



On routine enquiry – reflections from the evaluation of the Visible project

Introductory note: This paper draws together reflections from the evaluation, informed by relevant literature, on the issue of routine enquiry.

Since 2003 it has been DH policy that all adult service users should be asked about violence and abuse in mental health assessments - this has come to be known as 'routine enquiry'. A question about physical, sexual or emotional abuse at any time in the person's life is recommended practice. Practitioners involved in the Visible project (from many different organisational contexts) have been trained to ask more specific questions about childhood sexual abuse. In Wales the Ask and Act policy (2017) extends the requirement for practitioners to ask about abuse (again all forms of violence and abuse) to across the public service including in circumstances where practitioners recognise signs and symptoms, or information is received suggesting the client is experiencing an issue. While evidence on the implementation of routine enquiry suggests it is partial, and there is no evaluation yet of the Ask and Act policy, a third approach has also been developed in health care settings called trauma-informed care (TIC) which is being adopted by many agencies in the UK and mainstreamed by NHS Education for Scotland. This approach again highlights the context of mental health issues – it is sometimes defined as moving from symptoms (what's wrong with you?) to circumstances (what happened to you?), though present-focused therapies focus less on history taking and more on 'how can we help you now?' with people in distress. There is more recognition in TIC than in the 'enquiry' approaches of the complexity of responses to trauma, the need for compassionate awareness of the likely roots of distress even if the events are unknown, and the need for building trust and safe relationships and a flexible approach to conversations about the person's experiences. As other organisations consider their approach this paper presents some issues for consideration.

Given that child sexual abuse has historically been surrounded by silence, it is easy to conclude that opening up the issue by asking questions is universally the best way forward. At the time it became policy, routine enquiry represented hard won recognition of child sexual abuse (and other forms of violence and abuse) and their relationship to adult mental health. A new orthodoxy has since developed of 'Yes we can' which reflects and reinforces this emphasis on asking questions, and professionals' own wish to act on their growing awareness of child sexual abuse may contribute to a move to ask them more in all settings. There are however some legitimate reasons for caution about asking questions routinely and to coin a well-known phrase, less can sometimes be more:

- **Survivor perspectives** – There are many adults very grateful for practitioners asking them about experiences of sexual abuse in childhood which enabled them to speak of them when they had not previously done so and to receive help. Routine enquiry ensures that the issue is considered in relation to all those in mental health settings not just those who show signs or symptoms. As RE spreads beyond those settings however, a different theme is also emerging. A member of the Survivor Reference Group for the Visible project spoke of how tiring it is to be expected to tell your story again and again. Another member proposed a ‘not now/save for later’ option in assessment forms, indicating that he might not always want to talk about his experience. Some members of a group who self-harm, all of whom welcomed the idea of being asked what happened to them, also said they wouldn’t necessarily tell the truth because they still felt guilty and ashamed even though they knew their abuse was not their fault.
- **Professional perspectives** – In the evaluation of the routine enquiry pilots, while the majority of clinicians were supportive of routine exploration (probably a better word than enquiry), a minority were opposed or unsure (McNeish & Scott, 2008). Training had clearly increased awareness and confidence in this area. The concerns expressed by the ‘resisters’ merit attention however – they included that inexperienced staff members might cause harm to service users (some thought the training given was not enough to equip staff), that other issues may sometimes be more pressing, and that lack of availability of services may mean some people are asked questions only to be left feeling vulnerable and exposed without sufficient support. Some did not follow the prescribed wording when they asked, preferring to adapt to the individual client, their needs and the situation and some waiting to be led by the client as to whether to explore the issue or not. The researchers concluded that there were issues for health trusts to address in these comments. They can also however be seen as a defence of professional judgement against perceived bureaucratisation of a highly sensitive issue. Similar concerns have been raised about routine enquiry throughout the Visible project – that clinical judgement should not be lost and what is to be offered when the question is answered should be considered (from the statutory health sector), that without further training for staff there may be risks to routine enquiry and about the lack of services to refer people on to for help when they disclose child sexual abuse (from voluntary organisations). It is worth noting that routine procedures are sometimes introduced partly with a defensive function, to protect professionals from the anxieties of uncertainty which might better be managed in other ways (Cooper & Lousada, 2005).

