were all assistant support workers who said it was not possible for them to ask, as they did not interview the clients.

## Asking Routinely

Staff were asked whether they felt that the routine assessment of their clients should include questions about CSA. The table below summarises their replies:

Current Rates of Asking About CSA

Foyer Service	Staff Response			
	Always	Sometimes	Never	Total
Foyer Housing	8	10	6	24
Foyer Learning	2	6	9	17
Foyer Health	3	1	-	4
<b>Total</b>	13	17	15	45

Table 3

## Always ask About CSA

Those who thought you should always ask thought so because they recognised that a history of CSA could be one of the reasons why a client found themselves in the situation where they needed help from AF. They felt that this history could impact on all aspects of the client's needs, and having this information early on could greatly increase the likelihood of best outcome for the client. It was mainly staff working in Foyer Housing that thought this type of information should be routinely asked about.

*"The young people we work with often come with a background of some kind of abuse. We often find out about it at a much later date, from the young people themselves. We should always ask because we really need to know all about them at the beginning so we can support them in a way so they get the best outcome possible. You need to know that sort of information as early on as possible, if your work with them is going to be as beneficial as possible for that young person".*

Staff working in Foyer Learning generally thought that routinely asking was not appropriate. However one Employment and Training SW, who worked for Lifeshapers, thought it should be routinely asked, and should be included in the application form.

*“It is important for us to have an understanding of every issue that the client has. We work with them individually and in groups. In a general discussion it is good to be aware of any issues the client may have so we can steer the discussion, if necessary, to make it easier for the client, not put them in a difficult situation”.*

## Sometimes ask about CSA

38% of SW's thought that under certain circumstances questions about CSA should be asked at the initial assessment. Generally they believed that this type of sensitive question would only be appropriate to ask if the client gave some indication that they wanted to disclose.

*“You can sometimes tell that someone wants to say something and you give them the opportunity to disclose. I wouldn't ask unless I was led to believe that they wanted to tell me something or if it was in their referral form and needed to be addressed.”*

Or once a relationship had developed with the client.

*“Depends on the client. The opportunity to ask may come later, when a relationship has developed.”*

## Never ask About CSA

This response was generally from staff that were part of Foyer Learning. They were often helping clients with IT skills or helping them prepare for outside employment. The focus for them was on helping with CV applications, interview skills and specific job and learning skills. An Employment and Training support worker commented:

*“Our ethos is that people will tell you what ever they are comfortable telling you. We help people with IT skills, it's not appropriate to ask that sort of question, it would scare people away.”*

It was mainly assistant SW's in Foyer Housing who thought they should never ask. This was because asking about an abusive past was not suitable in the context of the help they gave the client.

*“It would only be appropriate for a support worker to ask that sort of thing. I only help the tenant with bits of their action plan.”*

There was mixed views on the appropriateness of routinely asking about CSA amongst staff at AF. Although some SW's believed all, or some, clients should be asked about a CSA history during their assessments, the discrepancies between Table 2 (current practice) and Table 3 (staff views) show that very few of these SW's actually ask. Many of these SW's felt frustrated about not asking and recognised it as a failing in their practice.

*"I'm not comfortable asking, but not because I don't want to ask. It is more my lack of knowledge about how to ask. How to ask the right things. If I knew how to ask I wouldn't have a problem."*

*"If I was trained, I would be more willing to ask. I think it is as important to ask as "do you smoke". I don't have any problems personally about asking, just my lack of knowledge about how to ask."*

Some SW's recognised the importance of asking clients about events from their past that might affect their current mental health state and pattern of behaviour. They understood how addressing a survivor's needs in the context of their abuse was crucial to their getting the best help possible, and maximising the effectiveness of that help.

There was a sense that many SW's believed that you could only ask about CSA related matters when the time was right, once a relationship had been built up with the client. However, for many clients with a history of CSA, asking may be the critical act that creates and promotes rapport. Not asking might create a barrier to developing a more open relationship.

## Staff attitudes towards asking and responding to CSA before the training course.

The majority of staff were not comfortable in asking or responding to CSA.

Findings from this survey are consistent with other research into staff attitudes towards dealing with clients who have a history of CSA (refs). Although many staff at AF recognised that CSA was high in their user group, most were not comfortable asking about, or responding to, a disclosure of CSA. The overriding reason for this was a perceived concern for the client. Four barriers (all related to attempting to 'do the best' for the client) were identified as the main reasons for not addressing CSA.

a) Some support workers thought that asking about CSA would be **too intrusive**. Although interview forms include questions about alcohol/drug use, personal hygiene, self-harm and criminality, **CSA was thought to be an intrusive question**. It was thought that if they asked about CSA they might damage the relationship with a client.

b) The majority of SW's did not feel that they had **appropriate skills** to help survivors. Staff lacked confidence in their own abilities. Staff concerns centred around their own perceived lack of experience and skill to deal with the situation following disclosure, a fear that their inabilities might make the situation worse in some way and a general feeling that they did not know how to respond appropriately. The vast majority of staff believed that CSA was an extremely delicate and complicated issue that could only be addressed by specialists.

c) Staff were also worried that they did not have the **appropriate language** to ask. SW's were concerned that they would not be able to ask sensitively and were worried how to actually word the questions.

d) There was also a widespread sense among SW's that asking about CSA could **open a floodgate** that they, and the survivors, might not be able to deal with. Staff were worried that asking about CSA could in some way coerce some survivors to disclose before they were really ready.

Staff were asked if they thought they had had sufficient training to ask about CSA. The table below summarises their answers.

### Current Rates of Asking About CSA

Foyer Service	Staff Response		Total
	Yes	No	
<b>Foyer Housing</b>	4	20	24
<b>Foyer Learning</b>	4	13	17
<b>Foyer Health</b>	1	3	4
<b>Total</b>	9	36	45

**Table 4**

In summary, 80% of staff were concerned that they lacked the skills and expertise to judge when to ask, how to ask and how to respond to a client’s disclosure in an appropriate supportive way. Because of this general lack of confidence, staff were worried that asking about CSA would actually damage their working relationship with clients, stop it developing or in some other way have a negative effect on the client.

**A minority of staff had no difficulty asking or responding to CSA.**

As stated above there was a high recognition that CSA was prevalent in AF’s user group and 20% of staff felt confident to ask and to respond effectively. Staff felt working in the caring sector had given them the skills to enable them to ask sensitive questions. They thought it was part of their job to ask uncomfortable questions and had confidence in their own skills and abilities to ask and respond to a disclosure appropriately and effectively.

All the staff had confidence in AF’s Health team and recognised it as a great asset to the overall service AF provides. There was a general consensus that the Health Team provided a very good service that greatly helped SW’s in their work with clients.

*“We have a health team here so we are equipped to call upon a specialist if the tenant wants counselling. We can also ask the health team if we need advice for the tenant.”*

*“I would always refer to the Health Team if the tenant wanted that. Every tenant gets an induction on what the Health Team has to offer when they arrive. I would also approach the Health Team for advice if I thought I needed it for any issue that arose that I felt I needed more knowledge about, but I wouldn’t use the tenant’s name.”*

In fact the presence of the Health Team made one SW think that AF was equipped to respond to a survivor, so asking about a CSA history could be beneficial for clients:

*“Here we have trained counsellors, so maybe it is something we as an organisation could investigate. If you ask a client about abuse they might want you to get them some sort of help. Unless you can offer a client something after disclosure there is little point in asking in the first place”.*

**Staff support within AF.** Staff were asked if they felt supported, within AF, in responding to a client’s disclosure of CSA. The overwhelming response was yes. All but one SW felt very confident in the support system at AF, as one SW stated:

*“As an organisation we are very good at supporting each other..... There’s good supervision from my line manager and also we are supportive of each other within our team.”*

This supportive culture provides a good environment for asking about CSA, by ensuring support mechanisms are in place to assist both the clients who disclose, and the staff who may have to deal with the emotional consequences of a disclosure.

