A BASELINE STUDY OF THE LEVEL OF AWARENESS AMONGST PUBLIC SERVICE PROVIDERS OF THE EFFECTS OF INSTITUTIONAL ABUSE ON SURVIVORS

A Report prepared for Caranua

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By

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Executive Summary and Recommendations

1. Baseline Study of the Level of Awareness amongst Public Service Providers of the Effects of Institutional Abuse on the Individuals who experienced it.

A large majority of the research participants have very low levels of awareness and understanding of the effects of institutional abuse. While they understand that institutional abuse comprises different forms of abuse, most of them are not familiar with the specific symptoms or effects of institutional abuse. Very few of them have been trained specifically to recognise or deal with the effects of institutional abuse. Less than one quarter of the research participants had encountered survivors of institutional abuse in their professional capacity. In most cases, they referred the person to someone they believed had more knowledge and expertise in this area.

Most of the research participants regarded their knowledge of institutional abuse as fair to good. However, in spite of their interest in the topic and their concern for survivors, a large majority of them admitted that they did not have any in-depth knowledge of the specific symptoms or effects of institutional abuse that would be different to the signs of abuse generally. Most of the research participants were reluctant to identify any specific signs of institutional abuse because of 'the danger of putting people into boxes' if they only look for specific signs and ignore people who don't show these signs. Most of the participants felt that any disclosures from survivors must be preceded by a trustworthy relationship. More than half of the research participants believe that any form of probing of people who may or may not be survivors of institutional abuse to be inappropriate and potentially dangerous. They believed that it might lead some of these people to withdraw from services they need or add to their frustration if they discover they are not entitled to assistance even if they were abused in an institution. Others might qualify for assistance but they may not want or need the services offered by Caranua. Most of the research participants believe that it is very important the client drives the conversation. The majority feel it is very important that the services know what services Caranua is offering and that Caranua follow through on their promise of assistance.

The media is perceived to be a valuable source of information for these professionals and sometimes a catalyst for disclosures. Most of the research participants said they got their information on institutional abuse from the media and a variety of public sources: TV documentaries (e.g., States of Fear), tribunal reports (e.g., Ryan Report), books (e.g., Suffer Little Children) and word of mouth. It is clear to most of them that the media emphasis on sexual abuse was not correct, but otherwise they generally believed that the media has fulfilled an important role in promoting a national conversation. However, some respondents believe that the impact of the media is relatively transient because Irish society is not ready to accept the reality of ongoing trauma experienced by survivors. Most of the participants believe that their services are not responding very well to the needs of survivors of institutional abuse for a variety of reasons, and especially budgetary cuts leading to a reduction in services and less opportunities for training. Most of the participants believe that training on institutional abuse would be beneficial for frontline staff, especially those who are most likely to be working with survivors of institutional abuse.

2. The Approach and Methodology Used by Other Issue-Based Organisations to Increase Sensitivity, Awareness and Capacity.

A number of organisations operating in Ireland have developed training that is designed to raise awareness and capacity for social care professionals e.g., Dublin Rape Crisis Centre and Women's Aid. Both have designed and delivered training modules on the general area of abuse to a variety of organisations upon request. They do not however provide specific training on institutional abuse, although they would be willing to consider such a venture with Caranua. Conversely, a UK based organisation (ICAP) provides specialist training to professionals working with survivors of institutional abuse. A number of organisations have also published good practice guidelines on how to deal sensitively with adult survivors of childhood sexual abuse (Schachter et al., 2009). ICAP is perhaps the most suitable of potential partners for Caranua. They have proven experience and expertise in working with survivors of institutional abuse, and their Toolkit of sensitive practice for practitioners working with survivors of institutional childhood abuse (Moore et al., 2014 (forthcoming)) is highly relevant to Caranua's remit. Their current offering of a two-day training course is, however, likely to be problematic for many public service providers because of the difficulty many of them will face in getting two days off for

a training course. Consequently, a variety of courses by the three agencies identified above would offer potential participants a greater choice, particularly if the suggestions of this study on training are taken on board e.g., multiple locations, a variety of courses designed for different professional groups, one and two day courses etc.

