

A View From Inside The Box

A Social Research Project Exploring Sexual Abuse/Violence
Service Provision across the Bradford District



Contents

- 2** [Introduction](#) 
Why look inside the box?
- 4** [Research Overview](#) 
This report provides an overview of a research project which sought to explore service user and service provider views on service provision for (adult) survivors of sexual abuse/violence in the Bradford area of West Yorkshire.
- 22** [Survivors Power Networks](#) 
Tapping-in to the power network in Bradford 'Can the voices inside the box be heard?'
- 24** [An Outside Response](#) 
Are the issues from inside the box engageable? This report highlights three key areas for development: Partnership, Empowerment and Diversity.
- 26** [Action Plan](#) 
What should happen next
- 28** [Research Information](#) 
Leaflets and questionnaires issued to service providers and service users.
- 34** [Survivors Trust Briefing](#) 
The inter-relatedness of sexual victimisation and priority social and health policy issues.
- 42** [A Scottish survivor - Centred Strategic Approach Survivors of Childhood Sexual Abuse](#) 
This report draws together the recommendations of a Short Life Working Group established by the Scottish Health Minister in 2003, views of those involved in the CPG and commissioned research findings.
- 46** [The Politics of Gender](#) 
A discussion paper looking at the impact of gender on sexual violence provision.
- 50** [Relevant Books](#) 
- 52** [Abuse Service Links](#) 
Services which may be helpful in Bradford, the UK and Internationally.

 hotlink to section



Introduction

Why look inside the box?

some of you who read this report, may ask the question, **Why look inside the box? Is it not better to leave these issues alone?**

I would be lying if I didn't admit that, over the six years I have been campaigning to bring greater awareness to the issues faced by adult survivors of child sexual abuse, that I hadn't at times considered such an option. Certainly I have asked myself many times why I keep on pushing, against the barriers and entrenched resistance, to acknowledge the issue itself. But such a response would fail to acknowledge the true scale of the human distress sexual abuse brings to its victims and the lifelong impact it can have across many other issues within our communities. Such a response would also fail to acknowledge the silencing of victims within our society.

So I found the title for this report easy to arrive at - 'A View From Inside The Box'. It might easily have been called the 'Opening of Pandora's Box or opening up the 'Can of Worms'. All such titles acknowledge the fact that many people who work in human services continue to hold the view that experiences of sexual abuse in childhood should not be discussed with victims.

As many victims have held their stories of abuse locked away without disclosure to anyone, some professionals continue to believe that it would be inappropriate to engage with survivors about their abuse experience and the impact it has had. For many who come into contact with survivors of abuse it is simply easier to focus on the current issues. In other words, to keep the lid on the 'Box'.

But as this report reveals, there has never really been a 'Box' with a lid that works in reality. Instead we have denial from society about the real and lifelong issues generated for many victims by their experiences - mental health issues, drug misuse issues, relationship issues, anger management issues to name but a few! And so we see that a survivor has to adopt some other label, e.g., mental health user. Rarely are they seen as victims of crime attempting to find coping strategies as a result of being victimised, in a world that refuses to validate them, except as 'damaged goods' in many cases. Perhaps the notion of 'victims' triggers too much discomfort by challenging the idealised views of childhood which our society holds dear. Such responses fail to acknowledge the true extent of abuse in society and the true reality of the numbers of victims. The courage and tenacity of the

survivor to function in a world of such 'silence', is frankly, a testament to human resilience. It is the silence in many ways which compounds the crimes committed against the victim, and helps to reinforce many of the negative coping strategies they adopt in order to make sense of a world which denies them a voice to express their experiences. This is not Pandora's Box with a lid on, it is a cultural 'solitary confinement' with no key available and no parole board to review the sentence!

I never intended to create a research project. It was generated by a comment from a leading figure in the local voluntary sector community, who during a meeting expressed the view that sexual abuse was a "heart on your sleeve issue" and "where was the evidence?" To put it politely I was really shocked! I knew this man to be a caring and thoughtful 'social justice' campaigner. How could such enlightened minds miss the connections between sexual violence, its long-term impacts, and its context within a culture of silence?

Well, here is my response - it is not perfect but it tells a story. We learnt many things in putting together a district-wide research project on a very small budget including how many barriers there are for example in reaching survivors themselves!

But importantly, what it has produced is a coherent summary of the current views of many who work with survivors, and a glimpse of the views of survivors themselves. We hope those who believe it is "a heart on your sleeve issue", will take the time to read and respond to the evidence we present. Of course sexual abuse is 'a heart on your sleeve issue - isn't every social issue until it gets a social justice tick box? But sexual abuse is far more than just that. In my view it goes to the very foundation of human rights.

As you will see in the course of this report this issue isn't going away, rather it is emerging. We have an opportunity to work together now, in partnership within the voluntary and statutory sectors, to attempt to get the story of that emergence right at the beginning. Surely this would be better than attempting to repair and rebuild damaged relationships later, when central government decides, as Bernie Stinson so correctly points out 'to make sexual violence a tick box performance indicator'. Well sexual violence isn't a tick box issue - it's a real social and human rights issue. We have the vision to tackle it now collectively as a Bradford community, we don't need to wait to be led by central government. We have an opportunity to show the rest of the UK that Bradford is not afraid to step outside of 'the Box and deal with such issues both proactively and pragmatically. For the sake of victims everywhere, let's take this opportunity!

I would like to thank some of the people who made 'A View from Inside the Box' possible. Firstly, Steven Kingston of the Communities of Interest Working Group, CNet (Bradford district) who provided the funding for this project. I suspect that he was not always sure where I would take 'A View' at times but he let us run with it regardless of any such reservations. Secondly, Martin Manby, Director of the Nationwide Children's Research Centre, who was a friend of this research when it had few!

Whilst not directly involved in the funding of 'A View' I would also like to thank Janet Ford and Bernie Stinson for the support they gave in the very early days of our attempts to participate in the Community Empowerment Network with its aim to pathway marginalised issues to the people

who decide strategy and priorities in Bradford. I'm not sure you understood all the issues when we first met but it didn't stop you from asking how you could help and delivering that help openly and proactively. Thank you, you're what Community Development should be about - it is amazing what a little risk can generate!

In addition I wish to express my deep respect and thanks to Fay Maxted of The Survivor's Trust and Ian Warwick, Survivors Sheffield/University of Huddersfield - your contribution is a great enhancement to this work, providing as it does, a link to the national picture. Also Jazz Kang, formerly manager of Derby Rape Crisis, Mike Lew, Thom Harrigan and Richard Hoffman, writers and healers - thank you for constantly telling us we were doing the right thing and encouraging us to keep fighting for our vision.

A big thank you of course to all who took part in the research, especially the survivors who took the time and courage to share their experiences with Claire and the Service Providers who completed the questionnaire. Particular thanks is due to Keighley Relate and Off The Record who gave the project direct support - you didn't have to and we greatly appreciate that you did.

And finally Claire Fraser for her belief, openness, hard work and professionalism, without which, 'A View From Inside The Box' would not have been possible.

As a survivor, I hope 'A View From Inside The Box' will allow those who read it to consider lifting the cultural silence on this issue and to begin engaging with it proactively, as others have started to do in Scotland for example. I believe you would be helping to create solutions to many issues across our community and I hope you can find the resilience to do that against the distress and discomfort the thought of sexual abuse generates in us all. Child victims of sexual abuse become adult survivors. The more we know of the adult they become, the more we can understand the needs of children when they disclose - the link and logic is clear to me.

So 'why look inside the box'? Well no one else was going to and I've never regretted ending my own 'silence'. It freed me in many ways to explore the possibilities of who I might become, without the legacy of abuse

"This is not Pandora's Box with a lid on, it is a cultural 'solitary confinement' with no key available and no parole board to review the sentence!"

holding me back. I hope you can help others to make that journey possible for them also.

Sexual abuse steals a child's dignity and profoundly affects their spirit in ways that reflect negatively for us all. Together we can help to restore that dignity by empowering the voice of today's children to speak sooner of their abuse. 'Challenging The Silence' is not only about freeing the adults they will become, it is also about freeing the voices of the children who sadly are still abused today. We must free them to speak out before they discover society's cultural 'solitary confinement'.

'As we let our own light shine, we unconsciously give other people permission to do the same. As we are liberated from our own fear, our presence automatically liberates others'. Nelson Mandela

With kind regards,

Bob Balfour
Founder
Survivors West Yorkshire
June 2006

CLAIRE FRASER 2006 Research Overview



this report provides an overview of a research project which sought to explore service user and service provider views on service provision for (adult) survivors of sexual abuse/violence in the Bradford area of West Yorkshire. The research was commissioned by Survivors West Yorkshire and funded by the Communities of Interest Working Group, Bradford.

The first section of the report provides an overview of the Communities of Interest Planning Process, a description of the Bradford area and an overview of previous research in relation to sexual abuse, its long-term impact, prevalence rates and current service provision for survivors. The research methodology and procedure is then detailed along with the findings, summary and recommendations.

Planning for the Bradford District

Public services and voluntary organisations are increasingly required to ensure that all sectors of their community access their services on an equal basis and that the

services provided are appropriate to community need. They must work towards community cohesion, ensuring that all citizens share equally in an improvement in quality of life. An essential part of this process is action planning and consultation at the local level. In the Bradford area the Communities of Interest Planning process evolved in the autumn of 2002 to underpin community planning in the district by influencing service delivery and the prioritisation/allocation of resources.

Communities of Interest

'Communities of Interest' are defined as those that are less visible than communities with geographic boundaries (e.g., residents living in a particular area of Bradford). They pull in and link, through common experiences and concerns, individuals scattered across the whole district. The community identity is something that is life-long - it is part of what that person is, and it plays a part in how others see them and how they see themselves. However, community-specific identities can often result in discrimination and/or exclusion from mainstream activities and as such, communities of interest often experience barriers to influencing decision-making and in accessing services and activities.

The Consultation Process - Survivors of Child Sexual Abuse

Survivors of child sexual abuse are one such Community of Interest in the Bradford area. The Communities of Interest Working Group provided funding to allow Survivors West Yorkshire to consult with organisations in the Bradford district that provide a service, either directly or indirectly, to survivors of child sexual abuse and their service users. This consultation process was envisaged as a real opportunity for agencies working with the survivor community to influence action planning and the development of service provision in the Bradford area. The funding provided required Survivors West Yorkshire to engage with service users on the 8 framework areas of the Communities of Interest planning process - economy and jobs; better education for all; health and social care; community cohesion and community safety; leisure and culture; environment and homes; building communities and voluntary sector service provision.

Local Area Information

Bradford has a population of approximately 477,800 residents living within higher than average population density areas (1292 per km² compared to 380 per km² nationally). Locally, unemployment rates are higher than

average and the city is located within the bottom 10% of the most deprived areas within the UK. The city has a large Asian community (mainly of Pakistani origin) with 18.9% of Census respondents describing themselves as 'Asian British' in the Bradford area compared to 4.4% nationally (Source: National Statistics Online - 2001 Census).

Literature Review - Child Sexual Abuse

Much has been written previously about the long-term effects of child sexual abuse. Poorer physical and mental health, substance abuse and disrupted personal relationships were noted amongst survivors in a study of the general adult population (Lovell, 2003). Significant problems in adolescence and adulthood have also been noted in longitudinal studies which have tracked abused children over time to assess functioning (Trowell and Kolvin, 1999; Gibbons et al, 1995).

The Survivors Trust (2004), Draucker (1992) and Browne and Finkelhor (1986) have provided useful summaries of the characteristic effects that survivors may experience in adulthood. Emotional effects include depression, anxiety, low self-esteem, a sense of shame, anger and obsessive/compulsive disorders (Bifulco and Moran, 1998; Sanderson, 1990). Other common effects include interpersonal relationship difficulties, suicidal thoughts and self-destructive behaviours such as alcohol/substance misuse, used as a means to escape the pain of the abuse experience(s) (Whiffen et al, 2000; Spak et al, 1997; Swett et al, 1991).

Overall, it is acknowledged that survivors of childhood sexual abuse may be more susceptible to problems which may affect their ability to function normally in a work environment and thus, are more prone to low socio-economic status as a result of lack of income (Katz, 2000). It has also been noted, following a study with female survivors that some abuse victims may go on to choose low status work due to low self-esteem (Lovell, 2003; Mullen et al, 1994).

Studies also indicate that approximately 50% of female mental health service users are survivors of child sexual abuse and this figure rises to around 70% when adult violence and abuse are also taken into

consideration. The figure for females in secure settings is higher still (Mayne, 2005). At the time of writing comparative figures for male mental health service users were not available but recent research by the Howard League for Penal Reform (2006) has highlighted the abusive backgrounds of many young men in prison.

Prevalence

Estimates of the prevalence of child sexual abuse were found to range from 3% to 36% for females and 3% to 29% for males in a review of previous research (Cawson et al, 2000). Cawson's (2000) own research with 2,869 UK 18 - 24 year olds found 21% of young women (16% involving contact abuse) and 11% of young men (7% involving contact abuse) had experienced child sexual abuse (prior to the age of 12 or non-consenting). The National Institute for Mental Health in England has recently reported similar prevalence rates for child sexual abuse at around 20 - 30% for females and 5 - 10% for males (Mayne, 2005).

But prevalence rates are only the tip of the iceberg as much sexual abuse is never reported (Lovell, 2003). It has been estimated, based on the prevalence studies noted above, that there would be approximately 1,100,000 girls (21%) and 490,000 boys (11%) in England who have been sexually abused (Nurse, 2005). Yet in 2003 (the latest year for which figures are available) there were just 2,700 children on the child protection register for sexual abuse in England. In Bradford, 20 of the total child protection registrations (300) as at 31st March 2003 were due to sexual abuse (National Statistics/DfES, 2004).

The most recent British Crime Survey data available (2001) reports that '24% of women and 5% of men (from a sample of 22,500) have been subject to some form of sexual victimisation in their lifetime'. Furthermore, 7% of women and 1.5% of men reported that they had suffered a 'serious sexual assault at least once in their lifetime' and for 5% of the female respondents and 0.9% of the male respondents this was rape (Walby and Allen, 2004).

In the year 2003/4, 36% of reported crime in the Bradford area was categorised as 'violence against the person' (11,297

“Prevalence rates are only the tip of the iceberg as much sexual abuse is never reported”

recorded offences). However, no further breakdown of statistics is available to identify the percentage of this figure which relates to sexual violence/abuse (Source: National Statistics Online - 2001 Census).

Recent media attention has highlighted the widening gap between recorded crime figures and corresponding conviction rates, with a particular focus on female rape. The recorded crime figures in this category were 1200 in 1980 and 12,867 in 2004-5, an increase of nearly 11 times the original figure. Meanwhile conviction rates for rape against females have taken a downward spiral from 38% in 1980 to 5.5% in 2004-5 (Rose, The Observer, 2006). Fears regarding delays in forensic examinations for sexual assault victims due to understaffing have also been raised and such delays are likely to impact on conviction rates (Goveas, Children Now, 2006).

CLAIRE FRASER 2006 Research

Current Service Provision for Survivors

From the prevalence and crime rates reported, it is clear that a significant proportion of adults will have experienced some form of sexual abuse in their lifetime. However, previous research and survivor accounts indicate that service provision and experiences of finding adequate support are limited (The Survivors Trust, 2004; Franken and Van Stolk, 1990; Armsworth, 1989). Warwick (2005) has highlighted some of the failings in professional responses to survivors such as failing to make links between abuse and mental health problems, failing to respond to disclosures and the lack of training in responding to survivors of child sexual abuse.

It has been suggested that the failure of statutory services to acknowledge and deal with the issue of sexual abuse and the potential long-term impacts can be seen as a reflection of the notion of 'silence' that is all too often seen in wider society in relation to sexual abuse (Gibbons, 1996). Rock (1990) has suggested that this may in part reflect a fear amongst policy makers of exposing a large area of need and dissatisfaction with current service provision, in other words, 'opening the box'. The fact that survivors themselves and the support groups working with survivors have rarely been consulted with about policy and services at local and national level appears

to further support this view (Taylor-Browne, 1997). However, in recent years, researchers have begun to explore service provision for this community of interest (e.g., Hamm, 2001) and it is hoped that the key recommendations raised by such research can be acted upon.

Whilst the impact of sexual abuse appears to be finally appearing on the agenda of policy makers in England and Wales (e.g., Victims of Violence and Abuse Prevention Programme, Department of Health/National Institute for Mental Health in England/Home Office), it is to Scotland that we must look for the best examples of current good practice. Following the establishment of the Cross Party Group for Survivors of Childhood Sexual Abuse in 2001, much work has been undertaken to develop a national strategic response to sexual abuse, including the formation of an Adult Survivors Reference Group and the establishment, by the Health Department, of a Survivors' Fund with a budget allocation of £2m. Recent publications have also produced timely guidance for service providers in working with survivors of child sexual abuse (Nelson and Hampson, 2005; Scottish Executive, 2005).

Sexual abuse remains a taboo subject for far too many in society to confront but many courageous individuals and groups, both locally and nationally, are choosing to stand up and challenge the silence. These

individuals and groups, who work tirelessly to support the survivor community, are helping to bring this important issue to the public eye. As the Scottish Executive (2005) has noted, "it (sexual abuse) requires above all, a recognition that it happens and that its impact can be lifelong". It is hoped this consultation in the Bradford area will be an important step towards 'opening the box' and 'challenging the silence'. Survivors West Yorkshire is grateful to the Communities of Interest Working Group for supporting this timely piece of research.

Methodology and Procedure:

The current research project employed three stages - an initial mapping exercise, research with service providers and research with service users. All stages were undertaken by Claire Fraser, Research Consultant.

Stage One - Mapping Exercise

An initial desk-based review was carried out to identify voluntary and statutory sector service providers in the Bradford area who might be working, directly or indirectly with survivors of sexual abuse. An example of a 'direct' service provider would be those organisations working directly with survivors such as rape crisis organisations. An example of an 'indirect' service provider would be those who might hear disclosures and then refer on to a direct service

provider, for example, General Practitioners and Social Workers. A range of local directories and online resources were searched to identify the 342 service providers who would receive the Service Provider Questionnaire in Stage Two.

Stage Two - Research with Service Providers

The Service Provider Questionnaire (SPQ) was designed specifically for this research study and explored current service provision, disclosures, referrals, inter-agency working and key issues for survivors of sexual abuse, particularly in relation to the communities of interest themes (see Annex). Some of the items on the SPQ were drawn from the questionnaire used by Sarah Nelson in her Needs Assessment of Adult Male Survivors in the Lothian region of Scotland (Nelson, 2004) and we are particularly grateful for her permission to do so. An 'open-ended' format was also incorporated into the last

section of the questionnaire to allow each organisation to raise any additional issues. All service providers were also asked whether they would be willing to consider inviting their service users to participate in Stage Three of the research project.

In October 2005 questionnaires were administered to 342 service providers in the Bradford area. 79 were administered via email and the remaining 263 were administered via surface mail. 114 of the recipients were located within the voluntary Sector and represented agencies providing a range of services in the areas of counselling (abuse, generic, relationship, gender, sexuality); mental health; faith; drug/alcohol misuse; domestic violence; BME support services; homelessness and housing; refugee and asylum seekers; disability and learning disability; health; eating disorders; looked after children/adoption and fostering; working women and generic support centres (youth, elderly, community).

Questionnaires were also administered to 228 statutory sector service providers. 121 of these were General Practitioners across the Bradford area and the remaining 107 were statutory agencies in the following areas - NHS (including mental health, learning disability, day centres, nursing, drug/alcohol misuse); child and adult protection units, police, probation, Her Majesty's Prison Service, youth offending team, victim support, education, social services, sure start, early years service and local academics.

Three follow-up interviews were also undertaken with service providers to explore the themes emerging in greater depth. The interviewees were located within the fields of learning disability (statutory sector), drug/alcohol misuse (voluntary sector) and direct support for victims of abuse (voluntary sector).