#### **Recognition of benefit of a training course about CSA.**

Most staff appreciated that training was available and thought it was valuable training for AF as an organisation. When asked if they thought they would benefit from a training course about assessment and/or treatment of CSA, 96% said yes. The two SW’s who did not feel that they would benefit from the training course worked in the Learning Houses, and felt that the training was not appropriate in their section of the training programmes:

*“I’m helping people with IT; it’s not part of my job to ask about that. It’s not relevant for the help I’m giving the client. I don’t think it is something I should be getting involved in. It’s crossing a line”.*

However, the vast majority of SW’s were keen to get training in this area, and welcomed it as a positive initiative for the Foyer:

*“This is something we come across in our daily work. The priority is the young person. Anything that is available to help the young person is good for the Foyer. The good from the training course will be transferred to our clients”.*

*“I think this is a very important issue that should be addressed, it is a problem in our client group. I think having the training course will be really beneficial for our tenants. It will be beneficial for the Foyer as a whole, for staff and tenants. I think we should all get the training eventually.*

Staff also recognised this as an opportunity for individual staff development:

*"I've had suicide training, and before that I would never ask that question, but now, after I've had that training (suicide training), I always ask that question. Before I never asked it, but now I feel comfortable asking because I am confident that I can respond well to any answer I get. My worry about asking about CSA is that I would make the tenant feel ashamed or uncomfortable by the way I worded the question or responded. If I get to go on the training I would feel better about asking."*

## **Staff Attitudes Towards Asking and Responding to CSA after the Training Course.**

Three training courses were held at AF; two for SW's and one for senior SW's and managers. The supervisor's course concentrated on supporting front line staff in supporting their clients. This next section will report on feedback from the two SW courses. Due to the time constraints of this project, it was not possible to get face-to-face feed-back from the managers' course. As the initial interviews identified that staff felt well-supported and thought support within AF was excellent, it was considered acceptable to do this.

Eighteen members of Foyer staff went through the training course, fifteen of these were interviewed. Generally staff experience of the training was very positive. Thirteen of the fifteen (87%) interviewees felt they had benefited from the training, that their awareness of the issues had increased and their confidence was significantly enhanced. However, two interviewees did not feel the training had been beneficial. Their comments will be discussed at the end of this section.

### **Positive Feedback From the Training.**

This section will concentrate on the thirteen support workers who found the course beneficial. Four main themes were identified from the interviews:

a) There was an **increased understanding of the long-term effects of CSA**. Staff said they had a better understanding of certain behaviours that may be related to past abuse and this helped to raise staffs' confidence in their ability to recognise that someone may have an abuse history. It also made them more understanding towards those clients, who may be more challenging than expected. There was also recognition that understanding what was behind difficult/strange behaviour can be helpful for the client, and also to the SW in trying to help the client.

*"The course made me realise that we need to ask ourselves: why is someone behaving in a certain way?"*

The training got rid of stereotypes and increased awareness of whom a survivor and a perpetrator might be.

*“Acknowledging that it’s not just clients who may have these experiences, CSA can be in anyone’s past. There were no hushed tones, we spoke frankly about everything. The facilitators were very good. I thought the survivor was really good; the fact that he was a man and so upbeat was really good. This training should be offered to all new support staff. It is an essential part of the work we do.”*

Being told about the continuum of abuse (which was very distressing to many), most staff thought very useful. This helped to prepare staff by showing how severe some people’s experiences could be, enabling the staff to accept and believe the disclosure without being shocked. This is very important for the survivor.

*“Someone may disclose something that is difficult to believe, hearing the continuum of abuse prepares you for a shocking disclosure.”*

**b) There was an increase in staff confidence in their ability to respond to CSA disclosure.**

Most of the SW’s thought that the course had shown them that in fact they were equipped to deal with a disclosure, that they didn’t need specialist training, just normal human emotions. They didn’t need to “fix” anything for the client, just be responsive to their needs. This could entail referring the client to a counsellor, but could equally be just to believe and listen to the client. Training highlighted that often the skills they already had were all that was needed.

*“I thought overall the course was very good. It took away my fear of not being able to deal with disclosure..... Showing me that what survivors want is normal human empathy and understanding..... My initial fears of not knowing what to do have been dispelled. The course was good at building up my confidence.”*

*“My expectations were met, I have a broader knowledge of how to deal with the issues and it reassured me that I was doing the right things.”*

*“I feel more secure that I’m able to ask that question and I have a better understanding of the issues. I don’t think you can ever have enough training, but I certainly feel more able to work with CSA. But you also learn as you work, so I’m sure once it has come up I’ll become even more confident.”*

**c) The training made staff more in tune with how they felt about the issue.** Staff thought the emphasis on recognising and acknowledging your own feelings and emotions about CSA was very helpful.

*“The most helpful part of the course, for me, was recognising your own fears and what would stop you helping a survivor and learning how to overcome that. It left you confident in being able to do that.”*

*“I thought the looking after yourself bit was so good, because I never thought about that. Being aware of how your body is reacting to a situation is essential. You have to be aware of how you react to being told, and acknowledge that.”*

*"Being aware of how your body is reacting was so good. I've had an experience with one of my clients since the training...I had a good cry, but I don't know if I would have allowed myself those feelings before the course. I would just have carried on and ignored how I was feeling. That part of the course was really good allowing you to recognise your own feelings,"*

d) **Asking clients about CSA.** Nine support workers interviewed thought they would be able to ask a client about a CSA history.

*"I am more confident to ask the question because I'm not frightened of not being able to respond well. I now know it doesn't need special skills, just normal human responses. I hope I would be able to be useful to the client."*

*"I'm more aware of it now, how common it is. I have more confidence in dealing with it and I would have no problem asking the question now."*

The training alerted staff to the possibility of letting someone down by not asking:

*"I can't think of any reasons not to ask, if I thought it needed to be asked I would. I would hate to be the person who they wanted to ask the question but never did."*

However, four said they would like more training on how to ask a client about CSA:

*"The course didn't concentrate enough on how to ask. I would like a bit more training on that. My confidence is much better, especially being able to respond, but I feel I would like more training on how to ask."*

But one staff member, who felt they hadn't had sufficient training in how to ask, said that if it was incorporated into the assessment form in a sensitive way that would take the pressure of her. It would become easier as she would routinely ask about it all the time, as she did for other sensitive issues.