Recommendations

The research suggests that there is a significant gap in awareness and understanding of institutional abuse in Ireland amongst a range of public healthcare workers. The following recommendations are made to promote discussion on how best Caranua could address this situation. First, Caranua should consider funding accredited courses in third level institutions, which currently educate health and social care professionals. The courses would need to be widely advertised to healthcare professionals and those intending to pursue a career in this area, so that they can generate interest and demand for the course. It would help if the practitioners' professional bodies validated the course as part of their CPD activities and lifelong learning, which is the responsibility of all healthcare professionals.

Second, a range of CPD accredited courses, provided by some of the specialist organisations identified in this report, should also be run in tandem to the college-based courses to serve the needs of healthcare professionals who have already qualified but who continue to engage in CPD activities. It is important that these courses are run in different parts of the country and not just Dublin. Caranua should monitor and evaluate the impact of the measures identified above in raising awareness and understanding of institutional abuse. Third, Caranua should engage in a public awareness campaign that would seek to raise the profile of Caranua and the issue of institutional abuse. Fourth, Caranua should follow-up with the specialist organisations identified in chapter three of this report to learn from their experience in working with healthcare professionals and raising their awareness of institutional abuse.

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CHAPTER ONE

INTRODUCTION

> Negative childhood experiences may lead to significant adjustment problems. These include psychological and personality disorders, relationship and parenting problems, occupational and health difficulties, self-harm and an impoverished quality of life (Carr, 2009).

1.1 Introduction

This study was commissioned by Caranua, the independent State Body set up to help people who, as children, experienced abuse in institutions in Ireland and have received settlements, or awards from the Redress Board or the courts. Caranua was established to offer support, information, advice and advocacy to survivors. One of Caranua's aims is to help survivors to get the services they are entitled to as citizens and to improve access to these services. While the help they can provide will depend on the needs and circumstances of the individual who applies for assistance, Caranua can provide assistance in the following areas: health and medical services, mental wellbeing, housing, and education. Another aim, which underpins this project, is Caranua's commitment to building awareness of the effects of institutional abuse in Ireland.

1.2 Research Aim

The primary aim of this study is to carry out a baseline study among public service providers of their level of awareness of the effects of institutional abuse on the individuals who experienced it. It is also envisaged that the study will inform the development of a programme of awareness-raising and capacity-building amongst public service providers and other relevant bodies. It is hoped that the programme developed and/or supported by Caranua will help service providers to recognise the effects of institutional abuse and to improve their capacity to understand and address the particular needs of survivors.

1.3 The Context of Institutional Abuse in Ireland

During the past fifteen years or so, Ireland has been shocked by disclosures surrounding the abuse of children by priests and religious. These disclosures emerged from a seminal three-part documentary series *States of Fear,* produced by journalist Mary Raftery and broadcast on RTE between April and May 1999. This documentary and a subsequent publication detailed the abuse suffered by children between the 1930s and 1970s in the Irish state childcare system (Raftery and O'Sullivan, 1999). In May 1999 the Irish government issued an apology to victims of child abuse and they established a commission of inquiry into child abuse in 2000. The Ryan Commission (previously the Laffoy Commission) delivered its report *The Commission to Inquire into Child Abuse* (CICA) in 2009 (The Ryan Report, 2009).

The horrific nature of the disclosures that emerged from CICA was compounded by the findings of other commissions of investigation into Irish dioceses (Murphy et al., 2005, Murphy et al., 2009, Murphy et al., 2011), and the publication of various articles, books, documentaries and studies, which detailed the abuse carried out by individual priests and religious (Mooney, 2011, Doyle, 1988, Moore, 1995, O'Connor, 2000, Tyrrell, 2006, Martin Ridge and Cunnningham, 2008, O'Malley, 2005, O'Beirne, 2005, O'Gorman, 2009, Goode et al., 2003). Institutional abuse by priests and religious was not confined to the Irish Catholic Church. A Canadian study of child abuse in religiously-affiliated institutions found, for example, that over one-third of their sample suffered chronic sexual problems and over one half had a history of criminal behaviour (Wolfe et al., 2006). Another study of the mental health of adult survivors of institutional child abuse by the Austrian Catholic Church, found that the majority of survivors reported emotional, sexual and physical abuse (Lueger-Schuster et al., 2014).