Sector Location of Agency	Yes	No	Not Sure	Total
Statutory Sector	10	17	2	29
Voluntary Sector	15	16	2	33
Total	25	33	4	62

Table One

Sector Location of Service Providers Wishing to Invite Service Users to Take Part in the Consultation

Stage Three - Research with Service Users

Individual qualitative interviews with four adult service users (2 male (both white); 2 female (1 mixed ethnic group; 1 white)) were also undertaken to explore issues for survivors in relation to the communities of interest themes, thoughts on possible solutions, experience of service provision and service delivery, and what service users would like to see available and how this should be delivered (e.g., via statutory or voluntary sector). An interview schedule was designed for this purpose (see Annex).

It had been hoped to consult with 20 service users and 25 of the 62 participating service providers were willing to invite their service users to participate as detailed in Table One.

But despite this welcome support from many voluntary and statutory sector agencies, and much time spent publicising the research, recruitment of service users beyond the four noted proved not to be possible. This 'finding' is discussed in further detail in the Conclusion section of this report. However, despite the relatively small sample size it should be noted that the respondents did reflect a range of ages, backgrounds and service provision experiences and their views provide important indicators of how service provision needs to develop.

“The psychiatrist said there are people worse off than you, you've not been raped”



Ethics

The research adhered to ethical and research governance guidelines on research with human participants set out by the British Psychological Society (2005; 2006) and Department of Health (2005). All participants from the service provider and service user samples were provided with a research information leaflet (see Annex) and asked to sign a consent form (see Annex) to indicate their informed consent. The research was also submitted to and approved by the Local Research Ethics Committee and Research and Development Unit to allow access to NHS staff and service users.

Findings

Service Provider Questionnaire Overview of Responding Agencies

62 Service Provider Questionnaires were completed and returned from the voluntary and statutory sectors as detailed in Table Two below. One further questionnaire

was returned too late to be included in the analysis.

The 62 completed returns represent an 18% response rate from the 342 questionnaires administered in October 2005.

It is acknowledged that this is quite a disappointing response rate given the extended period (6 months) allowed for returns, the use of extensive publicity at local events and in local publications and the use of direct reminders to non-returners. However, these overall figures can be further broken down to provide a more detailed response rate from the participating sectors as detailed in Table Three which clearly indicates the differing response rates across agency sectors.

The responding agencies were also located across a range of specialist fields as detailed in Table Four below. The fields of counselling (including specific sexual abuse support), mental health and health were particularly well represented as might be expected.

Service user Groups Represented

The majority of respondents (84%) were working with both male and female service users although 16% provided a gender-specific service for female service users only. Despite the existence of some male-only support services in the Bradford area, no responses were received from this sector. 4 service provider respondents (7%) did not routinely record the gender of service users.

Whilst it was acknowledged on the questionnaire that 'many people do not reveal their abuse history to services', respondents were asked to estimate how often their agency came across clients whom they knew had experienced sexual abuse. 64% of all service provider respondents noted that they regularly came across service users whom they knew were survivors of sexual abuse. 31% noted that they sometimes came across service users whom they knew were survivors.

Table Two - Sector Location of Agencies Completing Service Provider Questionnaires

Agency Location	Frequency	%
Statutory Sector	29	47
Voluntary Sector	33	53
Total	62	100

Table Three - Response Rate by Sector Location

Agency Location	Questionnaires Administered	Questionnaires Returned	Response Rate (%)
Voluntary Sector	114	33	29
Statutory Sector (excluding GPs)	107	24	22
Statutory Sector (GP Sample)	121	5	4

Table Four - Main Service Provided by Responding Agency

Agency Remit	Frequency	%
Counselling/support service - generic	10	16
Housing support	3	5
Domestic Violence Support	5	8
Substance misuse support	5	8
Mental health service	13	21
Sexual abuse - specific support	5	8
Learning Disability service	4	6
Police/probation/prison service	3	5
Faith	2	3
Health	10	16
Gay lesbian bisexual support	1	2
Social Services	1	2
Total	62	100

Disclosures, Information Recording and Sharing

Service providers were asked whether they would routinely ask about a history of sexual abuse and whether this information was recorded or shared with any other agency. 23% of respondents indicated that they would routinely ask service users about a possible history of sexual abuse, usually in the initial client assessment. One service provider noted:

“Most of our service users disclose childhood sexual abuse after trust has built up in our relationship with them and usually on a one to one basis. However, we have often seen the signs way before.”

Where disclosures were made (either as a result of initial assessment or without prompting), this was routinely recorded by the service provider in 40% of cases. 60% of service providers did not record disclosures and therefore held no information on the

numbers of survivors within their client group. Of the 40% of service providers who did record disclosures, this was shared with other agencies in 21% of cases. This was always done with the consent of the service user and was usually to facilitate access to therapeutic support (e.g., referral to Primary Care Trust Mental Health Team) or to support legal/statutory action against a perpetrator (e.g., referral to Police or Social Services).

Service Provision and Inter-Agency Referrals

Respondents were asked to indicate whether they provided a specific service for survivors of abuse, whether (if not a specific abuse service) they responded to abuse issues ‘in-house’ or whether they referred clients on for specific support in relation to abuse issues elsewhere. 21% of the participating service providers indicated that their agency provided a specific service for survivors of sexual abuse such as counselling, telephone help

lines/pathwaying and group work. As this group represents less than a quarter of the total respondents, it is interesting to note that almost two thirds (63%) of the total sample noted that they worked with abuse-related issues ‘in-house’ if they arose.

It is not clear whether this finding is due to a perceived lack of suitable specific agencies for service providers to refer onto in the Bradford area, waiting times for specific services, or because of service user reluctance to engage with specific sexual abuse support services. However, regardless of the underlying explanation, this finding suggests a clear need for training for service providers in all frontline agencies in working with survivors of sexual abuse.

The majority of inter-agency referrals for specific support for survivors of abuse were made to service providers within the voluntary sector (66%) although many were also made to the statutory sector (48%), particularly the statutory mental health and psychotherapy teams. It is considered that the high numbers noting that they dealt with survivor issues ‘in-house’ may be partly explained by the long waiting lists for referrals to specific support agencies and initial agency attempts to support survivors who are waiting for more specific support. The propensity for referrals to be made to agencies within the voluntary sector and the knowledge that much expertise is located within this sector further underpins the need for longer term funding for voluntary sector service provision in this area.

Respondents were also asked to indicate whether they felt current service provision met the needs of survivors of child sexual abuse. As detailed in Table Five below, the majority (69%) did not.

Table Five - Does current service provision meet the needs of survivors?

Response	Frequency	%
Yes	4	7
No	43	69
Don't know	15	24
Total	62	100

“ A clear need for training for service providers ”

One particular gap in service provision highlighted was the lack of support for victims of abuse with a learning disability. Difficulties in finding services for male survivors and the recent closure of a service which supported the mothers of abused children were also noted. It was felt that

an up to date directory of current service provision would be useful in making referrals for appropriate support. In addition it was suggested that many voluntary sector services could advertise their services better in order that service users are made aware of provision that **does** exist.



Presenting Problems

Service providers were asked to indicate which of a list of presenting problems they had witnessed in their survivor client group. The responses given support earlier research on the long-term impact of child sexual abuse and the array of problems experienced by some survivors.

The three most common presenting problems are highlighted in Table Six. Only 1 of the 62 service provider respondents indicated 'no particular problems (had been) observed amongst survivors' in their client group.

In addition, a number of respondents also cited additional presenting problems they had witnessed amongst survivors including somatic presentation of distress; difficulties with sexual relationships; the desire to see justice done; denial, secrecy & compartmentalisation of lives; arrested development; sleeping problems and nightmares; self-withdrawal and isolation; self-hatred and low self-esteem; spiritual distress; post-traumatic stress disorder; and eating disorders.

One service provider also acknowledged the wider impact of abuse in terms of how it can

affect not only the survivor, but their partner and family also:

"Many male and female survivors describe a sense of aloneness which is reinforced by the lack of service provision, especially in the case of men where no or little provision is available. Family and Partners also feel this sense of aloneness and don't feel their needs are met and given the lack of support for the survivor feel guilty about even having needs."

"Many male and female survivors describe a sense of aloneness"

Table Six - Presenting Problems Witnessed Amongst Survivor Client Groups

Presenting Problem		Frequency	%
Mental Health Issues	Yes	55	89
Self-Harming	Yes	57	92
Suicidal Feelings	Yes	49	79
Relationship Difficulties	Yes	57	92
Aggression/Anger	Yes	51	82
Parenting Difficulties	Yes	41	66
Substance Misuse	Yes	45	73
Housing Difficulties	Yes	27	43
Isolation within Community	Yes	36	58
Low Self-Esteem	Yes	57	92
Flashbacks	Yes	45	73
Hearing Voices	Yes	18	29
Sexual Identity Difficulties	Yes	29	47
Offending Behaviour	Yes	25	40
Alcohol Misuse	Yes	46	74
Employment Difficulties	Yes	27	43
Disruption to Statutory Education	Yes	37	60

Priority for Future Service Provision

Service provider respondents were also asked to choose and rank their top three priorities for service provision improvements from a list of 8 options. However, many of the respondents ticked more than three options and failed to rank the options chosen in order of priority. Therefore the options are simply presented in Table Seven with details of the numbers of respondents (and % of total sample) indicating an affirmative response for each suggested priority.

Table Seven - Priority for Future Service Provision for Survivors of Sexual Abuse

Priority for Future Service Provision		Frequency	%
Individual Counselling/Support	Yes	42	68
Group Work/Group Support	Yes	28	45
Challenging the Silence	Yes	29	47
Resources within Own Organisation	Yes	19	31
Resources within Other Organisations	Yes	27	43
Staff Training	Yes	23	37
Staff Supervision	Yes	8	13
Multi-Disciplinary Support Networks	Yes	24	39

There is clearly much support for increased service provision in the form of individual counselling and support for survivors of sexual abuse. Although it was acknowledged by some that what is important is that there is service provision available rather than what is on offer. The majority of respondents (85%) also indicated that they would prefer to see such provision located jointly within the voluntary and statutory sectors rather than become the specialism of either sector individually. A multi-disciplinary support network would certainly underpin such an approach. In addition, the need for preventative work to reduce the number of survivors in society was noted.

Almost half of the service provider respondents acknowledged that the silencing of abuse in society needs to be challenged, supporting one of the key goals of Survivors West Yorkshire. The following additional comments were also made by respondents:

“Anything which can improve the situation can only be a good thing - many people still feel they have no-one to turn to and that no-one will believe them.”

“At present, the majority of service users have lived in silence due to their age group. However, hopefully this will change as the next ‘wave’ of younger service users come through the system.”

“The lack of sustained and joined up service provision across all sectors in Bradford is a moral failure on behalf of all in our community to be adult and rational about servicing the legitimate needs of victims of major crimes. For some reason society forgets once the victim is an adult - even though our culture reinforces the silence which traps the child until adulthood (preventing disclosure until adulthood).”

Some respondents also chose to comment specifically on the current funding available for support for survivors of sexual abuse:

“Some good voluntary work is being done but we should not have to rely on funding for such an important initiative. Therefore some statutory provision and input to service is needed.”

“Joined up strategies across all sectors are needed, with long term secure funding linked to cutting edge best practice, service development and innovation in partnership with victims of sexual crime.”



To further develop ideas around future service provision respondents were also asked to indicate the best 'points of access' for support services for survivors of sexual abuse and responses are detailed in Table Eight below.

Points of Access		Frequency	%
Primary Care	Yes	46	74
Drug and Alcohol Services	Yes	35	56
Penal Establishments	Yes	30	48
Educational Settings	Yes	31	50
Mental Health Services	Yes	43	69
Homelessness Projects	Yes	29	47
Private Sector Counsellors	Yes	34	55
Social Work	Yes	34	55
Any Setting	Yes	33	53

Table Eight - Preferred Point of Access for Support Services for Survivors of Sexual Abuse

The need for community based settings was also noted as well as the choice of a range of services to respond to the individual needs of a range of survivors. In addition, the lack of support services and access routes for people with learning disabilities was noted.

Respondents also noted that, given the potential range of access points, it was imperative that front line staff were trained to recognise the signs of abuse to enable them to respond to service users with sensitivity:

"It is the reception a person receives and the subsequent service that determines whether they feel they can disclose and trust the support offered."

Suggestions for the core aspects of service provision were also made. These included the need for safe, informal, confidential and non-judgmental spaces to facilitate disclosure; specially trained staff and long-term provision to allow trust to build between counsellor and service user.

Findings - Service User Interviews

The findings from interviews with 2 male and 2 female service users are thematically organised under the 8 framework areas of the Communities of Interest planning process - economy and jobs; better education for all;

health and social care; community cohesion and community safety; leisure and culture; environment and homes, building communities and voluntary sector service provision. For each of the 8 areas respondents were asked to reflect on the key issues that arise for survivors and suggested possible solutions to any problems identified.

Economy and Jobs

Survivors are sometimes suffering financial hardship because of the extra challenges they are facing in day to day life. Examples were given of the difficulties some find in holding down a demanding job when dealing with the long-term impact of sexual abuse. For others the notion of 'career' is a somewhat alien concept, struggling as they do to function on a daily basis. As one respondent noted:

"Why worry about a job or a pension if you are suicidal"?

Quite clearly though some survivors do achieve success in their career but it was felt that for some this might be through a process of 'compartmentalisation', whereby the survivor's work and home persona are markedly different or where work is used as an escape mechanism.

For survivors who are working through their recovery process and keen to return to work

it was felt there was little understanding amongst staff in the Employment Service. A lack of training had left staff unable to understand the particular needs some survivors may have such as a need to be home before dark or the restrictions on distances that could be comfortably travelled for employment:

"It should not be a choice between trying to function independently or being fully in the system (i.e., a mental health user not able to work). The system should provide adequate support for those who are able to and want to work with some support."

Respondents also noted the stigma associated with an abuse history, linked to the wider societal stigma surrounding mental health issues in general. This led to fears of disclosing their survivor 'status' at work because of the perceived negative impact on a career. This was also increasingly problematic with the trend for some employers to require detailed medical histories for new job applicants, forcing some to lie when asked for such details. It was noted with irony by one respondent that many with mental health diagnoses are prevented from entering certain professions, e.g., caring professions, when they are the most likely candidates to be able to relate to patients.

“Service user interviews”

“I am not mentally ill; I am a victim of sexual abuse”

The cost of accessing support services in the private sector was also raised. Two respondents had paid for private therapeutic provision due to the length of waiting lists in the voluntary sector and within NHS provision. Clearly, many would not have such an option available to them, raising the possibility of a two-tier system for survivors with money and for those without.

Linked to this last point is the cost of seeing professionals to obtain reports to support CICA (Criminal Injury Compensation Authority) claims for victims of abuse. It was suggested that financial support to obtain such reports should be made available to all applicants.

Better Education for All

For many survivors sexual abuse occurs in the midst of mainstream education. As a result educational progress can be seriously jeopardised, affecting attendance at school or leaving the victim prone to bullying as a result of withdrawal and isolation from their peer group.

Clearly victims of abuse will require additional support within the education system but a lack of support during this period was noted by 3 of the 4 respondents. One in particular recalled a complete lack of

support whilst at school at the time of the abuse in the 1950s but suspected support systems may have drastically improved over the last 50 years. However 2 younger respondents recalled similar experiences in the 1980s and 1990s:

"Nobody spots it (abuse), even when you are suddenly absent, mis-behaved, or ill when you were previously a model pupil who was never in trouble or absent"

"I'm not working because I've got no qualifications - If I'd not been abused I might have stayed at school and not taken heroin and I might have a job now"

"How can you concentrate on your exams when you are going home and being raped on an evening?"

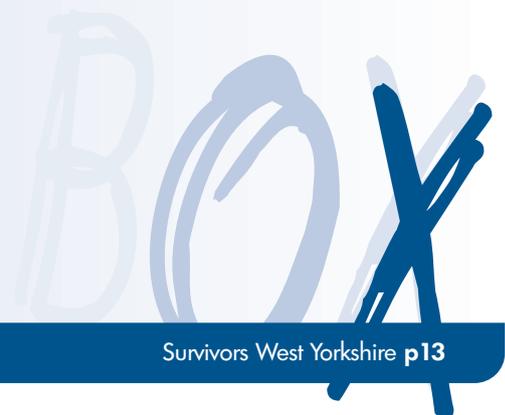
It was felt that the reason for this lack of support within the educational system was two-fold. Firstly there is a need for awareness training for teachers and all school staff to allow the signs of abuse to be detected and acted upon. Secondly, it was felt that the current "child protection culture" had built up a wall between teachers and pupils, with teachers perhaps afraid to ask questions and offer support.

The need to educate children and young people about appropriate sexual behaviour was also cited as a key element in preventing sexual abuse:

"How can survivors believe society wants them to thrive if nothing is put into prevention? We need to educate to prevent abuse rather than working out how to respond to it afterwards."

"Why is the onus on victims protecting themselves instead of teaching potential offenders about appropriate behaviour?"

“Schools need to deal with it, not sweep it under the carpet”



HEALTH & SOCIAL CARE

Health and Social Care Need for Staff Training

The overwhelming majority of responses in relation to health and social care related to respondent's experiences of the medical profession, particularly General Practitioners (GPs). It was felt that the majority of GPs lacked understanding of the impact of abuse due to inadequate training particularly in relation to identifying abuse and responding to disclosures. This lack of training could also lead to trivialisation of the abuse experience:

"The psychiatrist said there are people worse off than you, you've not been raped."

This lack of training (and lack of service provision as noted later) is thought to lead to an over reliance on the use of medication to treat the impact of abuse, as one service user noted:

"Some GPs are little more than drug pushers"

Overreliance on the Medical Model

GPs often seemed to need to explain the underlying causes and identify a diagnosis before they could help, utilising the medical model response to physical illness. This is of particular concern given the fact that many survivors will present to GPs with many 'symptoms' before disclosing abuse:

"I just felt he (GP) was unable to help as I couldn't disclose my abuse history at that time. Because he couldn't identify what was wrong he wasn't willing to help."

One respondent had made repeated presentations to their GP with "psychosomatic responses to my abuse" but the GP had failed to detect or even begin to probe the underlying problems.

In fact it was felt that many such patients are seen as a burden on the system rather than patients in need of further support.

Some positive experiences with GPs were noted but it was felt that this was only at a later stage, when the service user was not "in crisis" suggesting GPs are more responsive to those who are more able to clearly articulate their needs.

Responses to Service Users

In suggesting improvements to the relationship between medical staff and service users it was suggested that barriers needed to be broken down and that staff needed to begin treating patients with "warmth, honesty and compassion". A positive experience of support from one respondent was due to the fact that "he was down to earth, genuine and took time to listen." Many counsellors and psychologists were found to be white and middle-class which could lead to difficulties

in relating to service users from different backgrounds and cultures.

To ensure a compassionate response and greater understanding amongst staff it was felt that people with experience of mental ill health themselves should be given greater opportunities to work within the mental health system. However, it was stressed that such opportunities should be underpinned by adequate support systems for those staff.

The general ethos of the National Health Service was seen by one respondent as the cause of inadequate support for survivors of abuse and more generally mental health service users:

"The NHS needs to be more health orientated. It does not have a health focus; it is a system of containment and management of those who are seen as outside the norm. The idea seems to be to put everyone with problems together and contain them"

This issue was seen to be compounded by the vast amounts of paperwork and unnecessary bureaucracy which further limits human contact between patients and staff.

Service Provision

The need to increase NHS service provision and reduce the waiting lists for referrals to counselling and psychotherapy were seen as a priority for survivors. Suggested improvements included the use of surgery - based counselling to provide interim support and increased use of alternative therapeutic approaches within statutory provision, e.g., transactional analysis, reflexology.

The lack of support for survivors at major life stages such as during pregnancy and child birth and parenthood was also noted. More training appears to be needed to ensure that midwives and obstetric staff can appropriately support survivors at this time

Ultimately it was felt that policy makers and service providers needed to recognise the link between support at the time of abuse and the likely long term impact on the use of

services if inadequate support was provided. Related to this point is the need for specialist provision to support children at the time of abuse. One respondent recalled being referred to a counsellor who appeared to have no experience of working with children.

However, respondents were keen to note, in calling for better survivor service provision, that there is a need for the recognition of the stages of recovery:

"Some survivors are in crisis but not all of us are. There seems to be an attitude of either you are fine (recovered) or in crisis and a complete wreck. We need a less black and white approach."