*"I don't think the training concentrated enough on how to ask... It's probably never going to be an easy question to ask, but I could do it if it was part of the assessment.... The assessment form would be my guideline".*

Staff were asked if they thought that asking about CSA should be part of a client's assessment, and whether their opinion had changed since attending the training course. Three SW's thought it should always be asked:

*"We ask about a client's past, and drugs, and any family issues, we should also ask about that. This is different from before (the course), but now I realise that it is no different from asking any sensitive question, because I feel like I can deal with it now. It was my lack of confidence that made me feel it was inappropriate."*

*"I now think it's a necessary part of an assessment of a client. We ask them about other sensitive things, why not about whether they have been abused."*

Six SW's thought it would only be appropriate to ask sometimes:

*"I feel the same as before, you should only ask sometimes. If I was picking up the signs and signals then I think I should ask, but not routinely."*

And then only later on in the relationship with the client:

*"When appropriate, most definitely yes, but I think it should be built into a later stage of the client's assessment."*

*"I feel I would be more able to handle it, notice signs and signals. But I wouldn't ask at the initial assessment, at a later date".*

Three SW's thought you should never ask about CSA:

*"This is the same as before. I still think it needs to come from the client."*

*"Not sure you should actually ask – it's up to the client to disclose."*

*"I'm still not comfortable to ask, unless I thought the client wanted me to ask. I think it should come from them."*

Staff were asked if they had any barriers that would stop them from enquiring about a past history of abuse. Their answers were quite different than from before the course. No one had any personal reasons for not asking, and everyone felt equipped to deal with a disclosure. The only barriers identified were restrictions of the work place:

*"The only reason is the time factor. In my job I often have big time constraints. I wouldn't ask that type of thing unless I had time to follow it through."*

*"I feel confident I could ask that question and respond well. But it would depend on the day and what was happening on that day. If I'd been overwhelmed on a particular day I may not feel up to asking or dealing with it on that day. But I would go back to it if I couldn't address it on a particular day."*

**One aspect of the course that was highly valued was the input from the survivor.** SW's thought including a survivor in the training greatly increased their understanding of CSA. There was a strong sense that the survivor is the expert, and listening to the survivor's voice will improve understanding of the issues.

*"I thought the survivor coming to speak to us was really good, I really valued his contribution. It made me see things from his point of view, how things were for him."*

*"It was really good to get input from a survivor. Seeing things from a survivor's perspective was so informative."*

**A minority of staff did not feel they had benefited from the training course.** It is recognised that not everyone will benefit from any particular training course, and that in any training, some people may not benefit from the methods used. Two staff did not feel they had any deeper knowledge about CSA after the training course than they had before participating in it. One SW's comment's summarises this:

*"The best part was the survivor's visit, he was inspiring and the fact that he was male, doing well in his life and very articulate was good to break stereotypes... ..Looking back I didn't think there was enough substance for two and half days. It didn't have any role-play and we didn't get any back up sheets for the activities. There was no conclusion about how to deal with situations, no firm guidance."*

**Improvements staff wanted to the course.** Although there was a strongly positive response to the course, staff did suggest a couple of changes that could be made.

Staff on the first training course for frontline workers thought they would have benefited from some **role-play** to help them practice asking clients about CSA.

This information was fed back to the trainers, who responded by including role-play in the second course for frontline workers. This was well received, and staff attending the second course felt more confident asking about CSA than those who had attended the first course. The four support workers who said they would have liked more training on how to ask attended the first course. This comment was not made by any attendees of the second course, so the inclusion of role-play on the second course appears to have provided sufficient training on how to ask.

The other comment made by many SW's attending both courses was that they felt there were silent periods that seemed inappropriately long. Many staff appreciated the use of silence, using it to contemplate what had gone on before, and also using it to reflect upon how they were feeling at the time. However, the majority of staff felt periods of silence frequently were too long, which left what they felt to be an uncomfortable atmosphere in the room.

## 4.3 Conclusion

AF is a large organisation that offers supported accommodation and a wide range of employment and training programmes and community health services. Currently at AF there is no standardised procedure for routinely asking about, recording or storing CSA data, and staff do not routinely ask about CSA. If disclosed, CSA is often not recorded, or is recorded in a haphazard way on different media at varying levels of detail. There is a high priority put on confidentiality by staff and only staff directly involved with clients would have access to relevant CSA information. There is a culture of sharing expertise and a willingness for staff to access other colleagues' skills, knowledge and expertise in dealing with CSA.

**Aberdeen Foyer programmes and asking about CSA.** After consideration of staff interviews, a review of the application forms and the content of the programmes themselves, it is clear that in certain employment and training programs it may not be necessary or appropriate to routinely ask about CSA.

In the Training for Work programmes, the focus is on helping the client to get back to work. The Learning Houses concentrate on serving the learning and educational needs of clients in deprived communities. The Prince's Trust provides support for clients focused on team-working and working in groups.

There are no questions relating to mental well-being or relationship issues in the forms for these programmes, so asking about CSA might be seen as irrelevant in this context, or viewed by clients as inappropriate

However, it is recognised that CSA does affect a survivor's ability to learn and complete educational qualifications. Survivors often have concentration problems due to intrusive thoughts and memories or flashbacks. They can have low self-esteem, which means they may need extra encouragement and support to complete tasks and programmes. Poor school achievement, (brought about by the abuse-related concentration and self-esteem problems and compounded by bad school attendance and early leaving), impacts on a survivor's chances of doing well in further educational programmes. In addition, sudden bouts of mental illness, related to CSA, can adversely affect a person's ability to maintain long-term employment. To support these clients and help them get the most from the programmes on offer, SW's need to be aware of the impact CSA can have on their clients. It would seem worthwhile to consider that after the other changes have been piloted, the need for a CSA question in skills and employment programmes may be reassessed.

Clients on a number of these programmes often get a SW who is skilled in helping them make the most of the learning opportunities available. The SW builds up a relationship with the client especially when it is a long-term programme like the Family Project. Staff work in a very supportive way with their clients, and consequently clients may choose to disclose to staff on these programmes.

CSA training is essential for SW's working on these projects, to raise awareness about the common effects of CSA and to enable them to confidently listen to and support survivors. Raising staff awareness about the common effects of CSA will alert a SW to the possibility of CSA in the history of a client. Training will also give a SW the confidence to take an indirect approach to sensitively ask about CSA, based on their knowledge about the impact CSA can have on survivors.

This research project identified a number of programmes where routinely asking about CSA would be appropriate. Namely, the Lifeshapers, Progress2work, ICDRS programmes and Foyer Housing. Although CSA is not routinely asked about, there is a high level of awareness among the SW's that CSA survivors are in their client group. This awareness stems from staff having had clients disclose to them in the past and an understanding about potential effects of CSA in their client group. Staff realise that the prevalence of CSA is likely to be higher in their user group than in the general population.

Identification of abuse at the outset of these programmes has the potential to greatly improve outcomes for survivors, hence the importance of early identification through routine procedures. Routine enquiry allows the survivor to see that their abuse is significant to the problems they are experiencing and that the organisation recognises that and has the ability to deal with the issues. The existing forms used by these programmes could quite easily be adapted to include questions about CSA. The assessment forms do not need to explore the abuse in great detail, just allow recording of basic information. The confidentiality of clients is not being breached when recording this type of information within an organisation is in the best interest of the clients concerned.

**Staff attitudes.** Many staff thought that asking direct questions about CSA were too intrusive and not in "the best interests" of their clients. However, research shows this is not an opinion held by many survivors. They typically don't find it intrusive if questions are asked in a sensitive way. In fact, not asking about CSA often compounds the problem. Clients are asked other "intrusive" questions about equally sensitive personal issues, and not asking about CSA sends a message to a client that their abuse is not important, reinforces the stigma attached to CSA, and increases the feeling of taboo that keeps many people silent.

This research identified that many SW's believe that their lack of training in and lack of knowledge about, CSA prevents them from "opening the can of worms". They do not want to be responsible for triggering what they fear would be a crisis by delving into CSA when a client may not be able to cope with the pain of abuse. They also have concerns that their personal and professional resources may not provide the support necessary to help survivors. Thus there is a real anxiety that they can't "go there" because a client may not be strong enough, or the service may not be able to provide the appropriate level of care needed.