The long-term adverse effects of child abuse have been well documented internationally (Arnow, 2004, Kezelman and Stavropoulos, 2012, Springer et al., 2004) and in Ireland (Carr et al., 2010, Carr et al., 2009, Fitzpatrick et al., 2010, Flanagan et al., 2009, Flanagan-Howard et al., 2009). Carr et al (2010),

for example, found an association between the experience of institutional abuse in childhood and the prevalence of adult mental health problems, particularly anxiety, mood and substance abuse disorders. Other studies have described survivors' loss of trust, shame and humiliation, and a fear or disrespect of authority. Fitzpatrick (2010) reported that survivors of severe sexual abuse had higher rates of post-traumatic stress, alcohol and substance abuse, antisocial personality disorder, trauma symptoms and life problems.

While the public and the media perhaps gave most attention to sexual abuse, child abuse generally includes multiple forms of abuse. The Ryan report found, for example, that children were subjected to various forms of abuse: physical abuse, sexual abuse, neglect and emotional abuse. It uses these four categories in its definition of abuse.

Physical abuse: *The wilful, reckless or negligent infliction of physical injury on, or failure to prevent such injury to, the child*. The Ryan Report (2009) found physical abuse to be a pervasive part of children's' daily lives and that 'more than 90% of all witnesses who gave evidence to the Confidential Committee reported being physically abused while in schools or out-of-home care' (Executive Summary, p.13).

Sexual abuse: *The use of the child by a person for sexual arousal or sexual gratification of that person or another person*. Sexual abuse was reported by approximately half of all the Confidential Committee witnesses to CICA.

Neglect: *Failure to care for the child which results, or could reasonably be expected to result, in serious impairment of the physical or mental health or development of the child or serious adverse effects on his or her behaviour or welfare.* Many witnesses to CICA reported instances of neglect, which they felt had adverse implications for their health, employment, social and economic status in later life.

Emotional Abuse: *Any other act or omission towards the child which results, or could reasonably be expected to result, in serious impairment of the*

physical or mental health or development of the child or serious adverse effects on his behaviour or welfare. Children felt emotionally abused by their separation from other family members and their observing of others being abused.

While child abuse can take place within different contexts, such as familial, societal and institutional, the focus of the present project is on the effects of institutional abuse on adults who suffered institutional abuse in childhood in Irish religiously affiliated residential reformatories and industrial schools (Gil, 1982).[1] Institutional abuse is distinguished from familial child abuse, in that 'it is perpetrated by adults working within the context of various types of institutions serving children in the community' (Flanagan-Howard et al., 2009, p.586). Research suggests that some common mental health institutional practices can reinforce early childhood trauma experiences (Jennings, 1994).

One salient finding that emerged in empirical research (Arnesman and O'Riordan, 2007) and which is supported by anecdotal evidence suggests that survivors of institutional child abuse feel their circumstances are not well understood by professionals, such as GPs (Higgins, 2010). Other research by ICAP found that survivors felt that 'workers, even in culturally sensitive organisations, did not understand the severity and complexity of the impact of institutional upbringing' (Moore et al., 2014 (forthcoming), p.9). Accordingly, the present study seeks to measure levels of awareness of institutional child abuse among health professionals and others, and ultimately to improve their capacity to understand, recognise and address the particular needs of survivors.

[1] Gil (1982) identified three distinct forms of institutional child abuse. The first form is the overt physical, sexual or emotional abuse committed by those individuals directly responsible for the child's care. Programme abuse occurs when programmes operate below acceptable standards or rely upon harsh or acceptable methods to control behaviour. System abuse, according to Gil, is not perpetrated by any single person or agency, but rather occurs when the entire childcare system is stretched beyond its limits and is thus incapable of guaranteeing safety to all children in care .

1.4 Methodology

Social Research is 'the purposive and rigorous investigation that aims to generate new knowledge' (Sarantakos, 2005, p.4). It is 'fundamentally about understanding and explaining – about 'knowing' (Wadsworth, 1997, p.6). A wide range of research techniques are used to gather and analyse data, which may be categorised into two broad categories – quantitative and qualitative research. The quantitative approach almost always sets out to provide a numerical measure of some kind, and accordingly will usually make use of quite robust sample sizes. Conversely, a qualitative approach seeks to understand rather than measure and usually uses relatively small samples. Both approaches have strengths and weaknesses and there is no consensus within the social sciences about which methods to use. Quite often judgements are based on philosophical theories and/or pragmatic considerations.