Service User Involvement

The need for more genuine patient involvement and patient choice to reduce the great numbers of disempowered people

in the system was noted by service users. Whilst some attempts at developing 'service user involvement' had been seen in the Bradford area, it was felt that this was largely a "sham":

"Service user involvement is a sham - the ideas from meetings are taken away by people in power and nothing ever happens - this is more disempowering than being completely ignored in the first place."

The use of patient advocates was also suggested. These were seen as intermediaries who could liaise with clinical staff on behalf of patients, particularly where learning disabilities or language barriers might otherwise prevent real patient empowerment.

"You might claw your way back to respectability, but only if everyone manages to forget what you told them when you were ill. "

Community Cohesion

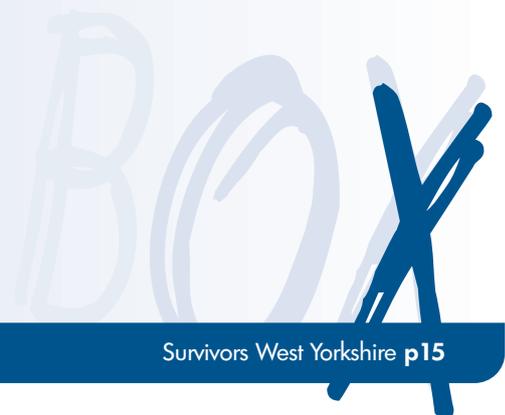
The stigma of the mental health 'label' was viewed as the main barrier to 'community cohesion' or full engagement with society. Disclosure of abuse was seen as an automatic precursor to the label of 'mental health service user' and, in some extreme cases, the risk of being sectioned and therefore further alienated from society.

Even in less extreme cases this labelling can result in exclusion from the local community, making it harder for survivors to build links and foster relationships - a problem which might only be overcome when the societal response to mental health issues is challenged.

For the present time though the mental health label is perceived as all enduring, a situation which undermines the recovery process for survivors:

"You might claw your way back to respectability, but only if everyone manages to forget what you told them when you were ill"

For some survivors their experiences have left them with difficulties in trusting others, further limiting community cohesion. Others will avoid situations which in some way remind them of their perpetrator, such as male-dominated events.



Community Safety

It was noted by one respondent that the assumption is all too often that survivors feel unsafe outside of the home and will not venture out alone, particularly after dark. But this was seen to undermine the true reality of sexual abuse - that perpetrators are often known to the victim and as such, victims may actually feel safer outside of their home. It was also suggested that the idea of community 'safety' may be a misnomer if the victim is unable to disclose because of the fear of death threats from a perpetrator.

Furthermore, it was suggested that many irrational perceptions seem to operate around sexual abuse and violence which undermine the very idea of community 'safety':

"Safety? Ha! Why are victims blamed?! Burglary victims are not asked by barristers, 'Could it not be said that you left your valuables on display in the window and were asking to be burgled?"

Environment and Homes

A number of issues for survivors in relation to the living environment and home were raised by the service users. In the first place, the home might not necessarily be a place of safety if the perpetrator of the abuse is a family member. Thus the idea of the 'safety' of the family home is something which should not be taken for granted and aligned to this is the need to challenge the disproportionate and inaccurate emphasis in society (and particularly the media) on 'stranger abuse'.

As noted in the earlier section on economy and jobs, the potential financial hardship that may be experienced by some survivors due to the impact of the abuse on their ability to work may prevent some from acquiring a home of their own. Further housing issues may also arise for survivors at particular life stages. For example, one respondent recalled being wary of sharing a house with strangers during University.

Another respondent who had recently acquired their first independent home was particularly grateful for the support received from a voluntary sector supported housing scheme who, it was felt, had shown more interest in the respondent's welfare than any of the many medical staff previously encountered.

Leisure and Culture

It was noted that participation in leisure activities can be a rare and daunting experience for some survivors as abuse can lead to shame and fear which results in withdrawal from social networks. Some survivors also note that this withdrawal is often channelled into solitary activities such as studying which, whilst having rewards such as good exam results, does little to improve the self-esteem and confidence of survivors.

However, the potential for leisure and culture to be a positive healing 'tool' was raised by all respondents:

"We need to use leisure and culture opportunities to facilitate survivors to re-organise and re-integrate themselves so they are not always a 'victim'."

Building Communities

The respondents interviewed felt that there were too many barriers which prevented survivors from actively engaging in their local communities and wider society:

"Survivors need to be given a voice; we don't want any special favours, just allow us to participate."

The need to identify and challenge perceived barriers in organisations making policy decisions, perhaps on the grounds of discrimination was also raised:

"Numerous research and reports have identified the need for better service provision for survivors, so why does it not happen? Because society can't deal with survivors! But surely anti-discrimination legislation would apply? There is protection from exclusion on the grounds of race, religion, disability and gender but there is no comparable system for survivors."

But it was acknowledged that the first step in addressing the wider engagement of survivors in society and providing better service provision was to remove the taboo that exists in society around victims of sexual abuse. In other words, it is time to 'challenge the silence'.

"We need to acknowledge the existence of survivors in society, to

"Art and Culture could be a way to return to or re-find your original (pre-abuse) identity and to build links with the community and generally be in contact with others."

One respondent's faith had provided an opportunity to be in a "positive environment with positive people":

"The faith movement, unlike society in general, has a real understanding of human potential"

The use of television to raise awareness of sexual abuse in society was also suggested (lightheartedly) by one creative respondent:

"Like 'Goodness, Gracious, Me' broke down multi-cultural barriers, maybe we should have a survivors comedy show!"

provide validation. This will eventually pave the way for better service provision, but first need to remove the taboo around being a 'survivor'."

And linked to this last point is the need for survivors to be able to have a voice without being a mental health service user:

"We're not all in crisis all the time. You might not be mentally distressed but still interested in campaigning."

Whilst survivor disengagement from wider society due to the stigma of abuse has been noted, it was suggested that even survivors themselves often fail to engage with one another. The need for survivor 'networks' which could provide opportunities to explore shared experiences and provide peer support were highlighted:

"It is good to talk to others with the same experience - in general society you always feel different from everyone else."

But it was acknowledged that some had tried in the past to develop such networks but that they always seem to fail. It was felt that this might be because of inherent issues around trust and contact within the survivor community and the fact that it is often one person trying to run a network in their spare time. The availability of funding to allow the appointment of a co-ordinator to facilitate such a network was suggested.

In addition, the use of non-threatening mediums such as radio were raised:

"We really need build to links amongst the survivor community - One idea we counted, that we haven't got too far yet with is a 'Survivors Radio Show', which I think would be brilliant because it's kind of unthreatening because it's non-visual, and it's something you can listen to kind of anywhere...a half-hour programme once a month, or something. You don't actually have to talk about sexual abuse the whole time. Survivors is about who you are, not just what's happened to you."

Voluntary Sector Services

In reflecting on the experience of voluntary sector provision this was described as "less constraining and powerful" than the statutory sector:

"She was just a human being, not a GP, I knew she didn't have the power to lock me up or section me."

However, the lack of funding within the voluntary sector provision was a key issue raised by all respondents. The existence of much expertise within the voluntary sector was acknowledged, but it was felt that this expertise may sometimes go unused because of the lack of funding to deliver specific support services for survivors. Where services did exist it was almost a matter of luck in finding them due to a lack of publicity about services on offer. It was felt that this lack of service provision publicity reflected the fragility of funding support and the reluctance to advertise something that might not exist longer term.

"The expertise is out there in voluntary sector and lots of organisations are desperate to provide support to survivors. We just need to remove the taboo and put pressure on funders."

This has resulted in a situation whereby only those survivors who have the ability and energy to "go that extra mile" are able to find support and many stories of the negative impact of the loss of support when

the service provision has to close due to lack of funding.

Some respondents commented that the voluntary sector currently appears too disparate and would benefit from a "joined up thinking strategy", something which could clearly be underpinned by a multi-disciplinary network of service providers. Related to this issue is the fact that some voluntary sector agencies have "too wide a focus" (e.g., mental health generally) although it was acknowledged that this may be a necessity in order for such agencies to receive funding.

What is needed though is specialist support for survivors of abuse and the availability at a policy level of funds to support such provision. This would also support work towards a distinction for survivors from the label of 'mental health service user'. As one respondent noted:

"I am not mentally ill; I am a victim of sexual abuse."

Service Provision

Some further general comments about service provision and survivor empowerment were also raised by respondents and these are summarised here.

The need for service providers who really understand the issues of abuse was expressed and it was suggested that survivors themselves might be the best people to work with victims of abuse. The need for accessible and community-based support services was also noted, not only because some people are less comfortable with travelling to the city centre but because some survivors do actually still work and therefore find daytime appointments difficult, particularly given the problems highlighted in disclosing abuse histories to employers.

The lack of choice in service provision for survivors of abuse was seen as one of the key issues that needed to be addressed. All respondents expressed a sense of survivors being expected to feel grateful for any support offered regardless of whether it was perceived to be adequately suited to the service user. For example, there was often a lack of choice in respect of the gender of the appointed counsellor and appointment times and if the counsellor-service user relationship failed to 'click' it was a case of

"well it is this or nothing else." As one respondent stated:

"There is a complete lack of choice in service provision for survivors; you're expected to feel lucky that you're being offered anything at all. In my experience it is a bit like the vegetarian option on a menu, you're lucky if anything exists."

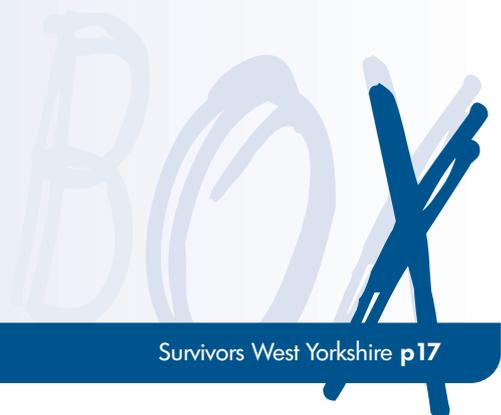
Empowerment

Respondents felt that survivors, like many other service users in the mental health system, were not sufficiently empowered. Medical staff were viewed as all powerful, with the ability to control (medicate) and section. Service users felt they had to accept any support offered, including unwanted medication prescriptions, since refusing help would undermine the perceived need for support and could result in the offer of support being withdrawn.

But the disempowerment of service users was not the sole preserve of the statutory sector. Respondents noted that voluntary sector service providers often appear to wrap survivor service users in a "blanket of protection", perceiving them to be vulnerable and therefore, incapable of an independent voice. The fact that less than half the service providers in this research

were willing to merely ask their service users if they wished to participate in the study seems to support this view. Similarly, one respondent had attempted to offer alternative therapies free of charge to survivor service users via the voluntary sector but had been told that survivors would not want this service, even though they were never asked!

"Like the vegetarian option on the menu, you're lucky if anything exists."



CLAIRE FRASER 2006 Research Summary

Research Findings Summary

This research provides an overview of service provision for survivors of sexual abuse in Bradford from the perspective of 62 service providers and 4 service users. Whilst the numbers participating are relatively low, it is considered that the findings from this research can be generalised to the wider survivor population since many of the findings support earlier research in this area (e.g., Nelson, 2004).

The findings reveal that survivors are presenting to a range of agencies in both the voluntary and statutory sectors and as such, there appears to be a need for greater awareness and training of front-line staff. In addition, it is imperative that specific services to support survivors are available to allow referrals to be made where the need for further support is identified. 69% of service provider respondents noted that such provision does not currently exist. Suggested priorities for specific service provision include greater availability of individual counselling and an increase in multi-agency working and sharing of good practice.

The service user interviews highlighted the potential life-long impact that abuse may have. More support is needed both within

the education system, to support children at the time of abuse, and later in life for adult survivors who are trying to find and hold down jobs. When reflecting on issues in relation to health and social care many examples of less than adequate responses from the medical profession were noted perhaps due to the lack of awareness training for medical staff and the lack of therapeutic provision. In addition, there appears to be an over-reliance on medication and the use of diagnostic systems due to the propensity to follow the medical model. A sense of isolation as opposed to community cohesion was also noted both in relation to wider society and within the survivor community. Such isolation and disengagement was widely believed to be underpinned by the stigma associated with abuse and more generally mental health and the need to 'challenge the silence' of abuse was highlighted. Although some good experience of service provision (largely in the voluntary sector) was noted, it was felt that service provision for survivors of abuse could benefit from additional funding and publicity. In addition, the need for choice and a range of accessible services which seek to empower service users was noted.

As noted earlier it had been hoped to recruit 20 service users to participate in this research. However, only 4 service users were recruited, despite great efforts to raise awareness of the research and the support of many of the participating service providers. It is considered that this difficulty in recruitment may reflect the long-term disempowerment and lack of voice amongst the survivor community and this is a key problem which must be overcome if we are to effectively 'challenge the silence'.

Future research should strive to engage further with survivor service users as recent research in Ireland has demonstrated the clear benefits of participating in such research (DRCC, 2005). Therefore, it is important that such benefits are made known to the survivor community to further empower this marginalised group. If further funding allows, it is intended to carry out further research in the Bradford area to identify the barriers to participation that may exist amongst survivor communities. Inherent in this approach will be an acknowledgement that not all survivors are mental health service users or indeed 'service users' at all and therefore additional recruitment sources and methods will need to be developed.

“ Challenging the Silencing and Stigma of abuse in our Society ”

Recommendations

- Increased availability of service provision including easier access and greater choice
- Increased funding to support service provision
- Enabling the empowerment of service users
- Publication of a guide detailing currently available support services
- Development of multi-disciplinary and cross sector support networks to facilitate sharing of good practice and provision of 'joined-up' services
- Awareness training for front line staff, particularly in the primary sector
- Challenging the silencing and stigma of abuse in our society

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NETWORK

SURVIVORS

POWER NETWORKS



■ Tapping-in to the power network in Bradford 'Can the voices inside the box be heard?'

There are two assumptions built into this title. The first is that a single 'power network' exists, and the second that it can be accessed by someone from outside of the inner circle. For those who are old enough to remember, there used to be a popular radio programme called The Brains Trust and one of its members was a certain Professor Joad. One of his favourite responses, when asked to explain something like, for example, "Why do birds fly south in the autumn?" was 'It all depends what you mean by...'

And so it is with Bradford. It all depends on what you mean by power and access. The question needs to be looked at from a number of angles, not the least of which are 'To what end do you wish to have access?' or 'What is your eventual aim?' This paper is working on an assumption that the eventual aim is to have some tangible recognition of a specific issue (such as sexual abuse) and for that recognition to be a lever for change, in ways such as through public funding for publicity and awareness and/or by discrete policy-making to build-in recognition and awareness on the part of every appropriate officer in the district.

One of the major problems facing anyone who wants to obtain enhanced support for a specific issue is the problem of getting that issue to be recognised as a priority on the local agenda. There is sometimes an assumption that this means nothing more than asking the council for money but, as with most other things, it ain't that simple. There are, for a start, a lot of people in front of you in the queue. And the council, particularly the crucial bits of it that deal with children (mainly Social Services and Education) are hamstrung by central government's habit of imposing statutory duties but forgetting to provide the money for their implementation.

If the council route appears to be a long and winding road then the next step may be to look at other forms and sources of support locally, perhaps in conjunction with other groups.

Money, of course, may not be the aim. Influencing the agenda may be the name of your game. So to whom do you speak to persuade them that you are a sincere and honest person and that your issue is the most important one around?

To return to our start point... how does one interact with the structures of decision-making in order to get what one wants?

Central Government regards 'Bradford' as a single political entity, so finding one's way through the local corridors of power and influence should be theoretically simple, if not easy.

Big mistake! Planet Bradford is multiple in all sorts of directions. Sometimes a series of parallel universes, at others competing worlds whose individual success depends upon others failure. And, before we slip into any easy assumptions, these dividing lines are not necessarily those of faith or ethnicity.

Let us take a look at some of the contextual 'facts on the ground', just to get a flavour of the background.

Fact one:

Two-thirds of Bradford is agricultural/horticultural/rural amenity land. There are great swathes of green between the centres of population that serve to reinforce the local sense of place - socially and politically as well as geographically.

Fact two:

'Bradford' (as seen by much of the rest of the district) is the big blob at one end of a shape drawn by London planners. Other bits of the shape encompass the ex-towns of

“ A single issue in need of support needs a friend ”

Bingley, Shipley, Keighley, Ilkley, Queensbury; and plenty of people still resist the Bradford-based hegemony that operates.

In addition there are other gravitational forces at work. Ilkley has a Leeds postcode, lies in a different valley over a range of hills and has no direct transport links to the entity to which it pays its local taxes. Similarly, a good chunk of Keighley thinks that it is in Craven, because Skipton is nearer in place, time and outlook than 'Bradford'.

And so it goes. A collection of separatist mini-states who were all forced at gunpoint into an arranged marriage and who still resent it. Thirty years is the blink of an eye within the geological time frame that is the Yorkshire mind set.

Fact three:

Bradford, or should that be 'Greater Bradford', has between three and four thousand voluntary and community agencies. On the one hand this is brilliant, an example of the best kind of widespread 'get up and go' that can be seen. On the other hand... it's total chaos in terms of getting a clear picture across the district on issues like assessing the needs of the population, or getting all relevant groups together on any particular topic.

There is, it goes without saying, not enough money to go round for public support of all this non-statutory energy. Which means one of two things: that groups compete with each other for available funding or they don't. Survival lies in either doing better than other people in the same situation or in doing one's own thing without reference to anyone else.

Fact four:

Until recently Bradford was a hung council. This makes for interesting politics but difficult strategic planning. Each administration has, in reality, a shelf life of about eight months before the next election looms that could change everything. In theory this is true of every local council in Britain but the 'fact on the ground' is that an administration with a longer-lasting or in-built majority will develop a different quality of relationships with senior officers, central government, local business organisations and other strategic players in a locality.

Fact five:

Some parts of the Bradford district are measured by government as being amongst the poorest in the country, whilst other parts are amongst the most affluent. But again we must be beware of easy assumptions. Some of the poorest wards have a super-rich contingent in their midst whilst other wards, which show a greater overall income and standard of living, have cohorts of people (such as teenagers, older people or people with disabilities) who are without any local facilities or support structures.

Fact six:

The Bradford district has a huge number of entrepreneurs who fall within the SME (small & medium enterprises) category. There are some large employers but the majority are small and localised. In terms of accessing employer and business support the biggest employers in the area are in the public domain - NHS, Council, Inland Revenue. The implication of this for anyone trying to influence local provision is that, although these organisations have strategic clout they cannot be seen to favour one local organisation or issue rather than another.

So, where does all this fact-finding leave us in our quest for recognition?

Bradford may be one of the most diverse and interesting cities in the country but how does that help us to get our case across?

We can see that there is no single, geographic entity, and, worse, that some parts are actively hostile to a 'Bradford' strategy on anything. We know that there are thousands of groups out there, which means that there are lots of nice people, but it will be hell getting through to them. Building relationships with major strategic players will be awkward because they are mostly public sector and cannot favour any one particular section. Working through the 'usual channels' is time consuming and has a low chance of success because one's issue is not yet seen to be important enough for urgent action.

Is there any point in trying to proceed, if all the various avenues are so tortuous or overcrowded or impossible?

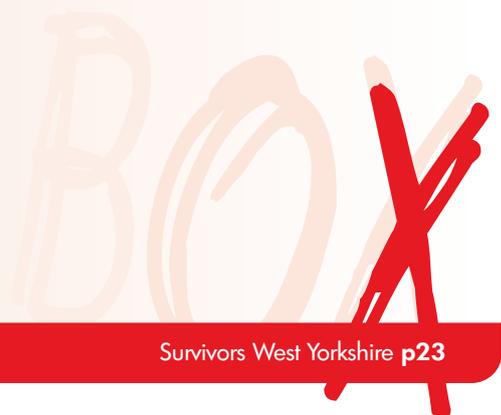
The answer is obviously "Yes" or we should not be wasting our time and energy in pursuing the goal. One way to move up the agenda is to be designated as a central government 'tick box' which means that local funding is linked to progress on your issue. Unfortunately this is a matter of luck rather than management and cannot be relied upon to ensure success.

A single issue in need of support needs a friend. That friend could be a 'champion' who would be a senior figure from within the established hierarchy. More realistic is that the friend should be some kind of network, and Bradford has a fair few to choose from.

