Developing a training programme for detecting and tackling childhood sexual abuse

A history of sexual abuse is common in people with mental health problems. A trust set up a programme to help staff broach this issue with service users.

INTRODUCTION
Sexual abuse is widely regarded as a contributory factor in mental health problems in later life (see Background box). Despite this, many health professionals do not consider it part of their role to identify patients who have experienced abuse. They may be concerned that raising the issue could open up a conversation they feel untrained to deal with. Yet mental health and substance use clients who have suffered sexual abuse say they would like the issue to be raised (Department of Health, 2002).

A main issue for drug/alcohol users is their substance misuse may increase temporarily during therapy for sexual abuse as a result of discussing sensitive issues, which can then exclude them from services based on certain criteria. DH (2006) inpatient guidance recommends that clients should have a full assessment in spite of substance use.

TRAINING PROGRAMME
As part of the second wave of the DH (2008) pilot programme on violence and abuse, Leicestershire Partnership Trust started to deliver training to 120 acute mental health staff over 12 months. It was rolled out across the trust to all levels and grades of staff from consultant psychiatrists to healthcare assistants. Three experienced practitioners from different backgrounds – drug and alcohol, psychotherapy and safeguarding – delivered the programme.

Each team was asked to nominate staff to attend. Several teams asked to train as a group, which worked well as staff then had the support of their team and the training could address each group member’s individual level of responsibility.

The response to the programme was positive, with 230 staff members receiving training in the first year.

Dealing with disclosures of sexual abuse
Practitioners felt the most difficult issue was not raising the topic but how to deal with clients’ responses. Many said they felt lost, scared, frustrated, angry and unsupported in dealing with this challenge, and that the issue should only be raised once a therapeutic relationship has been developed. However, by that point, service users may find it difficult to disclose past abuse.

The trainers addressed staff concerns about clients’ responses by explaining that, while few who have experienced sexual abuse want to discuss the details of their case, they do wish to talk about how they feel. It also became clear that practitioners do not consider asking about sexual abuse to be a part of their role but, instead, as part of the responsibility for either specialist services or the voluntary sector.

However, healthcare practitioners have an important role in encouraging those who wish to disclose past sexual abuse, as its long-term effects include:
- Relationship problems;
- Post-traumatic stress disorder;
- Depression;
- Anxiety;
- Feeling “dirty”;
- Inability to trust;
- Dissociation;
- Guilt;
- Self harm;
- Aggression;
- Addictive behaviour;
- Eating disorders;
- Phobias;
- Sleep disturbance;
- Behavioural problems;
- Suicidal attempts;
- Abusing others.

Delivering the pilot programme
The trust already had a successful and well-attended sexual abuse forum which had been running for four years, and a great deal of expertise in its personality disorder and specialist services. The pilot programme was
developed from and amended the DH’s set format to include eight relational positions:
- The unseeing, uninvolved parent;
- The unseen, neglected child;
- The sadistic abuser;
- The helpless, impotently enraged victim;
- The idealised, omnipotent rescuer;
- The entitled child;
- The seducer;
- The seduced.

Each session was adapted to meet the needs of the staff group attending; it was important to include those working with children and adolescents, older people and people with learning disabilities.

Safeguarding issues need to be considered in the context of people disclosing historical sexual abuse and the risks that a perpetrator may continue to pose to others. It was important that the trust was able to demonstrate its expectations for staff to act on these disclosures and that they understood the referral process.

During the training events, there were many discussions about how mental health services balance their duty to protect children with the need to maintain what is in many cases a therapeutic relationship with their clients. The trust ensures that supervision systems are in place to support staff with these issues.

The safeguarding adults process was reiterated when thinking about clients with ongoing abuse issues or when there may have been other vulnerable people in an abusive household. On all training days, we provided information on the safeguarding services available from external agencies.

Many examples shared during training sessions showed that domestic violence was often an issue for people who had experienced childhood sexual abuse, so this topic was also covered during sessions.

Finding the right time to ask was vital (Read et al, 2007) as was how to ask the question in a way that would maximise the client’s answer.

We provided emergency helpline telephone numbers for voluntary sector agencies, such as the Domestic Violence Integrated Response Project (DVIRP) and Women’s Aid, as well as contact details for the trust multi-agency risk assessment committee.

Time was also devoted to individual concerns and approaches. The training included information about the provision of care/counselling, treatment and support for clients and additional support for staff.

The issue of sexual abuse was added to the care programme approach documentation with a clause stating that practitioners should not raise the issue until they had received training, but they should consider its importance at assessment.

It was also seen as essential to recognise that some practitioners may have suffered abuse as children and to ensure they had access to confidential advice and support.

Table 1 outlines the main concerns that staff expressed about raising the topic of childhood abuse, as well as advice on how to overcome these.

### Table 1. Concerns and Solutions When Dealing with Childhood Sexual Abuse

<table>
<thead>
<tr>
<th>What if the client tells me the details?</th>
<th>The client is not likely to discuss details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reassure them it is fine to talk about the abuse; they are more likely to talk about how the experience made them feel</td>
</tr>
<tr>
<td></td>
<td>Seek supervision</td>
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<tr>
<td>I will make the situation worse</td>
<td>Ask the client what they feel they need</td>
</tr>
<tr>
<td></td>
<td>Staff cannot make it worse unless they tell clients they cannot listen to what they have to say</td>
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<tr>
<td></td>
<td>Offer to refer on</td>
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<tr>
<td>It’s not my job</td>
<td>Telling someone is sometimes all the client needs or wants to do</td>
</tr>
<tr>
<td></td>
<td>They will need assurance, just to know it is not their fault and that they can talk about it</td>
</tr>
<tr>
<td>Who will support me?</td>
<td>Specialist sexual abuse services</td>
</tr>
<tr>
<td></td>
<td>Psychotherapy departments</td>
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<tr>
<td></td>
<td>Child protection team/vulnerable adults team</td>
</tr>
<tr>
<td></td>
<td>Line manager</td>
</tr>
<tr>
<td></td>
<td>Police</td>
</tr>
<tr>
<td></td>
<td>Social services</td>
</tr>
<tr>
<td>What do I do with the answer?</td>
<td>Reassure the client and talk to line manager and specialist services for support</td>
</tr>
<tr>
<td>It happened to me</td>
<td>Support for staff is available through occupational health and specialist services</td>
</tr>
<tr>
<td>Do I call the police or social services?</td>
<td>Follow trust policy, advice from safeguarding nurse, line manager and adult protection</td>
</tr>
</tbody>
</table>

**Conclusion**

Staff need adequate supervision to be able to raise the issue of sexual abuse. Staff support groups should also be developed. All clinical staff need training on raising the topic when assessing patients. During the training, it became clear that teams needed to develop strategies and ways of broaching the issue that were appropriate for their specific service. They also did not know where or when to refer clients so they were given details on referral and services available.

**References**