Following some discussion on the relative merits of different methodologies, it was decided to adopt a primarily qualitative approach for a variety of reasons. First, a survey was initially considered for the research but it was eventually discarded in favour of a qualitative research approach because of inherent difficulties associated with survey research in this instance, and the type of data that we expected to collect by means of focus groups (see below). Face-to-face or telephone surveys were not possible because we did not have a comprehensive and up-to-date list of potential respondents. Accordingly, compiling such a list and generating an appropriate sample within the time allocated for the study would have been very time-consuming and too expensive. Furthermore, while a self-completion postal or Internet methodology would have been more cost effective, it was decided not to pursue this methodology because of the absence of up-to-date contact details, the time required to generate an adequate numbers of replies, the likely low response, and the inevitable uncertainty surrounding the statistical basis of any self-selecting sample. Response rates to postal surveys are often as low as 10%, especially when they are sent out 'cold', and they can be poorly filled out or incomplete (Domegan and Fleming, 2003).

Second, a qualitative methodology is consistent with the underlying interpretative epistemology, which seeks to understand how individuals 'interact and make sense of the world' (Smith, 1998, p. 171). The interpretative epistemology is based on the premise that reality is socially constructed and there is 'no fixed and unchanging 'Truth' (Etherington, 2004, p.27). Thus, our knowledge of the social world, 'can only be understood in the historical and social situation in which it was produced' (Smith, 1998, p.172). In brief, institutional abuse has an historical and a contemporary meaning that can only be understood by actors within that context. Third, qualitative research has inherent strengths that are different and sometimes superior to those of quantitative methods. A qualitative approach is widely regarded as most effective in 'increasing understanding' of a particular situation (Gordan and Langmaid, 1988, p.2). Qualitative research is also more flexible and well suited for studying naturally occurring real-life situations' (Punch, 1998, p.243). There are various types of qualitative research, including focus groups, which we used in this research.

A focus group is a group of people who are brought together to discuss a particular topic, under the direction of a researcher. The role of the researcher is to direct the flow of the discussion into pertinent areas and to encourage discussion of important areas. The informal nature of the group discussion is intended to encourage people to speak freely and to spark off other participants. A focus group takes place in a central location and is usually comprised of eight participants, although there can be more or less participants if circumstances demand. Each group took between one and a half and two hours. Twenty-five public service professionals were recruited by Caranua to participate in two focus groups in Dublin and Cork, respectively, during June and July 2014. One interview was also held with a nurse specialist in mental health. The participants agreed to take part without any financial incentive.

Focus groups are used widely in social and market research to explore and ultimately understand the meaning a group of research participants give to a particular social phenomenon. Like other forms of research, however, focus groups have limitations, such as participants speaking too much or not enough.

This was not an issue with the present groups, a point that was verified by a second researcher who subsequently listened to the recorded discussion. We decided to use focus groups because we felt that the group dynamic would generate useful data on the participants' understanding of institutional abuse. No research method is perfect, however, and qualitative research, like its quantitative counterpart, is perceived to have limitations and potential biases. Perhaps the most usual criticism of qualitative research is that the findings of qualitative studies cannot be taken as statistically representative of any larger group because they typically use relatively small samples. However, such an argument ignores the difference between quantitative and qualitative data, and the distinctive contribution of qualitative research to social research. It is possible for qualitative research to be valid and reliable, albeit less precisely than is the case with survey research (Sarantakos, 2005, p.86). Accordingly, the findings from the research can be taken as indicative of broader underlying trends because of the wide range of professionals that took part in the research (Table 1), and the high degree of consensus in the views expressed. A large-scale quantitative survey would be required to validate the findings statistically.

Table 1The Research Participants

	Number
Department of Social Protection/ Community Welfare Services	6
MABS	3
Advocacy Services	2
Housing Services	3
An Garda Síochána	2
Occupational Therapists	2
Local Authority	1
Disability Services	3
Citizen Information Centre	1
Irish College of General Practitioners	1
General Hospital Psychological Services	1
Education Training Board	1
TOTAL	**26**

CHAPTER TWO

A BENCHMARK SURVEY OF PUBLIC SECTOR PROFESSIONALS

2.1 Introduction

The primary aim of the study is to establish a baseline of the level of awareness amongst public service providers of the effects of institutional abuse on the individuals who experienced it. The main findings are summarised below.

2.2 The Research Findings

This section will summarise the group responses to a number of issues related to institutional abuse.

- Awareness of Institutional Abuse.
- Contact with Survivors.
- Understanding of Institutional Abuse.
- Recognising the Signs of Institutional Abuse.
- The Media.
- The Current Response to Survivors of Institutional Abuse.
- The Value of Training for Public Service Professionals.
- What they would like to say to Caranua.