Bernie Stinson

Former Co-ordinator

Empowerment Network Bradford (Cnet)





are the issues from inside the box engageable? This report highlights three key areas for development: Partnership, Empowerment and Diversity.

Partnership

The government's white paper 'Our Health, our care, our say: a new direction for community services' (DoH. 2006) has a number of aims, one of which is 'Promoting independence and wellbeing of individuals through better community health and social care and greater integration between local health and social care organisations'. The government states that 'to achieve all this will require the full participation of a range of stakeholders, including local people, the third sector, the independent sector, Primary Care Trusts (PCTs), local authorities, and community health and social care professionals'

The report highlights the lack of a co-ordinated response to survivors of sexual abuse and in particular the lack of collaboration between the statutory and independent sectors of health and social care provision. Moreover there is no identifiable agency in the statutory sector with responsibility for the care of sexual abuse survivors. This experience was

replicated across schools, health services and social services.

The lack of services is compounded by the lack of awareness and expertise with many of the respondents in the survey expressing disappointment at the service delivery. The need for training for all professionals is repeated across all areas; not only in health and social care, but in housing and education.

In 'Our health, our care, our say' the government demonstrates that service users 'want to see a wider range of professionals - particularly practice and community nurses and pharmacists - involved in health improvement, disease prevention and the promotion of independence. As with respondents to Independence, Well-being and Choice, they want to see more sustained and joint action across government and between local agencies, including education, housing, environment, transport and leisure services, to make this happen.' (Appendix para.11). The report found that there were good informal links between the statutory and non-statutory sector and with key workers, but that there was no concrete, sustainable and accountable contract for service delivery.

Local leadership and commitment is vital as highlighted in the government's white paper 'Choosing Health: making healthy choices easier' (DoH. 2004).

Responsibility for appropriate, accessible and accountable services lays with the statutory sector. There now is a need for formal arrangements that may include commissioning, that fully addresses the needs of survivors of sexual abuse.

Empowerment

The stigma faced by mental health service users has been highlighted by various organisations including the Royal College of Psychiatry (Changing Minds: Every family. 2002) and the Mental Health Foundation (Pull Yourself Together! 2000). There are increased issues of stigmatisation for survivors of sexual abuse in that they are very often labelled as mentally ill, as highlighted in Claire Fraser's report. This has a negative impact on survivors in two ways. Firstly, the distress they experience following trauma is not an illness and psychiatry offers little or no assistance of benefit and secondly, once in the mental health system survivors often become labelled as 'treatment resistant' or 'personality disordered' because the service is inappropriate.

Recently the NSPCC has instigated a campaign, 'Don't hide it' (2006), which encourages children to disclose their abuse. Campaigns such as this raise awareness of the issue amongst the general public. It is clear from the report that further awareness training is needed amongst staff delivering services in Bradford.

On the issue of stigma, 'Pull Yourself Together!' by (MHF 2000) concluded that 'The workplace appeared to be the second most likely place to receive discrimination (30%). A lack of understanding was most frequently cited as a reason for this. Some respondents gave very serious examples of discrimination, including a number of people who said that they had been dismissed or forced into redundancy due to their experience of mental distress. Fear of discrimination also prevented people from disclosing details of their mental health history on application forms.'

The report highlights the fact that current services are not meeting the need of survivors of sexual abuse in Bradford. Participants in the research repeatedly speak of the need for more specialist training for staff they come into contact with.

It would seem essential that survivors and agencies working with survivors should be represented on any training bodies.

Diversity

Claire Fraser's research showed that survivors of sexual abuse present with multiple needs. The response is too often focused within mental health services. Participants in the research talk about the long-term impact on educational attainment, on housing issues, on employment and on community safety. The response from services needs to recognise the diversity of impact and the consequent need for creativity and innovation. 'In the Your health, your care, your say exercise there was a strong desire for more help to support people to maintain their independence and feel part of society, with more emphasis on tackling loneliness and isolation' (DoH. 2006 Appendix para.8)

A difficulty is that many workers outside of mental health may not recognise they are dealing with survivors of sexual abuse on a regular basis and those that do are often ill-equipped to respond appropriately. Furthermore, where workers are aware they are working with survivors, there is often insufficient information of where to refer survivors on to. There is a need for a co-ordinated response and identifiable referral process. A suggestion for how this might be actioned is included in 'Our health, our care, our say' "a small, central team will oversee implementation" (9.5).

Recovery from the trauma of sexual abuse often requires a diversity of responses. For some survivors the most helpful interventions are those that improve their sense of safety, such as a change of housing, or interventions that improve their self-esteem, such as access to adult education.

Bradford must recognise the need for diverse responses and the consequent spread of training across the range of services on the frontline that encounter sexual abuse survivors.

Voluntary sector services have a long-standing history of working with survivors in ways that both empower them and acknowledge the diversity of response they deserve and need. The knowledge and expertise that the voluntary sector can bring to services provided for victims and survivors of sexual violence and abuse has now been acknowledged by both the Home Office and the Department of Health through their joint Victims of Violence and Abuse Prevention Programme.

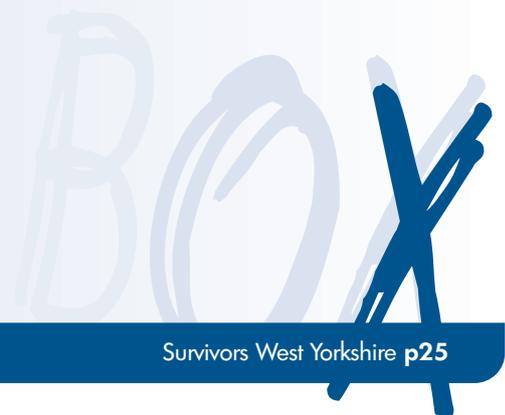
There is now a growing recognition that voluntary sector involvement is integral to ensuring that services for survivors are developed that match their needs. In addition, the voluntary sector is already providing specialist services for survivors, including counselling, support, advocacy and specialist training. Although it is important that all workers who come into contact with survivors receive thorough training to enable them to respond appropriately, it is essential that specialist voluntary sector services receive the recognition and support to allow them partnership status with statutory agencies.

Fay Maxted

National Coordinator of The Survivor's Trust

Ian Warwick

Head of Social Work and Police Studies at the University of Huddersfield



“ Numerous research and reports have identified the need for better service provision for survivors, so why does it not happen ?”

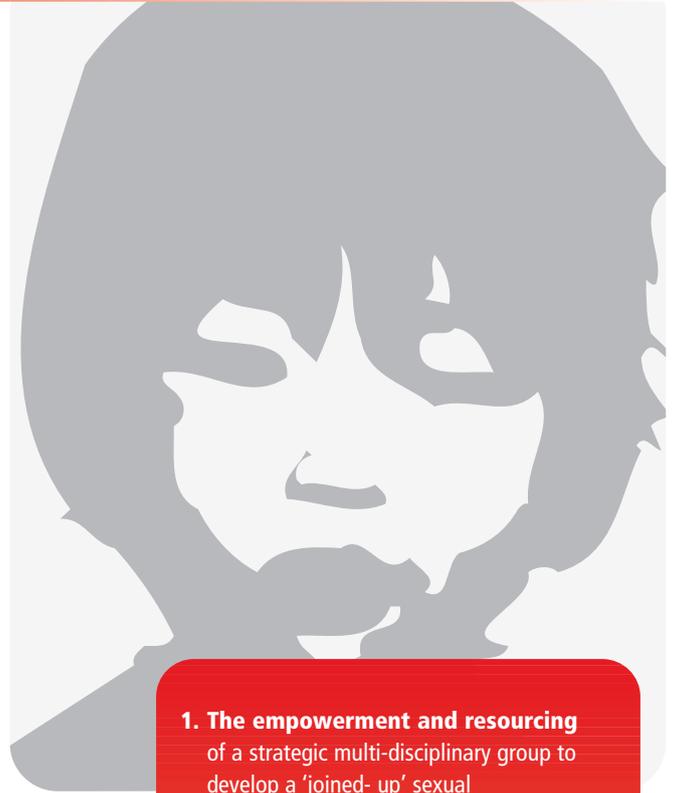
ACTION PLAN

Survivors West Yorkshire believes the following proposed model would serve as a starting point for planning a strategic development process in Bradford that would help to meet the needs of that process proactively.

The importance of service integration

'All work with victims/survivors of rape and sexual assault should take place within a culture of belief, and seek to restore a sense of control and self-worth. The initial response, whether from formal or informal sources, should be characterised by respect and should prioritise ensuring the safety and support of victims. Encountering disbelief during early contact with services and/or police can deter future engagement. Since sexual violence is particularly under-reported, those victims/survivors who come to the attention of formal services may not have reported their assault to the police, nor may they intend to. In addition, they may be seeking support in relation to a recent or more historical incident. All of these variations affect the type of assistance an individual will be seeking, and this may also change over time. Integrated projects offering a combination of practical and emotional support are likely to be the most effective in fulfilling these diverse needs, including: helplines; informal support; advocacy; assistance with sexual health issues; counselling; and in relation to the criminal justice system, where relevant, information about reporting, forensic medical examination, case tracking and support through court. Multi-agency initiatives that also operate a referral system for issues they are unable to assist with directly can be effective in responding to a greater range of issues. Until recently the practical and advocacy needs of sexual

assault survivors (for example, emergency housing, liaison with employers or GPs, or safety issues) have tended to be overlooked. However, addressing these can often be key to providing them with the space and peace of mind necessary to access emotional/therapeutic support and/or engage more effectively with the criminal justice system. Somehow we have lost a focus on meaning, and how survivors can construct accounts and understandings of their experience which restore worth and efficacy. This, too, needs to be part of what interventions, especially those that are health-based, see as part of their role. There should be multiple routes to provision (including directly by the victim/survivor themselves and referral from other sources) and as much as possible should be locally based. Research also suggests that periodical proactive contacting of service users, with the aim of reiterating the option of support and assessing changes in need over time, can increase take-up. The ambivalence, fear or mistrust some survivors feel with respect to the criminal justice system means that it is imperative that voluntary and community services, such as Rape Crisis and survivors' groups, continue to exist alongside those provided by some public agencies, such as Sexual Assault Referral Centres (SARCs), whose partners include the police. There are some survivors who, as a result of the impact of their experience, will need specialist (in some cases intensive, in some secure) residential therapeutic care. There is currently a prohibitive waiting list for such provision. Too often these facilities are located



- 1. The empowerment and resourcing** of a strategic multi-disciplinary group to develop a 'joined-up' sexual violence/abuse survivor strategy for Bradford in line with the emerging Local Authority Civic Pioneer initiative and the on-going Communities of Interest development programme.
- 2. The commissioning of a social action research project** to explore the views of survivors both within and beyond the service provision network on the training needs of primary and secondary care workers.
- 3. The commissioning of a website** to pathway survivors to services and support systems across Bradford and the UK.
- 4. Actual resourcing for all of the above** to be via a joint resourcing 'partnership'-joined up working from all stakeholders with funding power in Bradford who deal with issues identified (A proactive buy in to look at the way forward to invest in resolving the issues for victims of sexual abuse)

considerable distances from the individual's home or support network. All too often survivors of sexual violence want access to justice. One strand of effective intervention would be to provide it.'

Taken from a Government feedback paper (June 06) As part of a Delphi expert process on the design of a national service framework for sexual violence service practice - author unknown.

Bob Balfour

I founded Survivors West Yorkshire (SWY) in 2000. When elements of my own abuse history were flagged by the report of Sir Ronald Waterhouse into North Wales, 'Looked After Care' services, during the 1970's - Lost In Care. Using many of the skills I have gained over the last 30 yrs, whilst working in the public, private and volunteer sectors. In positions ranging from direct operational management, to new project development and implementation. I have led SWY during its six years of campaigning - whilst continuing to work as a full time mental health support worker for a joint Social Services/ NHS housing support service. My work experience has enabled me, both to lead SWY's strategic campaigning work, whilst also offering personal support and pathwaying to survivors, partners and supporters. I also train professionals in how to deal empathically and effectively with disclosure issues.

Survivors West Yorkshire

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E-mail: survivorswy@mac.com

Claire Fraser

Claire Fraser (BSc MSc) has over seven year's experience of undertaking research for the academic, statutory & voluntary sectors and is now working as an independent freelance researcher on projects throughout the UK. Research has been undertaken for a number of organisations including the NSPCC, local authorities, Relate, Children's Fund teams, Candlelighters, Police, Probation, Customs and Excise, CNet (Bradford District) & organisations representing survivors of child sexual abuse. She has a particular interest in research with survivors of abuse, research with children, young people & families, research with drug/alcohol misusers & evaluation research.

Claire Fraser

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Fay Maxted

Fay Maxted is National Co-ordinator of The Survivors Trust, a UK and Ireland umbrella agency representing 90 specialist voluntary sector services working with survivors of

rape, sexual violence and childhood sexual abuse. Fay's commitment to supporting the voluntary sector is informed by over ten years' experience of managing direct service provision for survivors as a trustee and project co-ordinator of Rugby RoSA (Rape or Sexual Abuse Support Group) and by her own experiences as a survivor. Fay now represents The Survivors Trust on the Department of Health Expert Group for Adult Survivors of Childhood Sexual Abuse, Victims of Violence and Abuse Prevention Programme, and on the Practitioner Group developing training for Sexual Offences Investigation Teams. Fay is also on the Advisory Group for the Stop It Now! UK and Ireland programme and has just been invited to join the Government's new Sexual Violence Stakeholder Advisory Group which will meet for the first time in June 2006.

Dr Carol Ann Hooper

I took my first degree in English Literature and Social and Political Sciences, then worked first in publishing and journalism, then in the voluntary sector as a counsellor and researcher at the London Rape Crisis Centre, before coming to the study of social policy as a postgraduate student. I was (and still am) particularly interested in women's experiences of the welfare state. In much early social policy literature women were invisible. Concern with inequalities focussed primarily on class divisions and families/households were treated as units, ignoring the different interests and access to resources of men, women and children within them. Since the early 1980s however the feminist social policy literature has expanded rapidly, highlighting gender divisions within families/households, within the labour market and within the welfare state, as central to understanding the development of social policies and their impact. Increasing attention is now being paid also to generational divisions and to children's experiences and perspectives in social policy, a development which is particularly important in relation to my other main area of interest, the problem of child abuse.

Interests

Women and social policy; child abuse and child protection; violence against women; personal social services

BA (Cantab), DipSocAdmin (LSE), PhD (LSE)

Lecturer in Social Policy

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Ian Warwick

I am currently Divisional Leader for Social Work, Police Studies and Applied Criminology at the University of Huddersfield. I have been a lecturer in mental health for eight years. Prior to this I spent fourteen years in various roles within the mental health services.

I have coordinated a project in Sheffield for adult male survivors of childhood sexual abuse and rape for the past twenty-two years. SURVIVORS (SHEFFIELD) was the first project for male survivors outside London and has been instrumental in supporting the development of male services throughout the country.

I have been conducting research in to the needs and experiences of male survivors for some time and have presented at conferences in the UK, Ireland and Australia.

Ian Warwick

Head of Division; Dept of Social Work

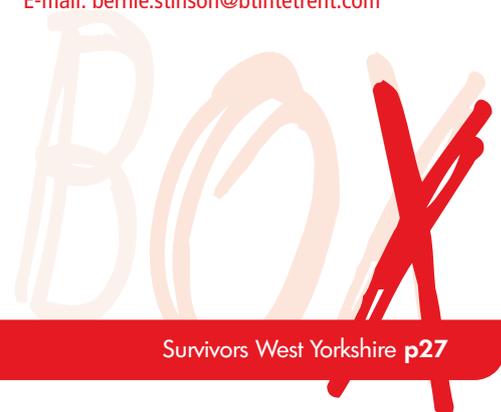
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Bernie Stinson

Bernie first started as a volunteer within the Community & Voluntary sectors in 1969 and has worked with a huge number of geographical and interest communities since then. He has had a significant amount of paid work via different projects with homeless people, unemployed people and individuals suffering from and recovering from mental health difficulties, and has run Adult Education centres funded by the local authority.

His most recent post was that of Co-ordinator of the Bradford & District Community Network (CNet) from which he withdrew because of health difficulties. These are happily being resolved and he hopes to spend more time in the future supporting organisations such as Survivors.

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Research Information

Research Information Leaflet - Service Providers

Research Title: A View from Inside the Box: Sexual Abuse Survivor Service Need and Existing Service Provision in the Bradford Metropolitan District

Background: Do you work with survivors of sexual abuse in the Bradford area? Survivors West Yorkshire (an activist and support organisation based in Bradford) has received funding from the Communities of Interest Working Group to explore service provision for survivors of sexual abuse in the Bradford area.



Communities of Interest are more invisible than communities with geographic boundaries (e.g., residents living in a particular area of Bradford). They pull in and link, through common experiences and concerns, individuals scattered across the whole district. The community identity is something that is life-long - it is part of what that person is, and it plays a part in how others see them and how they see themselves. However, community-specific identities can often result in discrimination and/or exclusion from mainstream activities and as such, communities of interest often experience barriers to influencing decision-making and in accessing services and activities.

Survivors of sexual abuse in Bradford are one such Community of Interest. The Communities of Interest Working Group (COIWG) has asked Survivors West Yorkshire (SWY) to consult with service users and organisations in the Bradford district who provide a service, either directly or indirectly, to survivors of sexual abuse. This is a real opportunity for service users and service providers to influence action planning and the development of service provision in the Bradford area.

Research Aims: We aim to map current service provision and to explore the views

of professionals (statutory and voluntary sector) and service users on the main issues facing survivors in the Bradford area and proposed solutions to such issues. The time has come to challenge the cultural silence which surrounds the issue of sexual abuse in our society...the time has come to open the box. In addition, it is hoped the exercise will also begin to improve collaboration between statutory sector and voluntary sector service providers.

Methodology:

1. A desk-based review of existing service provision ('mapping exercise') for survivors of sexual violence in the Bradford area - both statutory & voluntary sector agencies - to identify proposed questionnaire recipients for Stage 2.
2. A questionnaire will be sent to all agencies identified in stage 1. This will explore the number of disclosures, current service provision, current policy and practice, referrals and inter-agency working, and key issues for survivors of sexual abuse. In addition, an 'open-ended' format will be incorporated into the questionnaire to allow each organisation to raise any additional issues. Provision will be made for follow-up interviews with key players if the questionnaire stage indicates that there

would be value in exploring important themes or issues.

3. Individual qualitative interviews with 20 service users (10 male; 10 female) - on issues for survivors, thoughts on possible solutions, experience of service provision and service delivery, and what service users would like to see available and how this should be delivered (e.g., via statutory or voluntary sector).

Research Team: Survivors West Yorkshire has contracted an independent Research Consultant - Claire Fraser - to carry out this consultation process on their behalf. Claire has extensive experience of carrying out research in the academic, statutory and voluntary sectors and has previously worked with Survivors West Yorkshire in this area. Claire will lead the research project in collaboration with the Nationwide Children's Research Centre (NCRC), Huddersfield.

Dissemination: A report will be written for the research funders (COIWG) and the research commissioners (SWY). In addition, all participants (service providers and service users) in the research will be offered the opportunity to receive a summary of the findings.

Survivors West Yorkshire p28



A View From The Box Consent Form - Service Providers

Have you read the Research Information Leaflet for Service Providers?	yes	no	Would you like to take part in this research?	yes	no
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Do you understand what taking part in the research involves?	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to receive a summary of the findings of this research?	<input type="checkbox"/>	<input type="checkbox"/>
Do you understand that you can withdraw from the research at any time, and without giving a reason, if you decide you don't want to take part anymore?	<input type="checkbox"/>	<input type="checkbox"/>	Name <input type="text"/>		
			Signature <input type="text"/>		
			Date <input type="text"/>		



A View From The Box Consent Form - Service Users

Have you read the Research Information Leaflet for Service Users?	yes	no	Would you like to take part in this research?	yes	no
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Do you understand what taking part in the research involves?	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to receive a summary of the findings of this research?	<input type="checkbox"/>	<input type="checkbox"/>
Do you understand that you can withdraw from the research at any time, and without giving a reason, if you decide you don't want to take part anymore?	<input type="checkbox"/>	<input type="checkbox"/>	Do you agree to the research interview being audio-recorded ?	<input type="checkbox"/>	<input type="checkbox"/>
			Name <input type="text"/>		
			Signature <input type="text"/>		
			Date <input type="text"/>		

A View From The Box Questionnaire - Service Providers

Name of your agency

Which sector is your agency located within?