Some staff thought that asking direct questions about CSA was not in the interest of their client because the support they were giving should concentrate on helping the client with their presenting problems. Often they believed that clients would volunteer that sort of information once a strong relationship had developed. Unfortunately evidence indicates that survivors rarely spontaneously disclose and relying on spontaneous disclosure always results in under detection of CSA.

Research also shows that survivors want professionals to ask about these kinds of things as they feel an exploration of their abuse could help professionals understand their current problems, and survivors are concerned when they are not asked. Waiting for spontaneous disclosure results in failing to identify most cases of abuse, and losing the opportunity to provide optimal help to survivors.

The training course was well received at AF, with the majority of staff reporting increased awareness and confidence in dealing with CSA. However, staff did suggest a couple of proposed changes to the course. Staff on the first training course for frontline workers indicated they would have benefited from role-play to help them practice asking clients about CSA. Role-playing was added to the second delivery of the training course and it increased staff confidence in their ability to ask clients about CSA. The other comment made by many SW's attending both courses was that they felt there were periods of inappropriately long silence, which they felt created an uncomfortable atmosphere in the room.

As a consequence of the training course, there was an increased recognition that the post-traumatic symptoms some survivors have may need to be addressed within the context of their abuse history.

The increased knowledge and skills that staff gained, along with a growing self-confidence in their ability to deal with CSA within their work context, will help to build up a positive attitude towards disclosure and help AF in providing effective support to CSA survivors.

AF is a responsive service that works collaboratively between its different programmes; staff are motivated by their concern for the well being of their clients. In addition, AF provides a supportive environment that promotes a high level of trust within the organisation; this enables staff to fully engage with clients because they know that both parties will be supported. These factors play a large part in allowing staff to build up strong therapeutic relationships with clients, and ensuring quick and easy referral when needed. It also provides an environment that should allow for a sensitive exploration of abuse history, and the ability to provide appropriate support if the client requires it.

## 4.4 Recommendations

**1. The assessment form for Lifeshapers and Progress2work should include appropriate questions about CSA, and other types of childhood maltreatment.** There is likely to be a high rate of abuse in potential clients' histories, so sensitively incorporating abuse-related questions could greatly influence the outcomes of these programs and help ensure clients' needs are met. Identification of such a history will help the support worker understand and address certain behaviours; SW's ability to ask about CSA will increase survivors' confidence in the service being provided. Early recognition of CSA as a risk factor for substance misuse, self harming and other negative behaviours in this young client group will lessen the long-term impact of the abuse for these people and stop the long cycle of referral survivors often experience. Often a Lifeshapers' client will go on to Progress2Work. If this is the case, the form for Lifeshapers could be used to help fill out the Progress2Work form. This would enable the new Progress2Work support worker to only ask questions that may have changed during the Lifeshapers programme, and would alert the new SW to a CSA history without the client having to go through the assessment procedure again.

**2. Foyer Housing should gather information about CSA, and other types of childhood maltreatment, during the 1-month induction period.** The questions should be asked and the answers recorded as part of the ongoing assessment that the tenant has with their SW during the induction period. If the SW feels that it is inappropriate to ask such questions, (for example, if the client is in crisis, due to circumstances of their homelessness), then that should be recorded along with why it was felt to be inappropriate. This will enable the SW to ask at a later date when the time is right for the tenant, and will also remind the SW that it has not been asked yet.

**3. ICDRS should routinely ask about CSA.** There is likely to be a high prevalence of CSA in this group, so it is recommended that routine enquiry about CSA for ICDRS clients is undertaken at an early stage in the programme. This approach would need to be discussed with all service providers involved with the programme, including the referring GPs, to decide how best to implement an effective CSA enquiry.

**4. There should be an understanding and willingness from staff to ask questions about CSA more than once, to ensure there are further opportunities to disclose when the person is ready.** Even though the assessment stage of referrals to programmes contains an appropriate question relating to CSA, a client may choose not to disclose at that point in time. However, the question may signal to the client that the service offering the programme is prepared to deal with the issue. This may give clients the confidence to disclose at an opportune point. People often avoid disclosing and say 'No', because they are not ready to speak about their past at a certain point. At a later point in time, the client may want to disclose and if staff are knowledgeable about CSA, aware of common symptoms and sensitively enquire more than once, clients may find it easier to disclose when ready.

**5. Aberdeen Foyer should move towards developing a single shared assessment form for all appropriate programmes.** There is potential for developing a single shared assessment form that could be used by Foyer Housing, Lifeshapers, Progress2Work and ICRDS programmes. Clients within these services and programmes may go from one programme to another as they progress towards independent living. Using a single shared assessment form would stop the client being asked the same questions time and time again, and alert a new SW to the needs of the client. The advantage of a single shared assessment form is that it minimises duplication (for both the client and the organisation), and focuses on the needs of the client rather than the services provided. It also allows for a more coordinated and streamlined service for the client.

The ICDRS single shared assessment form could be adapted to be more relevant to the other programmes. It would not be suitable at the moment because it includes many questions that ask for detailed information about past and present drug behaviours. A new single shared assessment form could be used by ICDRS with the addition of a detailed drugs section specifically for their clients.

It would not be appropriate to record a detailed disclosure on a shared form. If necessary that type of information would only be recorded on a client's personal file that could only be accessed by appropriate individuals.

**6. If a client spontaneously discloses, or a support worker is disclosed to through sensitive enquiry, this information should be recorded in the client's file, (with the client's knowledge).**

This is recommended for all programmes and Foyer Housing. Because of the profound effect CSA can have on survivors, it is important that the information be adequately recorded. This allows for any problems related to the abuse being addressed in the context of the client's history. Recording the information provides continuity as clients move from programme to programme, and lessens the chances of the client's abuse going unnoticed.

**7. There should be procedures in place, and funding for the appropriate staff, so a central database can be developed to store anonymous CSA data from all sections of Aberdeen Foyer.**

This data would be used to produce statistics about the prevalence and characteristics of CSA survivors in AF's client group. This will help to improve understanding of the effects of CSA, and the health needs of survivors. In the long term this information will help AF to design services to best meet the needs of CSA survivors.

**8. If a client is referred to the in-house counselling service, questions related to CSA should be asked at the initial assessment.**

Issues related to CSA need not be addressed during the counselling period, (that should be client led), but the information is essential for the therapists to gain full understanding of the client.

**9. A CSA specialist based within Foyer Health should be established along with appropriate funding for the post.**

The specialist would help develop an organisational policy for AF in relation to CSA, and facilitate CSA training for existing and new employees. The specialist would also develop a toolkit to gather record and analyse CSA data. The specialist would also forge long-term links with the relevant outside agencies with the intention of developing appropriate services for survivors in the Grampian area.

**10. Due attention and consideration must be given to the way questions about CSA are developed and used.**

It is important to pay attention to the language used to formulate questions about CSA, because some people may not recognise their experiences as "abuse" or "assault". For example the following question, "Was there ever a time, before the age of sixteen, when someone had any type of unwanted sexual contact with you?" may be more meaningful for the survivor than simply asking, "Have you ever been sexually abused?" The questions also have to be asked in the right context, such as in a section asking about other childhood experiences. The questions should be incorporated into the form with information that helps the SW ask in a sensitive way. Written advice on how to ask could be incorporated into the form. For example, a written preface to the question that could be read by the SW before asking about an abusive past, such as: "I'm going to ask you about some unpleasant things that happen to some people in childhood. We ask because sometimes it helps throw light on difficulties later in life" (Read et al., 2007, p. 106 (65))

**11. When questions about CSA appear on assessment forms, staff need to know who to refer clients to, should they require it.**

Clients have expert knowledge of their own needs, and should drive responses to disclosure. Staff need to know where and how to refer CSA survivors if they wish to be referred, either inside or out with AF, and clear referral protocols need to be in place to assist staff. Staff should make clients aware of the in-house counselling available to all AF clients.