Awareness of Institutional Abuse

A large majority of the research participants admitted that they have very low levels of awareness and understanding of the effects of institutional abuse. While they understand that institutional abuse comprises different forms of abuse, such as physical, sexual, and psychological, most of them are not familiar with the specific symptoms or effects of institutional abuse. Most of them have offered or received general training on how to deal with sensitive issues and at risk groups, but very few have been trained specifically to recognise or deal with the effects of institutional abuse. Six of them had encountered survivors of institutional abuse in their work, and

others ‘knew’ people who had been ‘in an institution’. Most of them believe that institutional abuse remains a taboo subject in Irish society.

> The nature of abuse is that it is hidden. It is something people find hard to touch; like Pandora’s box it might overwhelm you if you open the box. The Ryan report is fine because it talks about what happened in the past. But in some way society despises the people who were abused – sure didn’t we give you lots of money, what more do you want? People get tired of charities looking for money all the time and they don’t want to hear about abuse – I have my own problems. It gets pushed under the carpet (Education and Training Board).

Contact with Survivors

Less than one quarter of the research participants had encountered survivors of institutional abuse in their professional capacity, often through the casework process when people disclosed information on abuse in their lives. In most cases, they referred the person to someone they believed had more knowledge and expertise in this area.

> It can happen in Welfare Clinics when you are doing a case history on people (Community Welfare Services).
>
> I work with people who have been in institutions in the past and through regular contact some of them would disclose instances of abuse. They need to trust you before they make a disclosure (Advocacy Services).
>
> People sometimes transfer into our services when institutions close or when their support services break down, and they might disclose something when they meet a doctor or psychologist. They would probe it, take a statement and hand it over to the Guards to follow up. A disclosure might happen once they feel comfortable in the service (Housing Services).

Understanding of Institutional Abuse.

Most of the research participants regarded their knowledge of institutional abuse as fair to good, at best. However, in spite of their interest in the topic and their concern for survivors, the following verbatim comments illustrate their low level of knowledge.

> The more that comes out in the newspaper, the more you learn. It is not surprising but appalling nonetheless (CIC).
>
> I am just finding out about it and I am very sorry I did not know before (CWS).

I studied it but it is so harrowing that I don't really want to know (CWS).

I never worked with survivors. What I know is from the movies and books (Housing Services).

I know a lot of the signs but you can't understand it fully unless you have been through it (Advocate).

I have worked with people who have suffered all types of abuse but not institutional abuse. I am sure there is a lot I don't know but I would hope my experience and knowledge of abuse generally would help me to deal with institutional abuse, but I don't know (GP).

I have a general interest but not a lot of detailed knowledge. You can only imagine it (Advocate)

I get most of my information from the media, movies and books (Disability Services).

I worked with survivors and they were very forthright about what happened to them. I am very aware of the daily cruelty and grind of children in orphanages (Local Authority).

I am still learning but you can't know 100% (MABS).

We are not trained for this and frankly I wouldn't know what to say to them (CWS).

Recognising the Signs of Institutional Abuse

A large majority admitted that they did not have any detailed knowledge of the specific symptoms or effects of institutional abuse that would be different to the signs of abuse generally. However, they thought the following symptoms could be salient identifiers.

Anxiousness about their health, which is disproportionate to their health problems (GP).

Males in their 50s or older with alcohol or drug dependency, sometimes hidden, in need of financial or housing assistance (Homeless Services).

A lack of confidence and insecurity, especially when interacting with officials (Education Training Board).

A lack of trust or engagement; difficulties forming relationships (CWS).

Overly dependent on social services (CWS).

Financial difficulties (CWS).

Aggressive, defensive, agitated (Disability Services).

Confused sexuality, often caused by severe sexual abuse in an institution and/or home (CWS).

Depression (MABS).

Deaf, possibly due to physical abuse (CWS).

Poor quality of life (Advocacy).

Scared of entering large buildings, filling in forms, looking for entitlements etc. (Education Training Board).

Dislike giving information about themselves or telling their stories (Homeless Services)

It is just the way they are (CIC).

If they refuse accommodation in hostel type emergency homeless services or services run by religious (Homeless Services).

Men on methadone maintenance programme can find it difficult to give a urine sample (Homeless Services).

A deep sense of shame (Hospital Psychological Services).