Statutory Voluntary

If you are completing this questionnaire on behalf of a team, department or service within the above agency, please specify details:

Please can you describe the main service(s) your agency provides and your main client group:

Does your agency work with:

Female clients only

Male clients only

Male & female clients

Many people do not reveal their abuse history to services. However, it would be helpful if you could give an approximate estimate in response to questions a and b:

- a) How often would your agency come across clients whom you know have experienced sexual abuse?
- Regularly
- Sometimes
- Not to our knowledge
- Don't Know
- a) How often would your agency come across clients whom you think have experienced sexual abuse?
- Regularly
- Sometimes
- Not to our knowledge
- Don't Know
- c) Would your agency routinely ask clients about a possible history of sexual abuse during assessment?
- yes no

Does your agency routinely record the number of sexual abuse disclosures made by clients?

yes no

If yes, please specify details, e.g., how recorded, whether gender details noted etc.

Is this information on the number of disclosures shared with any other agency, e.g., local care trust, government department, CVS?

yes no

If yes, please specify details

Does your agency record information on the gender and ethnicity of clients?

yes no

What, in your experience, are the main problems for survivors of sexual abuse as a result of their abuse history? (please tick all that apply)

- Mental health problems
- Low self-esteem
- Self harm
- Flashbacks
- Suicidal feelings
- Hearing voices
- Relationship difficulties
- Sexual identity problems
- Aggression/anger
- Offending
- Parenting problems
- Alcohol misuse
- Substance misuse
- Employment difficulties
- Housing difficulties
- Disruption to education
- Isolation within community
- No particular problems
- Other (please describe)

Does your agency:

Provide a specific service for survivors of sexual abuse? yes no

Work with abuse-related issues if they arise?

Refer clients on to another agency for abuse-related issues?

A View From The Box Questionnaire - Service Providers

If you provide a specific service for survivors, could you describe it?

If you refer clients on to another agency for abuse-related issues where would that usually be?

Voluntary Sector yes no

Please state specific agency:

Statutory Sector yes no

Please state specific agency:

Private sector counsellor

Church

Nobody suitable

Other (please describe):

Do you believe that current service provision meets the needs of survivors of sexual abuse?

Yes

No

Don't know

If you think service provision needs to be improved, what should the priorities be?

(Please list your 3 main priorities 1, 2, 3)

Individual counselling/support

Group work/group support

Challenging the 'silencing of abuse' in society

Resources within your own organisation

Resources elsewhere, where you can refer clients

Staff training

Staff supervision

Multi-disciplinary

Support networks

Other (please describe):

Do you think services for survivors of sexual abuse should be located within:

Statutory sector

Voluntary sector

Joint statutory/voluntary sector initiatives

Which setting(s) do you think would provide the best point(s) of access for support services for survivors of sexual abuse?

Primary care

Mental health services

Drug/alcohol projects

Homeless projects

Penal establishments

Independent counsellors

Educational settings

Social work

Any setting

Other (please describe):

If you wish to add any further comments please use the space below:

We also wish to consult with service users to get their views about current service provision for survivors of sexual abuse in the Bradford area. Would you be willing for a member of the research team to contact you to discuss, without obligation, inviting your clients to take part in this consultation?

yes

no

If yes, please provide contact details below:

Name

Job Title

Tel

E-mail

Research Information Leaflet - Service Users

A View from Inside the Box: A Social Research Project Exploring Sexual Abuse and Sexual Violence Service Provision in the Bradford Area

Would you like to participate in a research project?

Are you a survivor of sexual abuse living in the Bradford area?

Would you like to help influence service provision for survivors in the Bradford area?

Survivors West Yorkshire (an activist and support organisation based in Bradford) has received funding from the Communities of Interest Working Group to explore service provision for survivors of sexual abuse in the Bradford area.

There are no right or wrong answers. We are just really interested in what you have to say. If you decide to take part Claire will arrange to meet with you at a time, day and location that is convenient for you. The meeting would last about an hour. Claire would like to audio-tape the interview to ensure that she can really listen to your views without worrying about noting these down during the interview. This tape will be heard by Claire only and will be erased (or returned to you if you prefer) at the end of the research. If you would prefer to take part without being audio-taped that is ok.

Who's doing the research?

Claire Fraser is an experienced researcher and has been contracted by Survivors West Yorkshire to carry out this work, with the supervision of the Nationwide Children's Research Centre, Huddersfield.

Why am I being asked to take part?

Claire Fraser is contacting all service providers in the Bradford area to ask them if they wish to invite their service users to give their view on service provision for survivors of sexual abuse. Each service provider is inviting clients who have disclosed a history of sexual abuse/sexual violence.

What will I be asked to do?

Claire would like to meet with survivors of sexual abuse to explore:

- Their experience of service provision since disclosure
- Their thoughts on whether adequate service provision exists
- Their thoughts on whether improvements need to be made to current service provision, and if so, ideas for improvements.

Who else is being asked to take part in the research?

Claire hopes to chat to 20 service users in the Bradford area (10 male; 10 female). In addition, a survey of all service providers (statutory & voluntary) is currently being undertaken to ensure all views are collected.

What will happen to the information I give?

The information that participants share with us will be used to write a report for the research commissioner (Survivors West Yorkshire) and the research funder (Communities of Interest Working Group). In addition, we will write a report for all participants (service users and service providers) which will provide a summary of the feedback collected. No names or personal identifiers will appear in the report or summary. All information shared with Claire will be treated with confidence and all responses will be summarised to protect participant anonymity.

How do I take part in the research?

If you would like to take part in this research project please fill in your details on

the Consent Form & give this back to your counsellor/therapist/key worker. They will then pass the details to Claire & she will contact you to arrange a mutually convenient time/place to meet.

What if I change my mind later?

If at any time after agreeing to take part you change your mind you can drop out at any time without giving a reason. This will not affect any services you are receiving either now or in the future.

How can I get more information?

If you would like any further details on the research you contact either Claire Fraser (the researcher) or Bob Balfour, Survivors West Yorkshire:

Claire Fraser

Research Consultant

Email: Clairefraser@aol.com

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Bob Balfour

Co-ordinator, Survivors West Yorkshire

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A View From The Box Questionnaire - Service User Interview Schedule

I am interested in exploring your experience of service provision as a survivor of sexual abuse and your thoughts about the main issues faced by survivors. It would be helpful for me if we could begin by discussing your experience of disclosing to a service (statutory or voluntary) for the first time:

Which service did you first disclose to?
Statutory or voluntary?

Had you spoken to anyone else before this? E.g., Friend, partner, family, colleague etc.

What prompted you to seek support from statutory/voluntary service?

What was the response when you disclosed to the service?
Positive/Negative?

Overall, how would you say you were treated?

If you received a less than satisfactory response, how could the service have responded better?

What has been your experience of statutory support services to date?

What has been your experience of voluntary support services to date?

Have you experienced any difficulties in finding appropriate support?

Lack of service provision?
Location of service provider?
Language/access difficulties?

Have you received therapeutic services as a result of contact with above?

Did you find therapy helpful?

Where do you think support services for survivors should be located? Statutory or voluntary sector?

Why?

What, in your opinion, are the main issues for survivors in relation to:

Health?

Economy & Jobs?

Education?

Community Safety?

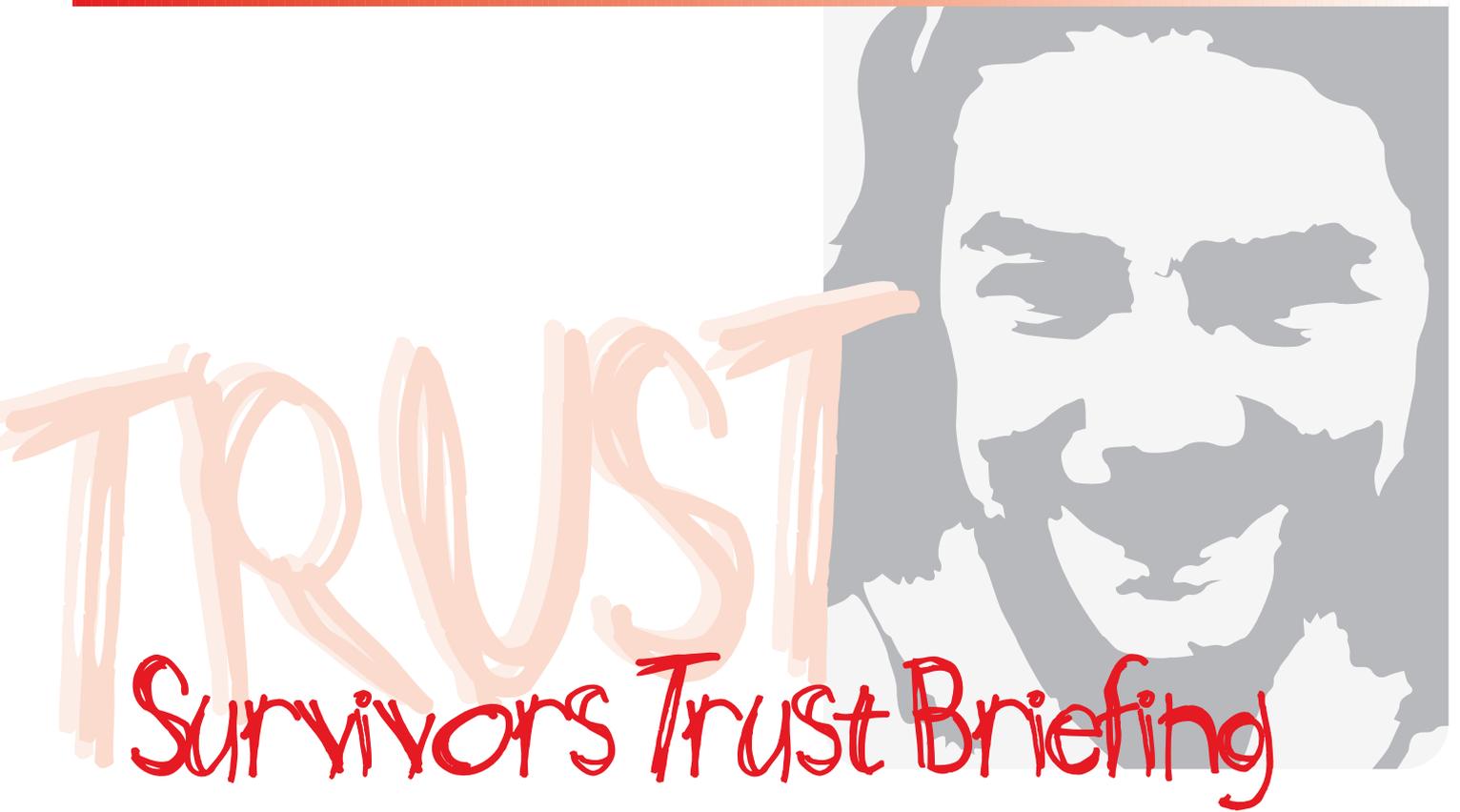
Leisure & Culture?

Environment & Homes?

Building Communities?

How can society best support survivors?

Any further comments to add?



the inter-relatedness of sexual victimisation and priority social and health policy issues.

A briefing from The Survivors Trust: June 2006

Contents

- Introduction
- Domestic Violence
- Drug and Alcohol Abuse and Dependence
- Crime and Anti-Social Behaviour
- Mental Health
- Suicide Prevention
- Deliberate Self-Harm/Injury
- Improving The Health of the Nation
- All Party Parliamentary Group
- Conclusion

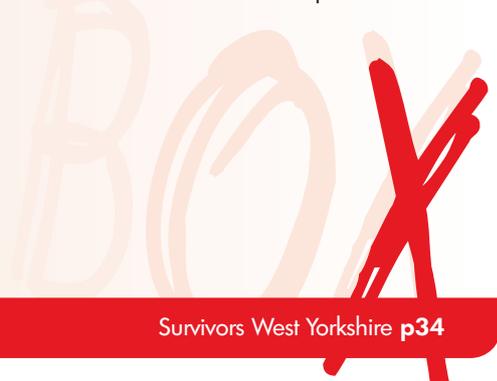
1. Introduction

The Survivors Trust is the first UK & Ireland national network to represent specialist voluntary sector agencies which provide emotional support and practical advice to victims of rape, sexual violence and childhood sexual abuse. Importantly, The Survivors Trust is not gender specific. Among it's 90 plus member organizations are projects working: only with women, only with men and with both women and men - plus some provide additional support for adolescents.

The Survivors Trust is a national voice for more than half of the 153 voluntary sector specialist agencies listed in the Spring 2006 edition of the DABS national resource directory [DABS, 2006] of services working with rape, sexual assault, childhood sexual abuse and related issues. The long term effects of such abuse include post traumatic stress symptoms; depression; anxiety; dissociation; sleep problems; flashbacks; nightmares; irritability and outbursts of anger; low self-esteem; lack of confidence; self-harming behaviours; suicide; alcohol and drug abuse and dependence; work-holism; prostitution; criminal behaviour (including - for a small minority - sexual offending); homelessness; revictimisation; relationship problems; lack of trust in others; sexual problems; confusion about sexuality; chronic physical pain and other physical health problems; eating disorders; transient psychotic episodes; borderline personality disorder; dissociative identity disorder; somatisation. This is not an exhaustive list. In fact the experience of sexual assault or abuse at any age and whether female or male can have devastating effects on every aspect of oneself, one's mind, one's body; one's behaviour, thoughts and feelings. Not all victims will have all effects; the mix, severity and complexity is a unique experience for each individual. Help and support is not

always available because specialist agencies for victims of sexual abuse, rape and sexual assault are overstretched; staff time has to be diverted to bidding for scarce funds which are usually short-term and insecure. Funding for core services is particularly hard to come by so agencies are frequently under threat of closure, with news of actual closures not infrequent.

This briefing focuses on how areas of health and social policy which have received some political priority are inter-related with the needs of victims of rape, sexual assault and childhood sexual abuse. It aims to show that enabling the survival and development of specialist agencies that work with such victims will support the achievement of objectives and targets within these priority health and social policy areas. It is also hoped that the briefing will raise general awareness of the complexities of the effects of sexual victimization and encourage involvement in the All Party Parliamentary Group on Survivors of Sexual Abuse and Rape.



2. Domestic Violence

Adults who were sexually abused in childhood are more likely to be victims of domestic violence. One study found that almost half (48.9%) of childhood sexual abuse victims became victims of a violent partner as an adult. This compared to 17.6% of non-victims of childhood sexual abuse. [Briere and Runtz, 1988] The risk of rape, sexual harassment and domestic violence in adulthood is approximately doubled for victims of childhood sexual abuse. In one study of women who had been incestuously abused in childhood, two thirds were subsequently raped. [Russell, D.H., 1986]

This increased risk of victimisation in adulthood has been theorised to arise from recognised traumatic effects of childhood sexual abuse. [Herman, 1981; McCann et al., 1988; Russell, 1986; Steele & Alexander, 1981] With help from specialist agencies to overcome such traumatic effects child, adolescent and adult victims of childhood sexual abuse can reduce their risk of becoming victims of domestic violence. Conversely, if adult victims of domestic violence who are also victims of sexual abuse in childhood are able to access services to address both these needs the risk of future victimisation may be reduced. Households in which domestic violence occurs are also at increased risk for rape within marriage/partner relationship and for the sexual abuse of children in the household. This is another reason why joint working between domestic violence agencies and specialist agencies working with victims of rape and sexual abuse needs to be funded and supported.

3. Drug and Alcohol Abuse and Dependence

Women who experience any type of sexual abuse in childhood are roughly three times more likely than non-abused women to report drug or alcohol dependence as adults. [Kendler, K.S., et al., 2000] 67-90% of women with alcohol and drug addiction problems are survivors of childhood sexual abuse. [Wilson, J., 1998a] Adult male victims of childhood sexual abuse are significantly more likely than their non-abused counterparts to meet diagnostic criteria for a substance use disorder (55.4% versus

26.7%, respectively) or for drug abuse/dependence (44.9% versus 7.8%, respectively) [Stein et al. 1988] Rape victims are 5.3 times more likely than non-victims to have used prescription drugs non-medically; 3.4 times more likely to have used marijuana; 6 times more likely to have used cocaine; and 10.1 times more likely to have used "hard drugs" other than cocaine [Kilpatrick, Edmunds, and Seymour, 1992].

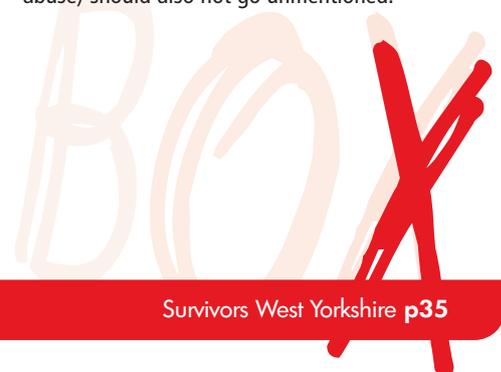
Such evidence is often interpreted as either a causal or collateral factor to the offence(s) leading to a 'blame the victim' attitude. However, combined with the statistics for addictions in adult survivors of childhood sexual abuse and evidence from the specific studies immediately below it is supportive of specialist agencies' experience that victims of sexual abuse, sexual assault and rape are much more likely than non-victims to use alcohol and other drugs as a way of coping with the trauma of victimization. Such substance use is clearly a consequence of their victimization.

One study proposes that individuals will often choose and use drugs which manage specific effects and consequences of abuse (such as intrusive recollections, flashbacks, nightmares, avoidance, numbing or hypervigilance) [Stewart et al, 1998] Addictive substances may also be employed by victims of childhood sexual abuse to counteract the effect of poor self-esteem [Paone, D. et al, 1992] If there was securely funded access to the services of specialist agencies to overcome these effects for all victims of rape, sexual abuse and assault then the need to self-medicate with drugs and alcohol could be reduced. However,

“ The lack of sustained and joined up service provision across all sectors in Bradford is a moral failure ”

because these are addictive substances it is also important to fund and otherwise facilitate partnership working between substance abuse services and specialist agencies working with victims of rape, sexual abuse and assault. The following two studies which look at the problem from the perspective of substance abuse agencies support this further. Responding only to the individual's needs as an addict is unlikely to have long-term success unless their needs as a victim of sexual violence are also addressed. A survey of workers at 47 drug addiction agencies in Scotland estimated that 50% of their clients had been abused in childhood. [Wilson, J., 1998b] A UK study in which the subjects were 40 male and 20 female patients in a regional in-patient drug detoxification unit found that 90% of the women and 37% of the men had been victims of childhood sexual abuse [Porter, 1994]

Finally, it should be noted that drugs and alcohol are frequently abused by perpetrators of sexual crimes. In this case the addictive substance lowers any natural inhibition the perpetrator may have against committing rape, sexual violence or the sexual abuse of a child. Also, the use of drugs and alcohol by perpetrators to lower or annihilate their victims' resistance (e.g. in so called daterape and in ritual or organised abuse) should also not go unmentioned.



TRUST

Survivors Trust Briefing continued...