Having an in-house counselling service reinforces the appropriateness of asking about CSA. Staff should also have the knowledge to signpost people to relevant outside agencies if required.

**12. All staff working with clients at Aberdeen Foyer, and staff working in services with a high prevalence of survivors, should have access to CSA training.** Training should be made available to all relevant staff, and relevant outside agencies, to establish a supportive culture for survivors and staff. It has been demonstrated that training in CSA can greatly improve case identification, supportive responses and initiation of appropriate care (66). Research also shows that supportive responses appear to lessen the negative effects of abuse for the survivor, whereas negative responses reinforce and intensify the negative effects of the abuse. A training course to build confidence and increase awareness of all staff working at AF is recommended, even for staff helping in areas that focus entirely on employment skills or teamwork. This would be beneficial for clients, since an unrecognised history of abuse can impact on a client's ability to sustain long term employment, or get the most from any learning and training opportunities on offer. CSA can impact on a survivor's ability to concentrate, (e.g., flashbacks, anger management, etc.), or work well in certain conditions, (e.g., being left alone with a male). Identification of a CSA history will enable a SW to help clients reach their potential. Training in this area will give confidence to SW's and help them respond to their clients' needs. Widespread training will also help to build up a culture of awareness and openness about CSA and its effects. This in turn will contribute towards a wider move to break the taboo about CSA within society.

**13. Targeted training courses should include more information about how to sensitively ask about CSA.** Although the vast majority of staff believed the training course had greatly increased their confidence in working with survivors, some thought they needed more training on how to ask someone about CSA. The increased knowledge about how to respond well will increase staff confidence to ask the question; however, it would be helpful for staff if there was more practical advice in this area. Training should cover how to inquire sensitively about abuse histories, and how to respond to the answers a client may give.

**14. Policy should include procedures that will be effective in providing support to someone when they disclose CSA and guidelines so support workers know what to do with the information.** It is recognised that staff can't be effective if they're not dealing with CSA appropriately, and training in CSA needs to be backed up by appropriate procedures, and reinforced by guidelines if it is to maximise its effectiveness within an organisation. This is especially important for SW's with clients aged between 16-25 years, because this is the client group where early recognition and support will have the most positive effect on long term well being. Procedures should include a unified approach to collecting, recording and accessing CSA data.

**15. Staff training needs to be backed up by education to promote a general awareness of CSA.** Practical visual reminders, (e.g., posters, leaflets, general information about CSA and pointers to web based support such as "Survivors Scotland"), all convey the message that CSA is an issue that staff are competent to deal with. This will help to create an environment where clients feel there are multiple opportunities to disclose, and will generally promote a feeling that the environment is a safe place. Referring to CSA in publicly accessible service descriptors would also help to raise the general awareness of CSA.

16. **Funders need to provide extra resources for support workers and managers.** Providing an organisation that actively encourages disclosure of CSA will inevitably increase the workload of staff. The resource requirement is needed both to provide the extra support disclosing clients will need, and to provide the supervision and support structures necessary for staff who receive disclosures. All staff currently need to meet targets and have programme/course delivery commitments. To deal effectively with a client base that has a high proportion of CSA in an environment that is supportive of disclosure, staff need to have sufficient time and resources, without being exposed to the extra pressure that comes from an additional responsibility.

## 5. Findings: Specialist Support Outside Aberdeen Foyer

### 5.1 Assessment of Potential Specialist Support Available for Survivors out with Aberdeen Foyer

The only specialist support identified specifically for CSA in Aberdeen and the surrounding area is Children 1st's Corrieneuchin project, who work with children and young people.

**The Corrieneuchin project** in Aberdeen and Aberdeenshire provides a therapeutic service for children and young people who have experienced physical, emotional or sexual abuse. Their service is predominantly for children and young people up to the age of 18, but they do see young people up to the age of 25 if they have been in the care of the local authority. They run individual counselling and therapy sessions and family group meetings. Referrals are primarily from social work, but they welcome other agency referrals and self-referrals. Corrieneuchin are currently looking for funding to expand their counselling services to the parents of their clients, as these parents have often experienced trauma in their own childhoods.

No dedicated service for CSA survivors over the age of 18 was identified in the Grampian area. A number of services were found who offered counselling and advice on a variety of issues, including CSA.

**Aberdeen counselling and information service (ACIS)** is a project run by Mental Health Aberdeen that provides a generic counselling service for adults (16+). ACIS offer individual counselling sessions for a wide range of problems including CSA. A client makes direct contact with ACIS and will get an initial appointment within about two weeks. However, after the initial appointment, they will go on to a waiting list of about four months before the counselling sessions will begin. Mental Health Aberdeen also runs the Banff & Buchan Voluntary Counselling Service and the One to One Counselling Service for people living in Aberdeenshire.

**Caledonia Youth** offer one-to-one and group counselling sessions for young people up to the age of 25. Due to cuts in funding the service only runs one day a week and has a waiting list of around six weeks.

**The Royal Cornhill Hospital** offer individual and group therapeutic sessions through the Psychotherapy Department (18+) and the Young Peoples Department (up to 18). These are both tertiary services and although they do currently get referrals from GPs, this is going to change. Referrals in the future will come from Community Health Teams only. GP's refer to the community mental health teams who would then decide where best to refer the client. Once referred there is a waiting list of 12-18 months.

**Rape and Abuse Support** provides advice and support to women for issues arising from rape and sexual violence (including CSA). This service currently includes an out of hours helpline, drop in, face to face support, telephone support, email and letter support, but is not a counselling service. They

also provide information, training and support to health professionals.

There are also a number of skilled and experienced individuals working with CSA in the Aberdeen and Grampian area. These include individuals within the statutory and voluntary sector services, and counsellors working independently.

## 5.2 Recommendations

1. **A specialist service for CSA survivors should be established in Aberdeen.** This service should include an outreach service so areas out with Aberdeen City can benefit from its expertise. In the planning stage for such a service, there should be close consultation with survivors. This service should provide support for both men and women. Funding for a specialist service has to consider the requirement for the long-term intensive therapeutic work and long-term counselling that some survivors need. A specialist service could develop a long-term programme, (which includes help in many areas of the survivor's lives), for survivors so that support can really help them rather than just dip in and out of their lives. For example, what is needed is an independent CSA project with available counsellors, drug workers, health experts and psychotherapists. CSA survivors need a specialist service with skilled staff that provide a range of expertise, are easy to access, (no waiting lists), and are flexible to the needs of survivors. Survivors often present with difficult and challenging behaviours that need long-term flexible support. There needs to be long-term funding for a specialist service for CSA survivors to enable this work to be carried out.

2. **Existing services need more dedicated funding to continue the valuable work they already do.** Funding is needed to employ more skilled specialists and to bring down waiting lists. Long-term funding initiatives are needed to guarantee or improve current resource allocation. Several services have restricted their opening hours to meet funding shortfalls. Long waiting lists for services are also prohibitive.

3. The Corrieneuchin project, for children and young adults, in Aberdeen would greatly benefit from additional funding to employ an adult counsellor to help the parents/carers of many of the children who are referred to them. It is recognised that many parents of the children referred to The Corrieneuchin project are also survivors themselves. Having an in house adult counsellor available would improve the service Corrieneuchin provide by helping all aspects of the child's well being, including offering appropriate therapy or counselling to parents.