- **Current thinking on trauma** – as van der Kolk argues in his book, ‘The Body Keeps the Score’ (2014) on the neurobiology of trauma and its implications, putting traumatic experience into words is not always possible or helpful. ‘All trauma is preverbal... Even years later, traumatised people often have enormous difficulty telling other people what has happened to them’ (p43). He further argues that requiring the telling of stories may impede healing and intensify distress. A recent online training on Treating Trauma (2019) informed by van der Kolk’s work and other key theorists such as Peter Levine, taught practitioners to recognise signs of trauma in people’s reactions and behaviour (with dissociation a key indicator) and to build and work with a relationship that promotes integration of traumatic experience, which by definition has overwhelmed the brain’s capacity to know it at the time and may therefore not be accessible to memory. Emphasis was placed on building safety first and on pacing/timing as critical to expand the client’s ‘window of tolerance’ as more of their experience and/or their physiological responses to it comes to the surface. Although parts of the story may need to be told to break internalised silences during treatment, coherent narrative memory may only come at the end of treatment or sometimes not at all. Trauma-informed care recognises this complexity but the literature on routine enquiry does not always do so.

Issues to consider as organisations work out their approach to asking questions about child sexual abuse:

- **Who are you asking for?** Is the question being asked to ensure the person is able to speak of their experience if they need to, to ensure they get appropriate support, to ration or prioritise services, to assess risk to them or others, to pursue a prosecution or to comply with procedure? All these reasons may have a place but practitioners should be encouraged to pause for thought about the question, and to consider whether they need to know the person’s story and how much of it they need to know. If the reason for asking is not for the individual’s benefit, there is a risk of retraumatisation by repeating the overriding of their needs that was part of the dynamic of childhood sexual abuse.
- **What’s the offer?** Speaking of child sexual abuse often brings intense emotions to the surface (related to the experience not only of abuse but of previous tellings) and what help service users will receive when they do deserves serious consideration. As the REVA briefing for Trust managers says, even in mental health settings identification is not enough - ‘routine enquiry is only effective if it leads to better support, understanding and quality of life (2015, p5). This may not necessarily mean having a pre-prepared treatment or service to offer but it does mean that workers need sufficient training and support that their immediate response is helpful and that they are able to work collaboratively with service users to find a way forward.

- **How to ask** – The recommended use of a question framed in terms of abuse may imply that only one question is needed and there is only one way to ask it. Many people will not have named their experience as abuse however – prevalence research has long used an extended sequence of questions about specific behaviours and experiences in recognition of this. Read et al (2007) suggest an alternative for CSA such as ‘when you were a child, did anyone ever do something sexual that made you feel uncomfortable?’ iAPT use the word ‘hurt’ and the reference group for the Visible project also suggested alternatives such as ‘has anyone hurt you, made you feel uncomfortable, made you scared or inflicted pain?’ When people disclose child sexual abuse, care should be shown for how they feel having done so, and a concern for their safety demonstrated (Fisher, 1999, Read et al, 2007). Without such care, the shame that can accompany disclosure can easily result in withdrawal from services (Hooper et al, 1999).
- **When to ask** - The context of asking also merits consideration in three ways – first, the individual’s timing and readiness to speak (whether sufficient safety has been built for them first), second, the organisational role (e.g. a family support worker in a voluntary organisation argued strongly in a training session that establishing a relationship with a struggling parent was their priority and that asking whether she has a history of child sexual abuse may or may not contribute to that goal and should be a matter for discretion) and third, the cultural context. While child sexual abuse occurs across cultures, Reavey et al (2006) who conducted research with professionals working in S Asian communities argue that the Western understanding of selfhood which underpins attention to the individual’s need for help is not necessarily shared by women there and intervention may be needed also at the cultural level to facilitate the speaking of it.
- **It is not a matter of asking questions routinely or doing nothing.** In some contexts it may be more appropriate for organisations to be aware of child sexual abuse (amongst other forms of violence and abuse, and other adverse experiences, in childhood and adult life) as part of the context of some adults’ distress, to aim to ensure that all adults in distress are treated with compassion, and to work to enable that those with histories of child sexual abuse are able to speak of it when they need to, and that they receive effective support when they do. This should include training workers to ask questions sensitively and with attention to appropriate timing for the person concerned, and go beyond that. This is essentially the approach of trauma informed care.