4. Crime and Anti-social Behaviour

Under this heading it is important to first of all dispose of the myth that people who have been sexually abused in childhood are more likely to commit sexual offences in adulthood. This is simply not true. If it were, the majority of perpetrators would be female as most victims (though certainly not all) of childhood sexual abuse are girls. The opposite is true. The majority of individuals convicted of sex offences of all kinds are male. So, is it true that the majority of male victims of childhood sexual abuse become abusers in adulthood? No, this also is a myth. A UK study published in *The Lancet* showed that 88% of men who were abused in childhood did not become abusers in adulthood. Of the minority that were convicted of a sexual offence in adulthood there were specific factors additional to the fact that they were themselves abused which increased the risk of becoming an abuser. [Salter, D et al, 2003]

US surveys of prison inmate and probation populations show that many people convicted of any criminal offence report having been sexually abused at some time before their current conviction. The prevalence figures are between 2 to 6 per cent for male prisoners/probationers and 22 to 39 percent for females. When asked about

rape before their current conviction these populations reported incidents of having been the victim of an attempted or completed rape at the rate of 1 to 4 percent for males and 21 to 38 percent for females. [Wolf Harlow, C, 1999] Victims of child sexual abuse are 27.7 times more likely to be arrested for prostitution as adults than non-victims. [Widom, 1995]. This may be the result of being forced into prostitution by their abusers. In adolescents and young women who have left home to escape the abuse, prostitution may be the only way they know to support themselves. For others, it can be a consequence of the low self-esteem and relationship difficulties which are almost universal results of being sexually victimised and make victims particularly vulnerable to exploitation in adulthood. Naturally, such figures are not conclusive of a simple cause and effect between sexual victimisation and criminal behaviour. They also have to be weighed against evidence that suggests some sex and violent offenders falsely claim they were victimized as a way of explaining or excusing their own crimes. One study of sex offenders showed that after they were told they would be subject to a polygraph test, the percentage of those claiming sexual victimization dropped from 67% to 29%. [Hindman, J. 1988]

However, the available evidence and the experience of workers in specialist agencies suggest that helping prisoners to overcome the trauma of prior sexual abuse and rape is a largely unmet need, which if addressed could contribute to crime reduction. One UK specialist agency for male victims of sexual abuse and rape has this to say on the subject: "Estimates vary, but at least 80% of the male prison population in the United Kingdom have suffered some form of sexual abuse, either as children or adults, and many men have been subjected to rape and/or sexual abuse by other prisoners, and in some cases, have also been sexually abused by staff in the jails. There are literally thousands of men who end up in prisons who have ended up there due to drug and alcohol misuse, anger issues etc., all of which have been caused by the fact that they were sexually abused as children, or as adults. With the right support, these men can turn their criminal behaviours around and overcome the past, and in doing so, leave the prison life behind, and become 'normal' citizens" [Survivors Swindon]

“ Anything which can improve the situation can only be good thing - many people still feel they have no one to turn to and that no one will believe them ”

5. Mental Health

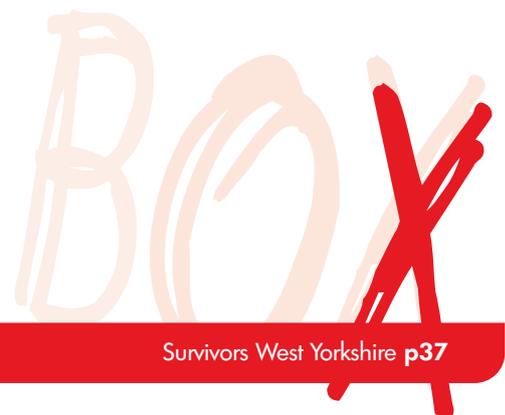
50 - 60% of psychiatric inpatients and 40-60% of outpatients were physically and/or sexually abused as children. [Jacobson, A. & Richardson, B., 1987; Bryer, J. B. et al, 1987; Jacobson, A., 1989; Briere, J. & Runtz, M. 1987] Where such abuse involved penetration there are 16 times as many psychiatric admissions compared to the general population. [Read, J., 1998] 50-80% of women who are raped develop post-traumatic stress disorder. This compares to 5-8% of combat veterans. [Putnam, F., 1998] Follow-up studies find that rape victims have high levels of persistent posttraumatic stress disorder, compared to victims of other crimes. [Breslau, N. et al, 1991]

Women who have a pre-existing mental health problem before they were raped suffer particularly severe and complicated post-traumatic reactions. [Burgess, A & Holmstrom, L., 1979] Men and boys who have been sexually assaulted are more likely to suffer from post traumatic stress disorder, other anxiety disorders, and depression than those who have never been abused sexually [Bauserman, R. B., & Rind, B., 1997; Black, C. A., & DeBlasie, R. R., 1993; Collings, S. J., 1995] 40 to 71% of people diagnosed with borderline personality disorder report having been sexually abused [Psychology Today] An audit of inpatients of a UK psychiatric unit found that 5% were highly likely to meet diagnostic criteria for dissociative identity disorder (formerly known as multiple personality disorder) yet none of the patients in this study had this diagnosis. The results of this study closely correlate with results of similar international studies. [Aqarone, R. 2002]. 97% of patients diagnosed with dissociative identity disorder have histories of major childhood trauma, most commonly sexual abuse [Putnam, F.W. et al 1986] Young girls who are sexually abused are more likely to develop eating disorders as adolescents [Wonderlich, S.A. et al, 2000]

It is clear that there is a significant correlation between severe mental health problems and experience of sexual abuse, sexual assault and rape. Yet, staff in statutory mental health services are generally inadequately informed, trained and supported to appropriately assess, diagnose and work effectively with victims to help them recover from the trauma of sexual violence. [Nelson, S. 2001]. Staff and volunteers in the voluntary sector's specialist agencies are generally more appropriately skilled in working with victims towards long term recovery but the main problem in this sector is lack of secure and core funding to ensure the organizations' survival and development to meet the high demands. Recent national policy and best practice guidance on women's mental health and personality disorders give some hope that more attention could be given to meeting the needs of victims of sexual abuse, assault and rape within mental health services. [NIMHE, 2003(a); 2002(a); 2003(b)]. However, there is still the risk that, buried within such wider issues, the specific needs of victims of sexual violence will not receive the necessary priority and development. Also, if the hopes raised by these initiatives are to be realised the national policies, strategies and best practice need to be implemented in all localities and given some priority in local commissioning and funding decisions. This local implementation and the funding available for it needs to be influenced by, accessible to and inclusive of the specialist agencies in the voluntary sector. Work also needs to be done on developing a complimentary men's mental health strategy which, among other things, recognises the needs of male victims of sexual violence within mental health services. Another positive recent development is the joint programme on Violence, Abuse & Mental Health which was announced at the Home Office National Victims Conference in April 2004.

The programme involves joint working between the DoH, NIMHE and the Home Office. It's purpose is to identify and address the health and mental health implications of child sexual abuse, domestic violence and sexual violence for professionals and services responding to the needs of victims, survivors and abusers, including children, adolescents and adults. The Survivors Trust is a key participant in developing and delivering this programme. Undoubtedly the statistics on mental health and sexual violence are convincing of the need for changes in the mental health system, including increased partnership working with the specialist agencies in the voluntary sector.

However, it should not be forgotten, that the vast majority of victims of sexual violence never come to the attention of mental health services. This is not because they are unaffected by their trauma history. Almost all victims will experience one or more of the long term effects listed in the introduction. Many turn to the voluntary sector specialist agencies for support, some referred from other related statutory and voluntary services such as domestic violence units and Victim Support Services. But classically, the funding to work with these clients does not follow them from the referring agencies.



6. Suicide Prevention

Adults who experienced childhood sexual abuse are 12 times more likely to attempt suicide than those who did not. [Fellitti, V & Anda, R. 1998] One study showed that nearly 20% of rape victims had attempted suicide compared to just over 2% of non-victims [Kilpatrick, D.G. et al (1985)] It is estimated that one in ten people who survive a suicide attempt will eventually make a fatal suicide attempt.

The suicide rate among sexually abused boys is between 11/2 to 14 times higher than their non-abused counterparts. [Holmes, W.C. 1998]. Sexually abused young men are amongst the highest risks groups for youth

suicide [O'Leary, T & Pratt, R. 2003] Again, it is good to report that national policy does now reflect that working with sexual abuse victims is a factor in preventing suicide. The DoH's Suicide Prevention Strategy for England [NIMHE, 2002(b)] includes a specific objective of promoting the mental health of survivors and victims of abuse, including child sexual abuse. And some of its other objectives could have impact on suicide rates in this group e.g. reduce the number of suicides in the year following acts of deliberate self-harm; and reduce the number of suicides of young men. Regrettably the actions specified in the implementation section of the strategy for the only objective specific to this group are relatively weak,

referring only to supporting the implementation of the Women's Mental Health Strategy (which excludes male victims) and liaising with other organisations about ways to achieve the objective. The Survivors Trust is a named liaison partner and is contributing towards achieving this objective through its work with the Violence, Abuse & Mental Health programme mentioned above. However, having been successful in getting NIMHE to recognise the risk of suicide in sexual abuse victims it was a disappointment that a suicide prevention toolkit issued to mental health services contains no mention of this at-risk group. [NIMHE, 2003(c)]

7. Deliberate Self-Harm

The most common method of self-harm involves repeatedly cutting the skin, but others include burning, scalding, hitting or scratching, hair pulling or swallowing small amounts of toxic substances to cause discomfort or damage.

The onset of self-harming behaviour has been linked to difficult things going on in a young person's life including (but not exclusively) abuse and rape. Rates of self-harm in the UK have increased over the past decade, making them the highest in Europe [National Institute for Clinical Excellence, 2002] Those who have self-harmed are 100 times more likely than the general population to die by suicide in the subsequent year. One-half of the 4000 people who die by suicide each year will have self-harmed at some time in the past. [National Institute for Clinical Excellence, 2002]

The connection between childhood abuse and self-harming behaviour is well documented. Repetitive self-injury develops most commonly in those victims whose

abuse began in early childhood. [Herman, J.L. 1992] Dissociative processes, including amnesia, depersonalisation (feeling of being detached from one's body and mental processes) and derealisation (feeling that the outside environment is unreal or changing shape/size etc) are increasingly recognised as underpinning much self-injury. [Sutton, J. 2004]. Yet, very little training is available in dissociation for mental health and other health professionals who may be working with victims of childhood sexual abuse who self-injure. Previous physical and sexual abuse is common amongst those who self-harm in prisons, especially young girls (15-17years) and women. [NIMHE, 2003(d)] In the United Kingdom 10,000 episodes of self-cutting come to the attention of the accident and emergency departments of hospitals each year [Williams, M. 1997]. This is likely to be a gross under-estimate of the actual incidence of self-cutting as many people who self-harm will not seek treatment for their injuries. A welcome initiative in the area of self-harm is the recently announced national inquiry into self-harm amongst 11

to 25 year olds. [Mental Health Foundation & Camelot Foundation, 2004] Given the known links between self harm, sexual abuse and rape it will be important that The Survivors Trust and its member organisations are enabled to contribute evidence and actively participate in this inquiry. The process of trying to influence the NICE clinical guidelines on self-harm, has been disappointing. Rigid adherence to a professionally dictated value hierarchy of evidence has meant that it has been difficult to get the experiences and results of service-user led qualitative research reflected in the guidelines.

It is important that the voice of voluntary sector services for rape and sexual abuse victims participates in such initiatives as these. The Survivors Trust and its member organisations do all that we can to ensure that voice is heard but doing so puts unneeded pressure on already overstretched services because of the lack of secure funding and funding for core activities of the specialist agencies.

8. Improving the health of the nation

Those who have experienced serious childhood trauma such as physical, sexual or emotional abuse, may have twice the rate of cancer, heart disease and chronic bronchitis than those who have not experienced such trauma. [Acierno, R. 1997]

Childhood sexual abuse can affect risk of infection with HIV. This is because sexual abuse in childhood distorts victims' physical, mental and sexual image of themselves. These distortions combined with coping mechanisms adopted to offset the trauma, can lead victims into high-risk sexual and drug-using behaviours that increase the likelihood of HIV infection. [Prillo, K.M. et al 2001] Women who were sexually abused as children are nearly four-times more likely to be current smokers than women who didn't report sexual abuse. They are also twice as

likely to have started smoking before age 14. [Figuroa-Moseley et al, 2004] Exposure to traumatic events such as sexual abuse and assault can be related to poor physical health. Posttraumatic Stress Disorder which is common mental health sequelae to rape, childhood sexual abuse and rape is also related to health problems.

There is not yet sufficient evidence to conclusively show a direct cause and effect between trauma / PTSD and poor physical health but a number of studies have noted the association. Particular physical health problems that have been reported in studies are cancer, ischemic heart disease, chronic lung disease, hypertension and other cardiovascular symptoms; abnormalities in thyroid and other hormone functions; increased susceptibility to infections, immunologic disorders; gastrointestinal and

musculoskeletal disorders. [Jankowski, 2003] The findings of these studies, which have mostly been done with combat veterans with PTSD rather than abuse or rape victims, are none-the-less supported by the observations and experience of workers in specialist agencies working with victims of sexual violence. The implications for health services of the inter-relatedness of childhood sexual abuse, sexual assault and rape and poor physical health need to be further researched. One possibility, is that helping victims to recover from post-traumatic stress will have a positive impact on targets in the improving the health of the nation programmes. A positive outcome could be a change in medical professionals' attitudes of dismissive-ness when victims of sexual abuse and rape complain repeatedly of physical health problems.

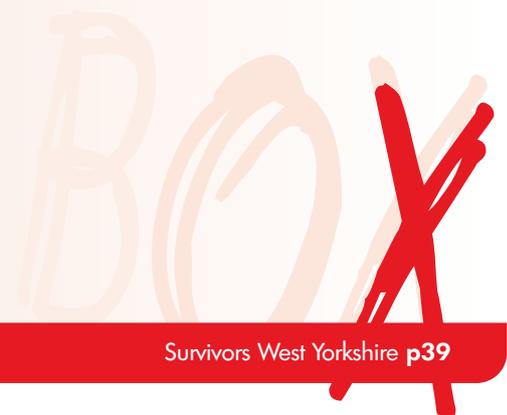
9. All Party Parliamentary Group - Rape or Sexual Abuse (APPG)

There is now an All Party Parliamentary Group on Survivors of Sexual Abuse & Rape (APPG), for which The Survivors Trust provides administrative support. This is a forum in which members of the Houses of Commons and Lords, together with experts and representatives from specialist agencies, can debate on the issues of childhood and/or adulthood sexual abuse and rape, its long term effects and links with mental health problems, alcohol and drug abuse, domestic violence, homelessness and other health and social care priority policy areas with the purpose of developing an agreed specific programme of targets and action. The group will ascertain the level of current service provision nationally, identify gaps in services and address funding issues. The group will

consider the requirement for care pathways for survivors as well as the need for joined-up policies.

The legal considerations surrounding such sexual abuse and those agencies over which Westminster has authority will be considered. The group will seek to create greater public awareness and understanding of the issues, and combat the many myths that surround sexual abuse and its impact on our society as a whole.

Vera Baird Q.C. M.P. is chair of the APPG
Sandra Gidley M.P. is vice-chair
Virginia Bottomley M.P. is secretary



SURVIVORS TRUST BRIEFING Conclusion

10. Conclusion

Domestic violence, drug and alcohol abuse and dependence, crime and anti-social behaviour, mental health, suicide prevention, deliberate self-harm, and improving the health of the nation are all areas of health and social care policy which have been prioritised for development by the current political environment. All have significant overlap, inter-dependence and cross-implications with services which help the recovery of victims of childhood sexual abuse, rape and sexual assault which have not been identified for priority development.

A briefing from the Survivors Trust.

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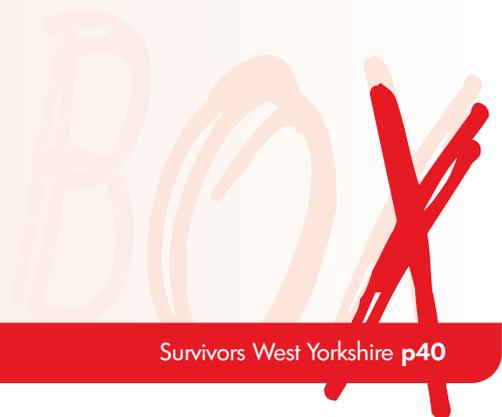
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Research and statistics quoted in this briefing should be regarded as indicative not conclusive of a simple cause and effect inter-relationship between sexual abuse & rape and the various policy areas covered. The reality of this inter-relatedness is surely complex and attempts to demonstrate it are hindered by the variety of definitions of rape and sexual abuse, inconsistencies of terminology used in the policy areas mentioned and differences in the methodologies used across the available research sources.

“ Some survivors are in crisis but not all of us are - we need a less black and white approach ”



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A Scottish survivor - centred strategic approach

Survivors of Childhood Sexual Abuse

when the Cross Party Group for Survivors of Childhood Sexual Abuse (CPG) was set up in 2001, its clear aim was to evidence the need for a strategy to improve the quality of life for those affected. This national strategy is the culmination of its efforts and those of many others. It draws together the recommendations of a Short Life Working Group established by the Health Minister in 2003, views of those involved in the CPG and commissioned research findings.

The strategic outline sets out what the newly established Adult Survivors Reference Group will be tasked with achieving in order to create and strengthen co-ordinated services where staff are aware of, and are able to respond to, the effects of past abuse. Membership of the group includes adult survivors, voluntary and public sector representatives including In Care Abuse Survivors (INCAS) and officials from across the Scottish Executive to ensure that essential cross-cutting work continues. Input from survivors in identifying what works best will be critical.

While the primary emphasis is on ensuring that existing services can deliver improved support to survivors of abuse, Scottish Ministers have recognised a need to pump-prime activity. The Health Department has established a Survivors' Fund with an allocation of £2m, and invited the Survivors Reference Group to co-ordinate bids for demonstration projects consistent with its remit and workplan.

I do not underestimate the scale of the challenges ahead. Health and social care services must become more responsive to individuals' needs, and offer the sensitive responses survivors of abuse need, when they need them. The strategic approach, as outlined, is designed so that the Reference Group can lead in rising to this challenge. I am confident that its groundbreaking work will pave the way for better quality and choice in the future.

Foreword by Lewis Macdonald, Deputy Minister for Health and Community Care, September 2005

Executive Summary

1. Many survivors of childhood sexual abuse have complex care needs, arising from its devastating and long term effects which may be overlooked by statutory service providers, and care professionals. Too many survivors report a 'revolving door' experience being

moved from service to service without having their needs satisfactorily addressed. Survivors frequently present in Health services with other symptoms e.g. depression, self-harm, drug/alcohol misuse, and in Maternity, Genito-Urinary Medicine and Accident & Emergency.

2. In 2001 the Cross Party Working Group for survivors of Childhood Sexual Abuse was set up as a forum to debate and to create a programme of action on the issue, its long-term effects and links with mental health problems. As a result of this activity, the Health Minister established a Short Life Working Group in 2003 to consider the care needs of people who had survived childhood sexual abuse. Its membership comprised a broad range of interest groups including health and social care professionals, voluntary sector providers, representative organisations and Executive advisers. Activity covered evidence gathering, prevalence rates, existing service models, existing training /awareness levels, and identifying gaps in current provision.

3. The outcome of this joint activity is outlined within this document, which sets out a strategic way forward, agreed by Scottish Ministers, which will be led and coordinated by a national Survivors Reference Group.

4. The Survivors Reference Group, which met for the first time this month, has also agreed that, while the main focus will be on survivors

of sexual abuse, wider issues of abuse will also be considered. It is in the early stages of developing a working plan spanning an 18 month to 2 year period to deliver on these key action points. The work to date has highlighted the complexity of issues which surround sexual and other forms of abuse, and of the need for consistent, co-ordinated action to shift cultural and service barriers to change.

Section 1 Childhood sexual abuse in context

1. Childhood sexual abuse (CSA) is increasingly recognised as a major cause of morbidity and mortality. Two recent World Health Organisation (WHO) reports - World Report on Violence and Health (2002) and World Health Report 2002 (2002) - acknowledge that CSA is common in both females (20%) and males (5-10%). CSA is even more prevalent in specific populations including substance abusers, the homeless and psychiatric inpatients.
2. It is clear that CSA is common. Historically, however, the prevalence of CSA in the UK may have been underestimated at 12% for females and 8% for males. Comparing the estimate for females with international studies shows that this estimate is at the lower end of the range (7-36%). The World Health Organisation (WHO) puts the prevalence of CSA at 20-25% for women.
3. Childhood sexual abuse has remained a taboo subject. That it happens is not in doubt, yet for many its existence challenges the accepted view of a caring and compassionate society which places a high value on the safe care and development of our children, to ensure they are nurtured to adulthood free from harm and exploitation. Even in adulthood, abuse and exploitation exist, sometimes going hand in hand with domestic violence, sometimes as part of organised criminal activity connected to prostitution and the sex trade. The physical and emotional damage for the victim can often be lifelong, and requires sensitive handling by committed and caring services which understand the trauma, and can offer responses which help survivors move on.
4. Many courageous individuals have chosen to speak out and to demand that their voices are heard. They, and those who advocate for them, have helped bring these issues to the public eye, and the increased focus on child

protection has helped raise levels of public awareness of abuse and its long term effects. It is clear however that more can be done in this area, and the strategic approach outlined in this document sets out a clear way forward to redress some of the inadequacies within existing services, and to deliver improved help and support for survivors.