4. **Closer communication between different services.** Services should share relevant information, while respecting confidentiality, in order to provide the best service for clients that are being referred from one service to another. Recognition that CSA can affect many aspects of a survivor's life means that many survivors will need multi-organisational contact. Developing partnership working, with all partners working to the same remit on CSA, will enhance support for the survivor. Clear referral routes and information sharing protocols need to be established. Focus group meetings between appropriate representatives of the partner agencies involved should be held to establish links, communication paths and common protocols.

**5. A supported and well-resourced self-help group for survivors of CSA.** A funded support group would be beneficial for the long-term well being of survivors. Sharing of personal experiences and providing mutual support to provide sympathetic understanding and address common problems is seen to be a valuable form of support for many groups in society. Although it cannot take the place of a specialist service for survivors, if it is well funded, for example, paid workers, it could be a welcomed addition to a professional specialist service. A well-resourced support group needs to be carefully facilitated to ensure there is safety within the group. Non-professional people could learn skilled facilitation so the groups could be self-sufficient. CSA survivors can often have a diminished support network; particularly if addictions and homelessness are involved, and may well feel isolated. If they can have a safe place to meet and communicate with other survivors, this could create an informal support network outside the structured official service provision.

**6. The provision of a childhood abuse service for survivors at The Royal Cornhill Hospital.** Research shows that there are very high prevalence rates of childhood abuse in people presenting to mental health services. Research carried out on the adult inpatients wards at The Royal Cornhill Hospital in Aberdeen (PhD Dissertation 2006) found that there was a high percentage of childhood abuse among inpatients (66%), with 35% having experienced CSA (Female 50%, Male 23%). The service should have a multi-disciplinary team working to alleviate the posttraumatic symptoms brought on by CSA. Research indicates that inpatients in psychiatric units who are survivors of childhood trauma are often treatment resistant and require more therapeutic methods that have a holistic approach. This psycho-social approach can focus on childhood trauma origins as well as treating current mental illness.

## 6. References

1. The report of the Scottish Executive Short-life Working Group on the care needs of people who have survived childhood sexual abuse. (2005). This report is displayed on the Survivor Scotland website, [www.survivorscotland.org.uk](http://www.survivorscotland.org.uk)
2. Nelson S. (2001) Beyond trauma: mental health needs of women who survived childhood sexual abuse. Health in Mind. Edinburgh.
3. World Health Report 2002. 2002 World Health Organisation.
4. Kendler K.S., Bulik C.M., Silberg J., Hettema J.M., Myers J., Prescott C.A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women. *Archives of General Psychiatry* 57, 953-959.
5. MacMillan H.L., Fleming J.E., Streiner D.L., Lin E., Boyle M.H., Jamieson E., Duku E.K., Walsh C.A., Wong M.Y.Y. & Beardslee W.R. (2001). Childhood abuse and lifetime psychopathology in a community sample. *The American Journal of Psychiatry* 158, 1878-1883.
6. Noell J., Rohde P., Seeley J., & Ochs L. (2001). Childhood sexual abuse, adolescent sexual coercion and sexually transmitted infection acquisition among homeless female adolescents. *Child Abuse & Neglect* 25, 137-148.
7. Johnson R.J., Rew L. & Kouzekanani K. (2006). In their own words: trauma and substance abuse in the lives of formerly homeless women with serious mental illness. *American Journal of Orthopsychiatry*. 76(4), 61-7.
8. Janssen I. Krabbendam L. Bak M. Hanssen M. Vollebergh W. de Graaf R. & van Os J. (2004). Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatrica Scandinavica* 109(1), 38-45.
9. Wexler B.E., Lyons L., Lyons H., Mazure C.M. (1997). Physical and sexual abuse during childhood and development of psychiatric illness during adulthood. *The Journal of Nervous and Mental Disease* 185(8), 522-524.
10. Simon D. (1998). Guiding recovery from child sexual abuse: horizons of hope. Jessica Kingsley Publishers Ltd. London.
11. Women's Research Centre. (1989). Recollecting our Lives: women's experience of childhood sexual abuse. Press Gang Publishers. Vancouver.
12. Doyle C. (1994). Child sexual abuse: a guide for professionals. Chapman Hall. London.

13. Desai S., Arias I., Thompson M.P. & Basile K.C. (2002). Childhood victimisation and subsequent adult revictimisation assessed in a nationally representative sample of women and men. *Violence and Victims* 17, 639-653.
14. Briere J., Woo R., McRae B., Foltz J. & Sitzman R. (1997). Lifetime victimisation history, demographics, and clinical status in female psychiatric emergency room patients. *The Journal of Nervous and Mental Disease* 185, 95-101.
15. Wexler B.E., Lyons L., Lyons H. & Mazure C.M. (1997). Physical and sexual abuse during childhood and development of psychiatric illness during adulthood. *The Journal of Nervous and Mental Disease* 185(8), 522-524.
16. Kaplan M. & Klinetob N., (1994). Childhood emotional trauma and chronic posttraumatic stress disorder in adult outpatients with treatment-resistant depression. *Journal of Nervous and Mental Disease* 188(9), 596-60.
17. Rodriguez N., Ryan S.W., Kemp H.V. & Foy D.W. (1997). Posttraumatic stress disorder in adult survivors of childhood sexual abuse: a comparison study. *Journal of Consulting and Clinical Psychology* 65, 53-59.
18. Grilo C.M., Stanislaw C., Fehon D.C., Martino S. & McGlashan T. (1999). Psychological and behavioural functioning in adolescent psychiatric inpatients who report histories of childhood abuse. *American Journal of Psychiatry* 156(4), 538-543.
19. Herman J.L., Perry C. & van der Volk B.A. (1989). Childhood trauma in borderline personality disorder. *The American Journal of Psychiatry* 146, 490-495.
20. Hammersley P., Dias A., Todd G., Bowen-Jones K., Reilly B. & Bentall R.P. (2003). Childhood trauma and hallucinations in bipolar affective disorder: preliminary investigation. *British Journal of Psychiatry* 182, 543-547.
21. Janssen I., Krabbendam L., Bak M., Hanssen M., Vollebergh W., de Graaf R. & van Os J. (2004). Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatrica Scandinavica* 109(1), 38-45.
22. Swett C., Surrey J., Cohen C., (1990). Sexual and physical abuse histories and psychiatric symptoms among male psychiatric outpatients. *The American Journal of Psychiatry* 147, 632-636.
23. Mullen P.E., Martin J.L., Anderson J.C., Romans S.E. & Herbison G.P. (1996). The long-term impact of the physical, emotional and sexual abuse of children: a community study. *Child Abuse & Neglect* 20, 7-21.
24. Moncrieff J., Drummond C., Candy B., Checinski K. & Farmer R. (1996). Sexual abuse in people with alcohol problems: A study of the prevalence of sexual abuse and its relationship to drinking behaviour. *British Journal of Psychiatry* 169, 355-360.