However, most of the research participants were reluctant to identify any specific signs of institutional abuse because of 'the danger of putting people into boxes if you look for specific signs and ignore people who don't show these signs'. Most of the participants felt that survivors must first learn to trust them before they are willing to share their secrets.

I don't think we can confine them to any one group (CWS).

You have to trust your instincts – you just know, and not only if they tick all the boxes (CWS).

Some are just people who have managed to blend themselves into society. They don't have any of the visible signs of abuse and they may have 'married well' and improved their situation. They don't have contact with the social services but they still carry the wounds of abuse (OT).

They have to hide so much more than others who come to us looking for assistance. There is a social stigma attached to it and they are not allowed to tell anyone their history because they fine now and it is better to forget their past because it doesn't matter (MABS).

More than half of the research participants believe that any form of probing of people who may or may not be survivors of institutional abuse to be inappropriate and potentially dangerous. It may lead some of these people to withdraw from services they need or add to their frustration if they discover they are not entitled to assistance even if they were abused in an institution, if they have not been to the Redress Board. Most believe that it is very important the conversation is driven by the client, some of whom may qualify for assistance but who may not want or need the services offered. The majority felt it is very important that service providers know what services Caranua is offering and that Caranua follow through on their promise of assistance.

> It is very important we know who qualifies and for what services. It would possibly disillusion people further if the services get it wrong. Some people may just want financial assistance (CWS).
>
> It would be unsavoury to have a question on any form asking them if they were a survivor of institutional abuse and had they received money from Redress Board. Our forms ask them to say if they have received any compensation, so there is a possibility of discussing it further. We need to know what Caranua services are offering and then we could give information in the course of a normal conversation' (CWS).
>
> In Homeless services we explain to everyone what abuse is and the type of services that are available. The client then decides if it is appropriate for them. It is very important we know what Caranua offer, so that we can tell them there is a service that exists and while it may not be applicable for you, I just want you to know what it entails. We know it is not applicable to young men or women, so personal judgement needed' (Homeless Services).

The Media.

The media is perceived to be a valuable source of information for these professionals and sometimes a catalyst for disclosures.

> It comes to the forefront of people's minds when reports are published or a documentary is on TV. We find that people are more likely to disclose abuse with us (OTs) when the topic is prevalent in the media. It brings up a lot of past memories and the OT department is almost like a counselling service at those times e.g., when the Philomena film came out and when Mary Raftery died, disclosures peaked, so the media has been helpful in that way to trigger disclosures (OT).

Most of the research participants said they got their information on institutional abuse from the media and a variety of public sources: TV documentaries (e.g., States of Fear), tribunal reports (e.g., Ryan Report), books (e.g., Suffer Little Children) and word of mouth. It is clear to most of them that the media emphasis on sexual abuse was not correct, but otherwise they generally believed that the media fulfilled an important role. The impact of the media is perceived to be relatively transient because Irish society is not ready to accept the reality of ongoing trauma experienced by survivors.

The Current Response to Survivors of Institutional Abuse.

With the exception of three agencies that have specialist staff who are trained to engage survivors of institutional abuse, none of the other participants had received specialist training in this area. Most of the participants said they had received, or that they could receive, generic training in how to deal with sensitive issues and difficult individuals. Most CWS staff had received *Children First* training years ago but it was not specific to institutional abuse. The usual response from frontline staff in most agencies is to refer difficult individuals, such as survivors of institutional abuse, onto a more appropriate service or expert e.g., GP, mental health services, An Garda Síochána, and in-house counselling services.

A number of the participants said that their role and level of work is sometimes overlooked and that while they would welcome training in this area, their role is quite specific e.g., to help people in financial or housing difficulties. It would be unfair to the other people queuing in the waiting rooms if they spent too much time with one individual. As one CWS worker said, 'Our role is to help them financially. It is not really our job to become experts in this field'. Another said that he would discourage staff from straying into areas they are not familiar or trained in because it would be a disservice to the client' it may possibly create evidential problems if it went to court'.

Most of the participants believe that their services are not responding very well to the needs of survivors of institutional abuse for a variety of reasons, especially budgetary cuts leading to a reduction in services and less opportunities for training. They were

especially critical of the replacement of staff who knew and understood an individual's background and circumstances, with a telephone helpline.

The Value of Training for Public Service Professionals.