5. The key emphasis is on improving care and support services, listening to survivors and providing them with choice in how they access help and support when they need it. Improving services for survivors of abuse is not a matter of creating a new suite of additional services. It is about getting existing services to respond to needs in a more co-ordinated way. While some good practice exists, there is still some way to go. There is a continuing need to remove barriers to joint working and co-operation in delivery of care services. For this to happen requires commitment and direction from service planners and commissioners - to better understand how and when survivors access services and what their needs are.
6. Survivors must be comfortable in trusting workers to feel able to disclose abuse and staff will need to know how to respond appropriately. Survivors make clear that the people who help them do not come from any one professional background or use a particular therapeutic approach. They do not necessarily have high professional status.
7. The majority of these staff have not attended specific training courses on child sexual abuse, although they had gathered expertise in other ways. Rather, they are secure and firm about boundaries, but relate with warmth and kindness. They are informed and aware about the main effects of CSA trauma and have examined their own personal issues around working with sexual abuse. They work non-hierarchically, consulting respectfully with survivors about what their main needs are and what their service can offer. They neither hide behind confidentiality nor break it insensitively. The strategy will develop training that promotes these ways of working.

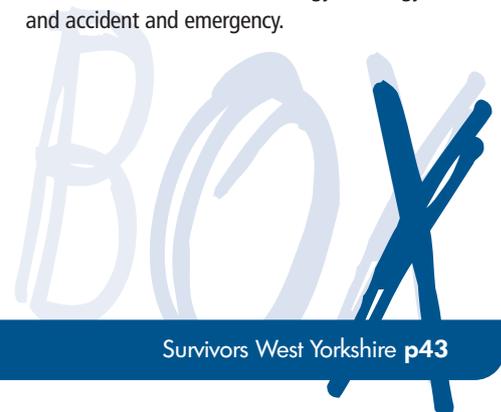
Section 2 - Future Action

The following action steps have been agreed as necessary by Scottish Ministers following the work of the Short Life Working Group, and in discussion with representatives of the Cross Party Group. It will be for the Survivors Reference Group to discuss and agree

detailed implementation. Integral to this will be scoping of what Community Health Partnerships and Managed Clinical Networks may offer to further develop existing services. A lead professional in the field will be invited to work with the Executive to assist with this and with the use of a £2 million Survivors Fund, including commissioning of training and education.

Better data collection

1. Whilst it is known that the consequences of CSA include mental health problems (including suicide and eating disorders), physical illness, and behavioural and social problems, only 1% of cases of childhood sexual abuse are documented in health records. One estimate of the increased cost to hospital services of managing the health consequences of CSA for women in Scotland is put at £30-60 million per annum.
2. There is no clear requirement placed on primary care or mental health services to identify those affected and so what current information systems are able to do is measure behavioural and pathological patterns, but not their underlying cause.
3. CSA is not widely enough recognised as a major contributing factor to a range of seriously disabling behaviours such as self-harm and substance abuse. The emphasis in practice is largely placed upon treating the symptoms and minimising harm rather than supporting service users to explore aspects of their sexual abuse history or to develop strategies for coping positively with daily life.
4. Obtaining better baseline data from current services is therefore a priority. The voluntary sector has considerable expertise in helping adult survivors of CSA and has data that could be the foundation on which to build. Additionally, it may be appropriate to set up better data collection systems in other services likely to have high numbers of adult survivors such as addiction services, mental health services, prisons, primary care, genito-urinary medicine (GUM), obstetrics and gynaecology and accident and emergency.



Executive Summary continued..

5. The Executive's Primary Care Division is part of the Information Services Directorate initiative to develop generic data standards for care information about people in Scotland. The standards developed by the eHealth National Clinical Datasets Development Programme and the Scottish Social Care Data Standards Project are for core and generic information about any individual person, in a health or social care context. The purpose is to facilitate the integration and sharing of information to support effective person-focused social and health care services for individuals, whether joined-up or single agency. There is no restriction on local partnerships collecting other data relevant to their local area/processes. It is recommended that the national generic data standards should be implemented within existing and emerging national clinical information systems.

Public awareness raising, creation of self-help tools and training for professionals across all disciplines and at all levels.

6. Current work on developing appropriate responses to the needs of adult survivors needs to be enhanced by increased awareness of the stigma and discrimination that survivors feel. A positive climate of discussion, honesty and safe space for letting go of and working through feelings is essential.

7. Media campaigns to date in the UK and Scotland have addressed the need to challenge and report childhood abuse, and focused on domestic violence - which may include sexual abuse. National and regional campaigns have been run successfully in Australia and Canada, primarily in response to major investigations of sexual abuse activity within religious institutions, and child care services. There are lessons to be learned from the See Me campaign and the possibility of a campaign directed at improving public understanding of the issues is one that will be explored further in the Survivors Reference Group. The present developments underway to improve the training and education of the

existing health and social care workforces also provide a timely platform to take this recommendation forward. The emphasis on continuous professional development will help underpin this process.

It is expected that Community Health Partnerships will continue to support the continuous professional development of their workforce by promoting initiatives such as protected learning times.

9. More specifically, improved health assessment within the Scottish Prisons Service is highlighting a significant proportion of prisoners with past sexual abuse history, particularly for women. While training for prison staff incorporates equality and diversity issues, and addresses health and psychological matters in general terms, with some inclusion of abuse issues, more can be done to improve screening and support services.

10. Developing self-help tools should form part of wider educational and awareness raising. There is a wealth of existing material which can be accessed via individual websites but its availability requires improved co-ordination. The 'Safe Hands' initiative developed by the Moira Anderson Foundation for primary school children and teaching staff to better understand protective behaviours is one example of useful self-help material.

A network of survivors, practitioners and researchers to collaborate on the systematic development of good practice across Scotland.

11. Scotland is uniquely placed with a small scientific community closely linked to clinical services. Consideration is to be given to how best to formally develop a network of practitioners and researchers from different disciplines and services alongside survivors to enhance our understanding and to find new ways of responding to the needs of this population. This network, which could be virtual, would have a wide remit e.g. from evaluating good practice in settings such as the voluntary sector or making inroads into the understanding of the neurobiological impact of early trauma. The cross fertilisation of these approaches will enhance knowledge of the biological underpinnings of trauma which can be utilised to maximum effect in the therapeutic field.

Local demonstration projects to develop and disseminate good practice nationally

12. There are currently a limited number of discrete specialist services for survivors, the majority of which are provided by the voluntary sector but it is more common that projects cover other issues e.g. rape, domestic violence. The Survivors Reference Group will discuss the main themes that demonstration projects are needed for and will develop a mechanism by which to receive and assess applications for funding.

13. A search of services provided by the voluntary sector revealed a number of innovative support and information services but with little evidence of systematic evaluation. However, the organisations that offer these services appear to involve survivors in their development, and are committed to ensuring their provision reflects what survivors value.

14. As far as individual and group counselling is concerned, the largest source of help in local areas tends to be in non-statutory services. Their main source of referrals is the health service, yet few receive funding from NHS boards. There also needs to be recognition of the different needs of male and female survivors, with skills and staff mix to match. Whilst there are both male and female survivors, it is also true that the majority of perpetrators are male. The shared understanding of gender-based violence set out in the Scottish Executive policies on domestic abuse applies here also.

15. Local partnerships are therefore essential for making an impact in terms of service provision for adult survivors. GPs in particular are a crucial first point of access for survivors seeking help. Pathways of care that connect primary care, non-statutory services and specialist mental health services can help. Again, there are models developing for domestic abuse that can be adapted for adult survivors. Indeed, if integrated services are to be developed, there may be potential for local domestic abuse forums to broaden their remit to cover this area of need.

Improved commissioning and resourcing of services at local level with more specialist and intensive support for those who require it, recognising the fluctuating and long-term needs of many survivors. For the vast majority of adult survivors, a warm, open and empathetic service response is all that is required. For survivors accessing support services, there is scope to incorporate these features into quality assurance with survivors themselves helping in the design of systems and their monitoring. Above all is the necessity to avoid re-traumatisation by services. It is also necessary to recognise the impact of abuse on the partners of survivors.

17. Survivors need to be sensitively supported to explore their sexual abuse history at a pace appropriate to them by staff who feel confident and who can offer safe responses to disclosure. It is usually non-specialist frontline services, dealing with issues like substance

misuse, homelessness or distressed behaviour, that survivors approach first for help, or to which they are referred. Sometimes staff do not feel equipped to deal with the subject of childhood sexual abuse. Recipients of disclosure should be trained to avoid panic and possible unnecessary referral to specialist services, especially since many survivors do not wish constantly to be referred on.

18. This strategic document emphasises the necessity for better co-ordination of local services, and illustrates the continuing difficulties the voluntary sector faces in being seen as equal partners when decisions are being made on provision of services. However, with the exception of services for men, there remains duplication of effort across Scotland which presents difficulties for local funders in meeting needs effectively. This is compounded in some respects by a lack of clarity on what constitutes effective outcomes. Planning and delivery of local services must remain a matter for local decision, and the Executive's

guidance on funding the voluntary sector stresses that the sector must be key players in policy development across sectoral issues like community planning and health strategies.

19. The Scottish Prison Service (SPS) is eager to engage with other stakeholders on planning and delivering services and support across a community. SPS already collects some relevant data on this matter, and proposes applied research. Again, they would wish to collaborate with other developers of information systems and research plans in order to yield the most consistent and durable results.

Clear inclusion of adult survivor issues in mainstream policies

20. It is essential that adult survivors work is integrated into existing areas of policy. Sexual abuse in childhood is a social and cultural phenomenon with potentially damaging effects. It requires above all, a recognition that it happens and that its impact can be lifelong,

and not only in childhood, where existing policy focuses.

21. Provision of help and support to children at the time abuse happens will always remain important, but more can be done to recognise and plan for continuing need in later life. To achieve the broad-based shifts in policy requires that it is integrated with policy development and practice around child protection and domestic abuse.

22. There are also important links to be made with mental health policy. Psychological services should be responding explicitly to the needs of adult survivors. This could be brought out in the psychological services addition to the national framework for mental health services. Services need to consider CSA survivors at all levels of service provision. This should become an aspect of performance management of mental health services.

Identification of adult survivors in the prison population.

23. At present, little is known about the numbers and needs of adult survivors within the criminal justice system in Scotland. It will be for the Survivors Reference Group to make recommendations on how best to undertake this work. Generally, the Scottish Prison Service (SPS) is increasingly aware of the relationship between abuse and addiction which, in turn, is a driver of much criminal activity. Psychologists, mental health professionals and addictions specialists are increasingly interested in the full picture of a prisoner's needs in terms of their addiction and mental health problems, and what may underlie them. SPS has an increasing understanding of the effect of abuse owing to the growing partnership with the voluntary sector and its specific skills in this area.

Creation of change programmes targeted at prevention of further sexual offending to take forward the Cosgrove Report Recommendation 26

24. Lady Cosgrove's report on sex offending recommended that the Executive must give priority to putting systems in place which will reduce the risk for those who might become victims of sexual abuse in the future, on the basis that prevention is better than cure. None of this detracts from the need to work with the current survivors of childhood abuse, but works on the premise that some perpetrators, or those who think they may become perpetrators, may also have suffered from sexual abuse and need access to ongoing

support and intervention while they are in the community- to reduce the risk they present to the public. We are committed to addressing this as part of the strategy through education programmes targeted at changing the behaviour of perpetrators and potential perpetrators as well as to look into other strands and behaviours that can be linked to abuse. This will go beyond education to include projects that give perpetrators as well as survivors better access to more sensitive and responsive support services.

Research - Underpinning and ongoing evaluation

25. In terms of what works, the evaluation of services and provision for survivors of childhood abuse are less developed than services and policies in related areas, such as domestic violence. Again, it will be for the Survivors Reference Group to define research priorities and the means to have these addressed.

26. There is a clear clinical and mental health emphasis in the available literature, and studies of sexual abuse outnumber those that look at childhood abuse in general or those that focus on physical or emotional abuse or neglect. Studies tend to focus more upon the mental health conditions for which survivors are at greater risk than on the high risk group itself. Indeed, it may be the case that survivors are not recognised per se, but as people who suffer from particular mental health problems

such as depression or borderline personality disorders. Many studies focus on a particular sub-group of survivors. The general theme of the literature is to document the adverse consequences in later life of childhood abuse, and clinical interventions. There is less research evident on the long-term consequences for physical health of childhood abuse.

27. There is also less research evidence on the social and familial consequences in adult life of childhood abuse but the dominant theme from such studies is that the legacy of childhood abuse in adult life is a much higher risk of problems in social functioning, in forming and sustaining intimate partnership relationships, and in parenting. Studies of services for survivors also have a clinical and mental health emphasis. Research on informal support networks and on services giving information and support that are provided in the voluntary sector is also sparse.

28. It will be important, in developing policies and provision for adult survivors of CSA that undue emphasis is not given to treatments, short term interventions and recovery programmes such as cognitive behavioural therapies, at the expense of other forms of provision that address the longer-term support needs of both survivors and members of their families.

The Scottish Executive 2005



The politics of gender

child sexual abuse became a widely recognised social problem in the 1980s, and remains one today, with growing evidence that a significant proportion of children experience some form of sexual abuse, and that such experiences increase the risk of a range of negative outcomes in adult life, including mental health problems, offending and parenting problems (see e.g. Fergusson et al, 1996; Ruscio, 2001; Hooper, 2003; Hooper & Koprowska, 2004).

Feminist research, analysis and activism played an important part both in achieving recognition of the issue and in the development of service responses to adults with a history of child sexual abuse (hereafter referred to as 'survivors' for brevity), particularly (but not only, cf Scott, 2001) within the voluntary sector. Since men predominate as perpetrators and girls as victims, the issue was sometimes included with other forms of 'violence against

women', and in relation to adult survivors services run by women for women tended to be the preferred response for feminists, following the model of voluntary sector responses to domestic violence (women's aid refuges) and rape (rape crisis centres). From the middle of the 1980s the anti-sexist men's movement began to develop parallel services run by men for male survivors although more services for male survivors have been established in the past ten years.

The sexual/gender politics of debates on child sexual abuse have often been fraught. Recognition of the involvement of some women in perpetrating child sexual abuse and of the victimisation of boys, both readily acknowledged by most feminists, was sometimes used by others to neutralise the gender dimension (in what Anne Worrall (2003) has referred to as an 'active search for equivalence'). Some rather crudely drawn positions have emerged, whose influence is still discernible in service responses to adult survivors. On the one hand, child sexual abuse may be perceived as a women's issue, and while significant gains have been made in some fields as a result, particularly in recognising its relevance to women's mental health problems (DoH, 2002) and offending (Hooper, 2003; Rungay, 2004), the needs of

male survivors may easily be overlooked (Holmes et al, 1997. On the other hand, the argument that since boys/men may be victimised too, child sexual abuse is not a gender issue is also heard in some contexts, e.g. some voluntary organisations, and the trend towards the professionalisation of voluntary sector provision, and to mixed services for survivors (i.e. attempting to meet the needs of both men and women survivors), seems sometimes to risk losing sight of the relevance of gender to the experience and needs of survivors.

In this paper, we aim to review briefly the evidence on gender in relation to the prevalence of child sexual abuse, its impacts, and the experience of services of adult survivors, in order to draw out some implications for service development.

Prevalence, patterns and impacts of child sexual abuse

While prevalence rates vary a good deal between studies, partly as a result of definitions and methodology, it is pretty much a universal finding (at least in the UK and other Western countries) that girls are significantly more vulnerable overall to child sexual abuse. The recent NSPCC prevalence survey found that 21% of girls and 11% of

boys had experienced sexual abuse, defined as sexual experiences where i) the other person was a parent or carer, ii) they were against the respondent's wishes, or iii) they were felt to be consensual but involved a person other than the parent who was 5 years older when the child was 12 or under (Cawson et al, 2000). Another common finding is that girls are more likely to be abused by someone within the family, boys by someone outside the family (though in the NSPCC research male and female respondents were equally likely to have been abused by a parent) (Faller, 1989; Gold et al., 1998). This partly reflects the patterns of children's lives, and the opportunities these present, since boys still tend to be less supervised outside the home than girls. The gender gap may well differ at different ages and the breaking down of prevalence figures by age would be useful in future research.

While boys are less likely to be sexually abused, they are also less likely to tell someone of their abuse than girls (though there is no evidence to suggest that this applies to the research context or affects the prevalence findings above - the NSPCC survey used computer-assisted interviewing to ensure privacy for respondents). While only a small minority of incidents of sexual abuse experienced by either boys or girls are reported to agencies, boys are significantly less likely to report than girls (Holmes et al, 1997; Kelly et al, 1998). Disclosure of child sexual abuse is difficult for many survivors (as children and adults), since the impacts of abuse may include shame and stigma, guilt and self-blame, low self-worth, lack of trust in others or sense of entitlement to help, and dissociation, amongst others. For boys the 'male ethic of self-reliance' and the effects of homophobia if they were abused by men (either their own or anticipated from others) may compound the barriers to seeking help (Mendel, 1995).

There are gender dimensions too to the impacts of child sexual abuse, alongside many common themes in the impacts reported by men and women: in addition to those cited above, fear, anger, insecure attachment, anxiety and depression, PTSD symptoms, difficulties with trust and intimacy, vulnerability to revictimisation. It is commonly noted that girls are more likely to internalise their distress (e.g. depression, self-harm), boys more likely to externalise

and display "hypermasculine compensation" (Lisak, 1995), e.g. aggression, anti-social behaviour, violence to others and homophobic behaviour (Finkelhor et al, 1990; Lisak, 1994; Durham, 2003), though this pattern may change as social constructions of gender and the constraints and pressures they impose change. There is some evidence to suggest that violence and aggression are increasing somewhat amongst women, although not to the extent sometimes suggested by the media (Batchelor, 2005), and self-harm is also increasing amongst men or has been previously under-recognised (Ray, 2001).

There are some other differences worth noting. For women, there is a growing body of research addressing the impacts of childhood sexual abuse on pregnancy, childbirth and motherhood - child sexual abuse has been found associated with increased risk of adolescent pregnancy (Raine et al, 1995), higher levels of stress, depression and negative life events during pregnancy (Stevens-Simon & McAnarney, 1994; Benedict et al, 1999), greater risk of childbirth complications (Farley & Keaney, 1997) and greater severity and length of post-natal depression (Buist & Janson, 2001). Qualitative research suggests also that women's wider role in 'kin and caring work' within families may contribute to the difficulties of separating from abusive parents - via a sense of obligation to care for them in their old age, the desire to maintain grandparents for children and/or an attempt to protect a wider kin network from the disruptive effects of disclosure (Hooper & Koprowska, 2004). All these may be issues for men too, but are likely to be more common amongst women.

For men, constructions of masculinity and in particular male sexuality in which men are expected to be active, initiators, powerful may make coming to terms with the experience of abuse, involving being powerless and acted on, difficult in a particular way (Lisak, 1995). It is perhaps in dealing with that contradiction and attempting to live up to dominant constructions, that men's expressions of distress tend to be more angry, aggressive, threatening to others, as well as risky to themselves (for example through dangerous sports or excessive bodybuilding and steroid abuse). At the same time, while the greater

cultural fit between femininity and victimisation may make it easier for women to speak at all of their abuse, it may also make it particularly hard to find a way of voicing their experience in a way that is empowering. In contemporary narratives of child sexual abuse, political analysis has largely been eclipsed by concerns with individual mental health (Armstrong, 2000; Haug, 2001; Scott, 2001). While child sexual abuse is both a political and a mental health problem, survivors who speak about their abuse in the current context may find themselves positioned as 'other', damaged and different, in a way that reinforces their disempowerment (Profitt, 2001). In some ways the silence about child sexual abuse is broken at the societal level (although many distortions of reality persist). At the same time it remains a challenge for individual survivors to negotiate a narrative of their own lives which offers a positive identity in the contemporary cultural context (Naples, 2003), and this challenge is somewhat different for women and men.