25. Kendler K.S., Bulik C.M., Silberg J., Hettema J.M., Myers J. & Prescott C.A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women. *Archives of General Psychiatry* 57, 953-959.
26. Lipschitz D.S., Winegar R.K., Nicolaou A.L., Hartnick E., Wilfson M. & Southwick S.M. (1999). Perceived abuse and neglect as risk factors for suicidal behaviour in adolescent inpatients. *The Journal of Nervous and Mental Disease* 187, 32-39.
27. Tobin D.L. & Griffing A.S. (1996). Coping, sexual abuse and compensatory behaviour. *International Journal of Eating Disorders* 20 (2), 143-148.
28. Brand E.F., King C.A., Olson E., Ghziuddin N. & Naylor N. (1996). Depressed adolescents with a history of sexual abuse: diagnostic co-morbidity and suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry* 35, 34-41.
29. Briere J., Evans D., Runtz M. & Wall T. (1988). Symptomatology in men who were molested as children: a comparison study. *American Journal of Orthopsychiatry* 58 (3), 457-461.
30. Windle M., Windle R.C., Scheidt D.M. & Miller G.B. (1995). Physical and sexual abuse and associated mental disorders among alcoholic inpatients. *American Journal of Psychiatry* 152, 1322-1328.
31. Gold S.N., Lucenko B.A., Elhai J.D., Swingle J.M. & Sellers A.H. (1999). A comparison of psychological/psychiatric symptomatology of women and men sexually abused as children. *Child Abuse and Neglect* 23 (7), 683-692.
32. Mullen P.E., Martin J.L., Anderson J.C., Romans S.E. & Herbison P.G. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry* 163, 721-732.
33. Read J. (2007). To ask, or not to ask, about abuse: New Zealand research. *American Psychologist* 62, 325-326.
34. Gladstone G., Parker G., Mitchell P., Malhi, G.S, Wilhelm K. & Austin M. (2004). Implications of childhood trauma for depressed women: an analysis of pathways From childhood sexual abuse to deliberate self-harm and revictimisation. *American Journal of Psychiatry* 161, 1417-1425.
35. Garno J.L., Goldberg J.F., Ramirez P.M. & Ritzler B.A. (2005). Impact of childhood abuse on the clinical course of bipolar disorder. *American Journal of Psychiatry* 162, 121-125.
36. Dube S.R., Anda R.F., Felitti V.J., Chapman D.P., Williamson D.F. & Giles W.H. (2001). Childhood Abuse, household dysfunction, and the risk of attempted suicide throughout the life span. *JAMA* 286 (24), 3089-3096.

37. Herman J.L. (1992). Trauma and recovery. From domestic abuse to political terror. Harper Collins Publishers. London.
38. National Institute for Mental health in England. (2002) Personality disorder no longer a diagnosis of exclusion. [www.nimhe.org.uk](http://www.nimhe.org.uk)
39. Kendall-Tackett K.A. (2001). Chronic pain: The next frontier in child maltreatment research. *Child Abuse and Neglect* 25, 997-1000.
40. McCauley J., Kern D.E., Kolodner K., Dill L., Schroeder A.F., DeChant H.K., Ryden J., Derogatis L.R. & Bass E.B. (1997). Clinical characteristics of women with a history of childhood abuse. *JAMA* 277, 1362-1368.
41. Drossman P., Talley N., Leserman J., Olden K. & Barreiro M. (1995). Sexual and physical abuse and gastrointestinal illness: Review and recommendations. *Annals of Internal Medicine* 123(10), 782-794.
42. Williamson D.F., Thompson T.J., Anda R.F., Dietz W.H. & Felitti V. (2002). Body weight and obesity in adults and self-reported abuse in childhood. *International Journal of Obesity* 26, 1075-1082.
43. Golding J.M., Wilsnack S.C. & Leerman L.A. (1998). Prevalence of sexual assault history among women with common gynaecologic symptoms. *American Journal of Obstetrics and Gynaecology* 179, 1013-1039.
44. Talley N.J., Fett S.L. & Zinsmeister A.R. (1995). Self-reported abuse and gastrointestinal disease in outpatients: Association with irritable bowel-type symptoms. *American Journal of Gastroenterology* 90, 366-371.
45. Nelson S., Baldwin N. & Taylor J. (2007) Mental health problems and medically-unexplained physical symptoms in adult survivors of childhood sexual abuse: A literature review and scoping exercise. National Programme for Improving Mental Health and Well-being. Small Research Projects Initiative (Scotland)
46. Leserman J. (2005) Sexual abuse history: prevalence, health effects, mediators, and psychological treatment. *Psychosomatic Medicine* 67, 906-915.
47. Walker E.A., Unutzer J., Rutter C., Gelfand A., Saunders K., VonKorff M., Koss M.P. & Katon W. (1999). Costs of health care use by women HMO members with a history of childhood abuse and neglect. *Archives of General Psychiatry* 56, 609-613.
48. Navalta C.P., Polcari A., Webster D.M., Boghossian A. & Teicher M.H. (2006). Effects of childhood sexual abuse on neuropsychological and cognitive function in college women. *Journal of Neuropsychiatry and Clinical Neuroscience* 18(1), 45-53.

49. Wells R.D., McCann J., Adams J., Voris J. and Ensign J. (1995). Emotional, behavioural, and physical symptoms reported by parents of sexually abused, nonabused, and allegedly abused prepubescent females. *Child Abuse & Neglect* 19 (2), 155-163.
50. Perez C.M. & Widom C.S. (1994). Childhood victimisation and long-term intellectual and academic outcomes. *Child Abuse & Neglect* 18 (8), 617-633.
51. Browne A. (1993). Family violence and homelessness: The relevance of trauma histories in the lives of homeless women. *American Journal Orthopsychiatry* 61(3), 370-384.
52. Koenig L.J., Doll L.S., O'Leary A. & Pequegnat W. (2004). From child sexual abuse to adult sexual risk. Trauma, revictimisation, and intervention. American Psychological Association, Washington DC.
53. McMahon J. & Clay-Warner J. (2002). Child abuse and future criminality: the role of social service placement, family disorganisation and gender. *Journal of Interpersonal Violence* 17, 1002-1019.
54. Coid J., Petruckevitch A., Feder G., Chung W., Richardson W. & Moorey S. (2001). Relationship between childhood sexual and physical abuse and the risk of revictimisation in women: A cross-sectional survey. *The Lancet* 358, 450-454.
55. Promoting capacity with homeless women survivors of child sexual abuse misusing alcohol, drugs or gambling. 2005 Final Report. Research Unit Royal District Nursing Service (RDNS) Foundation.
56. Johnson J.J., Ross M.W., Wendell C., Williams M.L., Carvajal R.I. & Peters R.J. (2006). Prevalence of childhood sexual abuse among incarcerated males in county jail. *Child Abuse & Neglect* 30, 75-86.
57. McClellan H., Farabee D., & Crouch B.M. (1997). Early victimisation, drug use, and criminality: A comparison of male and female prisoners. *Criminal Justice and Behaviour* 24(4), 455-476.
58. Brodsky B.S., Oquendo M., Ellis S.P., Haas G.L., Malone K.M. & Mann J.J. (2001). The Relationship of childhood abuse to impulsivity and suicidal behaviour in adults with major depression. *American Journal of Psychiatry* 158 (11), 1871-1877.
59. Heller S.S., Larrieu J.A., D'Imperio R.D. & Boris N.W. (1999). Research on resilience to child maltreatment: Empirical considerations. *Child Abuse & Neglect* 23 (4), 321-338.
60. DuMont K.A., Widom C.S., & Czaja S.J. (2007). Predictors of resilience in abused and neglected children grown-up: The role of individual and neighbourhood characteristics. *Child Abuse & Neglect* 31, 255-274.