To expand, trauma informed care in relation to childhood sexual abuse might include the following actions:

- 1) **Building awareness of the impacts and dynamics of abuse amongst workers.** Routine awareness should aim to include CSA and other ACEs and their effects, the ways in which impacts can either reduce or accumulate over time, depending on the presence of mediating factors and reparative experiences and/or cumulative effects including revictimization and retraumatisation, i.e. the need for attention to both past and present. Training may be needed and a bookshelf of relevant books can be an ongoing resource. The aim should be that staff are aware that troubling behaviour is likely to reflect troubling experience, and recognise signs and symptoms of child sexual abuse, and therefore that even if service users do not speak about their experience, those who are suffering are treated with care and compassion, and the risks of negative transference, retraumatisation and vicarious trauma for staff are reduced.
- 2) **Making child sexual abuse speakable for service users.** This can be done by displaying posters acknowledging its prevalence and impacts and offering a contact number or person for those who need help, and by offering talks or making available information leaflets which offer psychoeducation about the impacts of abuse/trauma including child sexual abuse. The aim should be to help people with histories of child sexual abuse recognise that they are not alone in their experience, to reduce the isolation which trauma creates, and to help them understand and manage their responses better.
- 3) **Building safety.** This can be done by offering social spaces for connection with other service users, caring relationships with staff and volunteers, teaching relaxation techniques (e.g. breathing, yoga, meditation) etc. The aim should be to facilitate the safety and stabilisation work which is the first step towards recovery, promoting self-care and connection with others, reducing isolation and building trust, helping people develop a new scaffolding with which they can tolerate more of their experience.
- 4) **Sensitively timed asking about abuse.** In some contexts there will be reasons to ask questions about childhood sexual abuse and other ACEs at a particular time, during a mental health assessment or for a prosecution, for example. Where possible however, attention should be given to the relationship context in which questions are asked and to the timing of asking, to minimise the risk of overriding the individual service user's needs, and maximise the possibility of the speaking being beneficial for them. This requires professional judgement, to ensure that people are asked in ways that offer care and containment. There should not be any pressure in the asking, but a readiness to listen with attention, both to what is and what isn't said, and openness to the need to revisit the issue another time or simply to respect someone's choice not to speak about their experience. In responding to a disclosure of child sexual abuse, the value of being listened to attentively should not be underestimated - witness is sometimes all people need. As a member of the Reference group put it in an email after one meeting, 'I have been really struggling to see a point in

anything and everything..... but for a couple of hours today you just listening to what I had to say and not dismissing me really validated my existence.’ If more is needed than ensuring people feel heard there and then (as it often but not always will be), a way forward should be worked out with the person, consulting about the support they already have and other sources of help in the light of available services. It should not be assumed that everyone with a history of CSA needs a specialist service or that further action is always necessary (other than to comply with organisational procedures). A more fitting phrase than the Welsh policy’s ‘Ask and Act’, might be ‘Ask, listen, consult and act as appropriate’.

- 5) **Support for staff.** If staff are to listen to service users in distress with compassion, they need support and compassion for themselves – whether this is in supervision, or through reflective practice groups (within or across organisations), and/or in broader support for staff well-being. Some will have histories of childhood sexual abuse and/or other forms of abuse themselves, and all will be vulnerable to secondary or vicarious trauma. In the training events offered by Visible in the first year to practitioners (Making it Safe to Say 1 & 2), the most useful thing in the workshops was identified as sharing experiences with others in groupwork, and the opportunity to reflect which that offered. While many of those who attended had a good understanding of the issues already, people were glad to have participated for that reflective space as much if not more than for the input. In response to the question what could have been better, many simply wanted more time. Some also wanted more training on the ‘next step’, how to support someone after they disclose child sexual abuse. While some staff may need further training to be confident in starting conversations about child sexual abuse and managing them in ways that are beneficial for the service user, the need for reflective space is an ongoing one which also deserves attention.

These thoughts are offered to help organisations consider their own approach as they commit to the **Visible Policy Statement, Supporting adults who have experienced child sexual abuse.** It is not necessary for all organisations to follow the same approach – on the contrary attention should be paid to what is appropriate in particular contexts with their own distinct goals and roles. The aim has been to show that there is much that can be done that is helpful for people who have experienced child sexual abuse without necessarily incorporating routine enquiry across the board. In some organisations, a poster naming the issue and giving a contact number and/or name for those in need of help may be enough. In others it may be possible to offer relaxation classes or other practices supportive of well-being that benefit all service users (and/or staff) including those suffering from trauma or vicarious trauma. In others where a high proportion of service users are likely to have experienced child sexual abuse and/or other ACEs, incorporating the issue into assessment forms is an important step forward, and there needs also to be flexibility and sensitivity about when and how questions are asked. Overall, the paper aims to contribute both to making the Visible project’s vision a reality and to Leeds’ commitment to being a compassionate city towards all its citizens.

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