Experience of services

Adult survivors of abuse come into contact with a wide range of services - probably all services - and there is a growing literature on their experiences of services (Richey-Suttles et al., 1997; Hooper et al, 1999; Nelson, 2001; Lab et al, 2000; Agar et al, 2002). It is clear from this that while certain professionals (especially psychotherapists and counsellors) and certain services (especially voluntary organisations) are particularly highly valued, contacts with many other individuals and in many contexts may contribute to a reparative experience for survivors. At the same time, as the DoH now recognises, in any service context there are risks of retraumatisation if services or professionals, wittingly or unwittingly, replicate the dynamics of abuse, for example by reinforcing stigma and powerlessness (see Hooper & Koprowska, 2000 for fuller discussion of this). A number of points where gender may affect whether a reparative or a retraumatising experience is offered may be identified.

POLITICS OF GENDER

continued...

Disclosure

Many survivors are in contact with services for years without telling anyone of their abuse. Increased public and professional awareness of the issue may make this less common today than it has been in the past, and in some contexts (e.g. some psychiatric and ante-natal care services) questions are now routinely asked about childhood experience including sexual abuse. Research suggests that survivors usually appreciate being asked such questions, which help to make the issue speakable even if they choose not to speak of it at that time, and also to validate the relevance of their experience to their distress (as opposed to simply labelling the latter with a psychiatric diagnosis) (Hooper et al, 1999). The evidence also suggests that professionals are more likely to raise the issue if the client is female than male, although whether this reflects lack of awareness regarding the sexual abuse of boys or greater hesitancy about raising the issue with someone who may be a more aggressive and threatening client, is not clear (Holmes et al, 1997). Female workers have also been found more likely than their male colleagues to ask male clients about the possibility of abuse, perhaps reflecting greater awareness of the issue (Agar & Read, 2002).

Survivors do not of course always tell a person who asks, but rather make

judgements about who to tell and when, influenced by their own life circumstances and their perceptions and experience of the worker concerned. When they do, whether disclosure results in a reparative or a retraumatising experience depends partly on the immediate response of the person told and partly on whether services are available for the survivor to be referred to for further help, if further help is needed. Survivors sometimes experience dismissive responses from people they tell as a result of the person's assumptions about gender, e.g. that sexual activity in childhood is damaging for girls but less so for boys (Holmes et al, 1997), or that survivors disclosing abuse by women are probably avoiding their abuse by men (Livesey, 2002). Recent research suggests that disclosures of childhood abuse from women are more likely to result in referral for abuse related therapy, although again it is not clear whether this is a result of perceptions of need or of availability of services (Agar & Read, 2002)

Allocation of workers. Gender is a highly charged issue for many survivors of child sexual abuse, and many have a strong preference regarding the gender of their workers, though such preferences may also change over time and reflect various motivations (Dale, 1999). In recent research, women survivors talked of their distress being intensified by male workers who reminded them of their abusers, either just

by being male or by associated characteristics e.g. size, and the difficulty of managing relatively intimate one to one work with a focus on abuse in such a context. Female workers could help them feel more positively about themselves as women. Some also appreciated encouragement to work with a male worker however, despite initial reservations, to help change their experience and expectations of men (Hooper et al, 1999). Preferences are not always predictable, and other factors such as the worker's personality, personal experience of abuse, ethnicity, status as a parent, may be more important to some people than gender. However, since child sexual abuse involves the overriding of the child's needs and preferences, the respecting or dismissing of such preferences itself is one location in which a reparative or retraumatising experience may occur.

Groups

Groups offer powerful potential to reduce survivors' isolation by sharing experiences, feelings and activities. Most groups for survivors are single-sex, and many survivors express a clear preference for single sex groups. The mix of members is a common reason given for negative experiences of groups, both self-help and therapeutic, though the range of issues cited is wide - sex/gender, mental health problems, personality, nature of abuse experience,

attitude/mood. As well as the associations with gender discussed in relation to workers, difference is often a painful issue for survivors, whose experience may have made them feel different from other children (and bad/stigmatised) from an early age. The differences which are salient to different individuals vary, however, and may also change over time.

Qualitative studies report that some survivors feel unable to talk about their experience of abuse in a mixed sex group or a group in which the focus is on mental health problems rather than life experience. Others however report positive experiences of mixed-sex groups, whether for survivors only or more broad-based therapeutic groups. While different kinds of groups are needed at different stages in the process of recovery (cf Herman, 1992 for discussion), at the right time mixed groups have potential for enabling participants to recognise similarities and differences in ways that challenge rather than reinforce gender stereotypes and defensive splitting (e.g. the construction of women as victims, men as perpetrators in a way that may reflect a past reality but distort a present one). Such groups can also offer reparative experiences with members of the other sex in a relatively safe environment and thereby expand opportunities to restore connections with the wider community that traumatic experience may have destroyed (Herman, 1992).

Voluntary organisations/specialist services. Specialist voluntary organisations play an important role in service provision, whether in offering one to one support or counselling/therapy, opportunities for self-help or therapeutic groups, or a range of other services, e.g. resource information, self-help books etc. While more is sometimes expected of them than they can realistically deliver (given the common problems of voluntary organisations, e.g. insecurity of funding, difficulty of finding management committee members etc.) they are often preferred by service users over statutory services where statutory obligations, management priorities, and professional cultures may contribute to the experience of less priority being given to users' needs and views. Voluntary organisations run on self-help principles also offer opportunities for survivors to give as well as receive help, and sometimes to contribute to service developments elsewhere through, for example, involvement in mental health user forums. Such involvements can be empowering, enabling survivors to shift from 'other'/client/user to educator and

contributor to service provision, and helping to break down myths and stereotypes amongst service providers in the process. They can also however risk replicating the dynamics of abuse, if those survivors involved find themselves (once again) taking excessive responsibility for the needs of others.

There is a current trend amongst formerly single-sex specialist voluntary organisations to 'go mixed', but no research as yet on the form this trend is taking or its implications. The changes are occurring for a number of reasons - recognition of the needs of male survivors (for formerly women-only organisations), the funding priorities of health trusts, the changing nature of the voluntary sector and the need to compete for funding, and the personal and professional development interests of workers, amongst others. Mixed organisations may take a range of different forms, from combining separate services under shared management, through a shared service operating with sensitivity to gender issues (offering options for single sex or mixed groups, taking into account preferences for counsellors of the same sex, and addressing potential safety issues for example) to a mixed service where gender issues are paid little attention, and whether the trend offers more benefits or risks clearly depends partly on what form such organisations take. Its implications may be different for different groups of survivors - not just in terms of their gender but their ethnicity, whether they were abused by men or women, their level of distress/stage of recovery etc. There are potential losses even where services are kept largely separate (offering separate helplines for men and women for example), if the safe space and positive role modelling offered by voluntary organisations run by and for women (or men), are undermined. Alongside this, the professionalisation of voluntary organisations with which this trend is closely associated risks eclipsing survivors' voices, which self-help oriented provision is committed to hearing. On the other hand, a commitment to women-only provision, at least unless parallel services are developed for male survivors, risks obscuring the needs of male survivors - and groups involving male survivors have interpreted the current proposal for a national rape crisis line for women only in this way. In the 1970s and 80s women-only provision offered an important space for countering the silencing of women's experience. While the gains of greater recognition are always fragile, in a different context, some form of mixed

provision may also offer valuable opportunities to challenge the fixing of a gendered dichotomy with women as victims and men as perpetrators which may limit both male and female survivors' ability to integrate their experience in an empowering way.

Concluding comments

Many adults who were sexually abused in childhood live adult lives manage to resolve the legacies of their experience, and it should not be assumed that all are in need of help. But it is also clear that child sexual abuse increases the risk of a wide range of problems, and prevalence rates are particularly high amongst those with drug and alcohol problems, mental health problems, parenting problems and amongst runaways (Stiffman, 1989) and offenders (especially women offenders) (see Hooper, 2003; Hooper & Koprowska, 2004 for further references). While there is a huge literature on the impacts of child sexual abuse now, it is useful to add to this the frame offered by the growing literature on the politics of recognition - that recognition is a fundamental human need. The denial of recognition experienced by children who are sexually abused through their use for the sexual gratification of the perpetrator, the secrecy which commonly surrounds it and the frequent disbelief or invalidation they meet in others' responses is particularly strong. Many of the experiences of retraumatisation which adult survivors encounter in their contact with services are the result of misrecognition of their experience or needs, and both denial of the relevance of gender and exaggeration (through reliance on stereotypes) can contribute to this, inhibiting caregivers from responding to the survivor's need 'to be met as a person' (McCluskey, 2005). Debates over single sex or mixed sex organisations may also be partly fuelled by reluctance to share those hard-won spaces for recognition. Whatever the way forward, attention to gender remains crucial - in training, supervision, workforce planning and service planning - if opportunities to offer reparative experiences are to be maximised and retraumatisation minimised.

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Survivors Trust

Purple Phoenix Sexual Abuse Training
and Consultancy

Relate Keighley



Relevant Books

The Survivors Guide

Robert Kelly and Fay Maxted
Paperback 344 pages (September 2005)
Publisher: Rugby RoSA
Language: English
ISBN: 0955103703

Synopsis

Every day, all over the world, millions of people, young and old, women and men, live with the harsh realities of rape and sexual abuse. Many of them believe they are alone in coping with a range of feelings from isolation and helplessness to guilt and low self-esteem. But they are not alone. The Survivor's Guide is for every one who is affected by abuse issues - whether a survivor themselves, a friend, relative, health professional or counsellor. It offers helpful and friendly advice that can be used in everyday situations to encourage survivors to work through the emotions that they feel and to develop a wonderful vision for themselves of the person they want to be and the life they want to live - not just making do with surviving. This book features a collection of unique illustrations to portray the stories of survivors of rape or sexual abuse in easy-to-read chapters. Funded purely

by goodwill and donations, The Survivor's Guide is the result of an ambitious campaign by a team of volunteers at UK support group RoSA (Rape or Sexual Abuse Project) who were frustrated by the lack of self-help literature for abuse victims worldwide. It was written and produced with the backing of professional women's organisation Soroptimist International of Rugby, UK, who fundraised tirelessly for a year to get the project off the ground.

Victims No Longer (2nd Edition): The Classic Guide for Men Recovering from Sexual Child Abuse

Mike Lew
Paperback 464 pages (May 2004)
Publisher: HarperCollins Publishers
Language: English
ISBN: 006053026X

For millions of men on the path to recovery, Victims No Longer is the next step.

The first book written specifically for men, Victims No Longer examines the changing cultural attitudes toward male survivors of incest and other sexual trauma. Now, in this Second Edition, this invaluable resource

continues to offer compassionate and practical advice, supported by personal anecdotes and statements of male survivors. Victims No Longer helps survivors to:

- Identify and validate their childhood experiences
- Explore strategies of survival and healing
- Work through issues such as trust, intimacy, and sexual confusion
- Establish a support network for continued personal recovery
- Make choices that aren't determined by abuse

Psychotherapist Mike Lew has worked with thousands of men and women in their healing from the effects of childhood sexual abuse, rape, physical violence, emotional abuse, and neglect. The development of strategies for recovery from incest and other abuse, particularly for men, has been a major focus of his work as a counsellor and group leader.

Thoroughly updated and revised, and including an expanded Resources section, Victims No Longer educates survivors and professionals about the recovery process - speaking to the pain, needs, fears, and hopes of the adult male survivor

“ Challenging the Silence is not only about freeing the adults they will become, its about freeing the voices of the children who sadly are still abused today ”

**Ghosts in the Bedroom:
Guide for Partners of Incest Survivors**

Ken Graber

Product Details:

Paperback 160 pages (March 1, 1991)

Publisher: Health Communications,U.S.

Language: English

ISBN: 155874116X

Partners of survivors are forgotten in many cases - Ghosts in the Bedroom helps to redress the balance.

**Protect Your Child from Sexual Abuse:
A Parent's Guide**

Jamie Hart-Rossi

Publisher: Parenting Press Incorporated

Language: English

ISBN: 0943990076

A useful guide to empowering your child to protect themselves and speak out if abused.

**The Courage to Heal: A Guide for Women
Survivors of Child Sexual Abuse,
Featuring "Honouring the Truth: A
Response to the Backlash"**

Ellen Bass, Laura Davis (Preface)

Product Details:

Paperback 608 pages (June 1994)

Publisher: Harper Perennial

Language: English

ISBN: 0060950668

One of the most read and recommended self help books written for survivors.

Half the House

Richard Hoffman

Publisher: New Rivers Press

Language: English

ISBN: 0898232287

An insightful and powerful look at the perspective of a survivor exploring their own personal journey of recovery.

Abused Boys

Mic Hunter

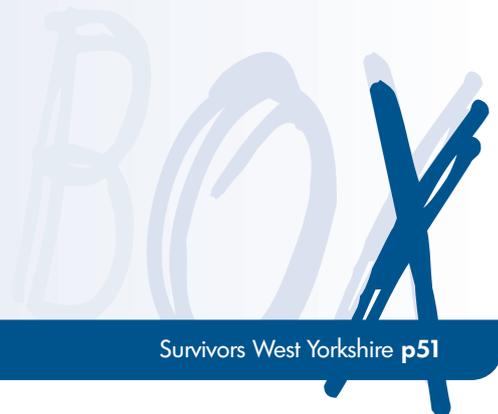
Publisher: Ballantine Books

Format: Trade Paperback, 352 pages

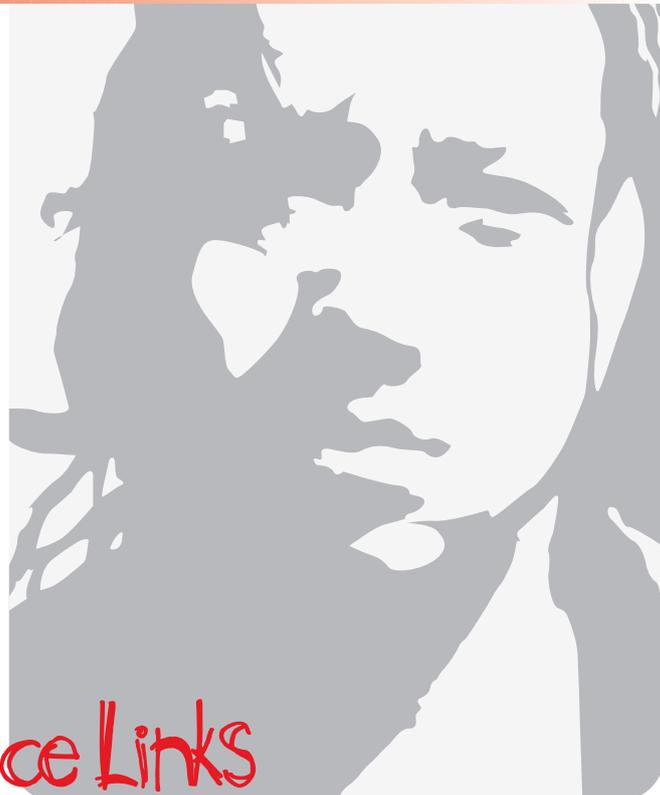
Pub Date: June 1991

ISBN: 978-0-449-90629-3 (0-449-90629-9)

A long overdue book by a psychologist who has extensive clinical experience treating male victims of child sexual abuse, it explodes the myth that sexual abuse of male children is rare, or that the consequences are less serious than for girls. Hunter examines the physical and emotional impact of abuse on boys.



SUPPORT SERVICE LINKS



Abuse Support Service Links

Bradford

Bradford Rape Crisis and Sexual Abuse Service & Project Jyoti

C/o 19 - 25 Sunbridge Road
Bradford
BD1 2AY

Helpline: 01274 - 308 270
Email: Info@brcg.org.uk

A service by women... for women who have been raped or sexually abused at any time in their lives.

The Lily Project

Relate Keighley and Craven
Acres House
Berry Lane
Keighley
BD21 1DN

Tel: 01535 - 605 047

A group counselling service for women who have experienced sexual abuse as children.

Off The Record (Bradford Counselling Service)

3rd Floor
24 Barry Street
Bradford
BD1 2AW

Tel: 01274 733 080

A general counselling service for men and women with extensive experience of dealing with sexual abuse issues.

Purple Phoenix: Sexual Abuse Training and Consultancy Services. (A SWY Social Enterprise Pilot Project)

Survivors West Yorkshire
C/o Bradford CVS
19 - 25 Sunbridge Road
Bradford
BD1 2AY

www.sexualabusesurvivortraining.org.uk
Email: purplephoenix1@mac.com

The Shed Project

Relate Keighley and Craven
Acres House
Berry Lane
Keighley
BD21 1DN

Tel: 01535 605 047

Email: theshed@relate-keighley.co.uk

Group counselling service for men who have experienced sexual abuse as children.

The Star Project (Surviving Trauma After Rape)

www.starproject.co.uk
Helpline: 01924 298 954
Email: star@starproject.vianw.co.uk

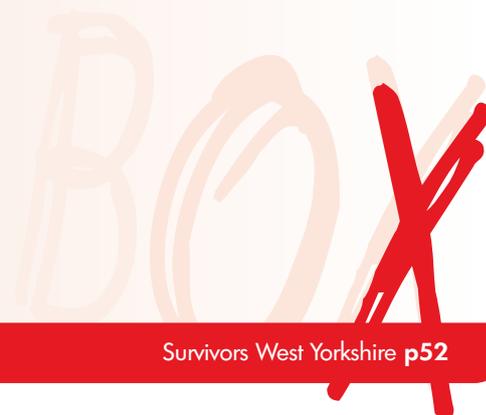
The STAR Project provides support for females and males, aged 14 and over, throughout West Yorkshire who have been raped or seriously sexually assaulted.

Survivors West Yorkshire (Bradford) C/o Bradford CVS

19 - 25 Sunbridge Road
Bradford
BD1 2AY

Helpline: 07950 263 975
(voice mail - all calls returned asap)
Email: survivorswy@mac.com

General support, advice and signposting, for male and female survivors of sexual abuse including their partners and supporters. Campaigning and Strategic development projects in support of sexual abuse survivor service provision, awareness and improvement.



“ Joined up strategies across all sectors are needed, with long term secure funding linked to cutting edge best practice, service development and innovation in partnership with victims of sexual crime ”

United Kingdom

NAPAC

(The National Association for People Abused in Childhood)

42 Curtain Road
London
EC2A 3NH

Support Line: 0800 085 3330

A small charity offering general support and signposting nationally for survivors of sexual abuse via a free phone helpline.

Rape Crisis Movement

www.rapecrisis.org.uk

Feminist umbrella organisation for services supporting female survivors of sexual abuse.

The Survivors Trust

27B William Street
Rugby
CV21 3HA

www.thesurvivorstrust.org

Tel: 01788 550554

Email: survivorstrust@btconnect.com

A non gender specific umbrella organisation for services supporting sexual abuse survivors.

Web based resource - UK & International

General sites: non gender specific

www.abuse-survivors.org.uk

www.angelashelton.org

www.aest.org.uk

www.alice-miller.com

www.dabsbooks.co.uk

www.darkness2light.org

www.giftfromwithin.org

www.havoca.org

www.jimhopper.com

www.operationemotion.co.uk

www.oneinfour.org

www.phoenixsurvivors.com

www.safelinewarwick.co.uk

www.safehaven-uk.org

www.survivorguide.co.uk

www.siari.co.uk

www.supportline.org.uk

www.sasa.org.uk

www.thisisawar.com

www.victimsnolonger.org.uk

Female Survivors

www.crcl.org.uk

www.krasacc.co.uk

www.users.zetnet.co.uk

www.womenstherapyleeds.org.uk

Male Survivors

www.leedsmalesurvivors.co.uk

www.male-rape.org.uk

www.mash-online.org

www.malesurvivor.org

www.nextstepcounselling.org

www.namsas.org.uk

www.survivorsswindon.com

www.survivorsuk.org

www.survivorsfellowshiplondon.org.uk

Clergy abuse

www.holywater-gate.com

www.snapnetwork.org