61. Lynskey M.T. & Fergusson D.M. (1997) factors protecting against the development of adjustment difficulties in young adults exposed to childhood sexual abuse. *Child Abuse & Neglect* 21, 1177-1190.
62. Romans S.E., Martin J.L., Anderson J.C., O'Shea M.L., & Mullen P.E. (1995). Factors that mediate between child sexual abuse and adult psychological outcome. *Psychological Medicine* 25, 127-142.
63. Agar K., Read J., Bush J.M. (2002). Identification of abuse histories in a community mental health centre: The need for policies and training. *Journal of Mental Health* 11(5), 533-543.
64. Read J., Hammersley P. & Rudegair T. (2007) Why, when and how to ask about childhood Abuse. *Advances in Psychiatric Treatment* 13, 101-110.
65. Lab D.D., Feigenbaum J.D. & De Silva P. (2000). Mental health professional's attitudes and practices towards male childhood sexual abuse. *Child Abuse & Neglect* 24(3), 391-409.
66. Denov M.S. (2003). To a safer place? Victims of sexual abuse by females and their disclosure to professionals. *Child Abuse & Neglect* 27(1), 47-61.

## Appendix A

### Interview Schedule

## Questionnaire – Asking about Childhood Sexual Abuse (CSA)

The purpose of this questionnaire is to find out how you feel about asking clients questions relating to childhood sexual abuse (CSA). It is important that your answers reflect what you do rather than what you feel would be the ideal thing to do, and how you feel rather than how you think you ought to feel. Please answer as accurately as possible.

### Questionnaire

Gender: Male  Female

Department: Housing  Employment & Training  Health

Post: Support worker  Manager

1. How long have you worked in your current profession? (.....) in years

2. Do you feel that the assessment of your clients should include questions about CSA?

Always  Sometimes  Never

.....

.....

.....

.....

3. During your assessment of clients, how often do you ask about a past history of CSA?

Always  75% of time  50% of time

25% of time  Never

4. If you have asked a client about CSA how do you record that information?

.....

.....

.....

.....

.....

5. Where do you store CSA information?

.....

.....

.....

.....

.....

6. Do you/your department access CSA information? If so, how do you go about doing that?

.....

.....

.....

.....

.....

7. How do you use the CSA information in supporting your client?

.....

.....

.....

.....

8. Are others within Aberdeen Foyer made aware of CSA information to assist the client? .....

.....

.....

.....

.....

9. Within Aberdeen Foyer is the information used anonymously to compile statistics about the prevalence of CSA in your user group?

.....

.....

.....

.....

10. How does your department tap into existing knowledge about CSA – e.g., accessing other colleague’s skill/knowledge/experience in dealing with CSA and surrounding issues?

.....

.....

.....

.....

11. Are others agencies out with Aberdeen Foyer made aware of the CSA data?

.....

.....

.....

.....

12. Does your department tap into existing knowledge about CSA from other agencies– e.g. accessing another agencies skill/knowledge/experience in dealing with CSA and surrounding issues?

.....  
.....  
.....  
.....  
.....

13. When you learn that a client has a history of CSA, does it change your approach to their care program?

Significantly                       Somewhat                       Not really

.....  
.....  
.....  
.....  
.....

14. What action, if any, do you usually take when you learn that a client has a history of CSA?

No particular action

Address the issue of CSA myself

Refer to another professional

(if so, which type of professional?) .....

Give client information on appropriate services available

(if so, which type of service(s?) .....

.....

15. Have you had any training in the assessment and/or treatment of CSA?

Yes                       No

If yes – please give details

.....

.....

.....

.....

.....

16. Do you feel you have had sufficient training in how to ask clients about CSA?

Yes                   No

.....

.....

.....

.....

.....

17. How do you personally feel about asking clients questions related to CSA?

.....

.....

.....

.....

.....

18. Do you have any reasons for not asking clients about CSA?

.....

.....

.....

.....

.....

19. Do you find it difficult to ask clients about CSA?

.....

.....

.....

.....

.....

.....

20. What do you think the barriers/obstacles are to your asking clients about CSA?

.....

.....

.....

.....

.....

23. Do you feel equipped to respond to a client's disclosure of CSA?

.....

.....

.....

.....

.....

23. Do you feel supported in responding to a client's disclosure of CSA?

.....

.....



## **Appendix B**

### **Training Course Details**

# **WORKING WITH ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE**

**A TWO AND A HALF DAY TRAINING COURSE FOR FRONTLINE WORKERS IN HEALTH, SOCIAL WORK AND THE VOLUNTARY SECTOR**

Presented by Sue Hampson, Safe To Say Training for Trainers Coordinator with SAMH, and Lynn Simpson Assistant Manager, Kingdom Abuse Survivors Project Fife.

This course is experiential, and provides participants with the opportunity to develop their knowledge and abilities in relation to childhood sexual abuse. It aims to help workers feel more confident, competent and aware, when working with adults who do disclose sexual abuse. It includes raising awareness of abuse, and the obstacles to disclosing in the black and ethnic minority communities. The course explores the effects of CSA on survivors, and also allows time for reflection and for paying attention to the impact of this work on frontline workers.

Participants work in pairs and small groups throughout the course.

The course explores the following themes:

- WHAT IS SEXUAL ABUSE?
- THE CONTINUUM OF ABUSE
- WHO ABUSES? IS ABUSED?
- THE EFFECTS OF SEXUAL ABUSE
- WHAT SURVIVORS VALUE
- ISSUES THAT GET IN THE WAY FOR WORKERS
- A SURVIVOR TALKING ABOUT THEIR EXPERIENCE
- WHAT DO I DO IF?
- RESPONDING SENSITIVELY TO THE CULTURAL NEEDS OF BME SURVIVORS
- LOOKING AFTER YOURSELF AS A WORKER WITH CSA
- PRACTICAL RESOURCES AND A BOOKLIST

# **SUPERVISING STAFF WHO ARE WORKING WITH ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE.**

**A TWO AND A HALF DAY MULTI AGENCY TRAINING COURSE FOR STAFF WHO HAVE SUPERVISORY RESPONSIBILITY FOR FRONTLINE STAFF WORKING WITH SURVIVORS.**

Presented by Sue Hampson Safe To Say Training for Trainers Coordinator with SAMH, and Lynn Simpson Assistant Manager, Kingdom Abuse Survivors Project Fife

This course will provide participants with the opportunity to focus on enabling staff to be reflective practitioners. It will include working to create a safe supervisory relationship, and supporting staff with the emotional content of this work. It will cover working sensitively with the cultural needs of BME survivors. It is an experiential course that involves working in pairs and small groups.

The course will explore the following themes:

- WHAT IS SEXUAL ABUSE?
- THE CONTINUUM OF ABUSE
- THE PRACTICE OF GOOD SUPERVISION
- WORKING COLLABORATIVELY IN THE SUPERVISORY RELATIONSHIP
- WORKING WITH THE CULTURAL NEEDS OF BME SURVIVORS
- WHAT WORKERS WILL NEED FROM A SUPERVISOR
- HOW TO LOOK AFTER YOURSELF AS A SUPERVISOR.

**For further information please contact:**



Jennifer Upson  
Aberdeen Foyer  
Marywell Centre  
Marywell Street  
Aberdeen  
AB11 6JF

**Tel:** 01224 212924

**Fax:** 01224 252899

**Web:** [www.aberdeenfoyer.com](http://www.aberdeenfoyer.com)

For more information, feedback  
or comments

**email:** [SurvivorscotlandFeedback@scotland.gsi.gov.uk](mailto:SurvivorscotlandFeedback@scotland.gsi.gov.uk)

The Scottish Government team working on  
the National Strategy is part of the Adult Care  
& Support Change team at the Department  
of Health, Scottish Government.

Scottish Charity Number: 23655