Most of the participants believe that training is important so that they would know the proper boundaries, and what they can and shouldn't do if approached by a survivor. They made a number of suggestions regarding training for professionals that could potentially work with survivors of institutional abuse, including:

- Two days training would be ideal but possibly unrealistic because of the difficulties getting time off. Perhaps split two days across the year?
- One day training held in different locations around Ireland better than two days in Dublin or Cork.
- Support personal training with online e-learning training.
- Link in with existing training on abuse with specialist module on institutional abuse.
- Provide training on a sectoral basis, so that the course can focus on the work and experiences of different groups e.g. OTs, GPs, social workers, CWS staff etc.
- Train one person properly so that this person can skill up other staff in their organisation.
- Ensure there is a trained first responder in every organisation and that other staff know this is the most appropriate and timely contact if approached by a survivor of institutional abuse.

What they would like to say to Caranua.

The final section of the groups gave the research participants an opportunity to highlight any issues they felt Caranua should consider in the months and years ahead. Their responses are itemised below:

- All of them believe that Caranua has an important role to play.

- It is important that the diverse services that work with survivors know what services Caranua offer so that they can inform their clients. There is 'an awful dearth of information' about Caranua and no one could recall any radio or TV advertisements by Caranua. One person had heard the name on the Joe Duffy Show. Many survivors are illiterate and they will need more than leaflets or posters. One person recommended that Caranua use the national representative bodies to get information 'out there' and allow it filter down through the systems. A multi-sensory approach should be adopted in advertising their services.

- It is important that Caranua work with front-line staff and don't become too bureaucratic i.e., less forms and more listening.

- It is important to have information and support nationwide, with contact details and a description of what each organisation offers widely available. It is very important that this information is kept up to date.

- Focus on services that are likely to engage with survivors and ensure a first responder is present in that organisation. It is very important that the reaction of the first responder assists their recovery rather than sending them away dissatisfied or frustrated.

- Be aware that institutional abuse is still around, albeit in smaller settings.

- It is very important that the clients know they are being listened to and that Caranua follow through with their services.

- Keep the training simple and relevant. Inform the services of best practice.

- Provide frontline staff with clear pathways so that they know where the person should go for help and that the advice given is not dependent on which staff member is working that day. One person may have a preference to refer a person to the GP, while another may prefer a social worker. Consistency is best.

- Go to the colleges and talk directly to the future GPs, social workers, occupational therapists etc. Adopt a sectoral approach.

- Ensure all of the professionals employed by Caranua to provide a service (e.g., OTs, physiotherapists) receive training in institutional abuse.

- Be encouraging and reduce the isolation of survivors. Arrange a meeting for survivors and interested groups to come and ask questions. Also, reduce the isolation of professionals working with survivors by linking up with them from time to time.

- Train people who can in turn train their colleagues. Develop a culture of understanding and awareness within organisations and sectors.

- Caranua need to develop its brand so that it is regarded as the 'go to' organisation for clients and service providers/ professionals.

- Do whatever it takes to reach survivors.

CHAPTER THREE

A REVIEW OF SELECTED APPROACHES TO SENSITIVITY RAISING AND CAPACITY BUILDING

3.1 Introduction

The aim of this chapter is to review a selection of existing programmes and approaches, which aim to increase sensitivity, awareness and capacity amongst target audiences. While some of these programmes are directly concerned with addressing institutional abuse, others have a more general remit on abuse. It is hoped that the review will assist Caranua to identify best practice and innovative ways of providing training on diverse aspects of institutional abuse to healthcare professionals. In the first instance, contact was made with organisations in six countries, including Ireland. A summary of their work and relevance to Caranua is summarised in Table 2.1 below.

Table 2.1 Overview of Organisations Providing Awareness-Raising, Training and Capacity-Building Programmes.

Organisation	Location	Relevance to Caranua Study?
Dublin Rape Crisis Centre www.drcc.ie	Ireland	Yes. The Education and Training Department of DRCC has developed and delivered awareness raising and capacity building programmes to a wide range of professionals.
Women's Aid www.womensaid.ie	Ireland	Yes. The Training and Development Department of Women's Aid provide training and awareness-raising to health and social care professionals.
One in Four www.oneinfour.ie	Ireland	No. Their primary focus is on the victims of abuse and the needs of survivors of institutional abuse.

Table 3.1 Overview of Selected Organisations Providing Awareness-Raising, Training and Capacity-Building Programmes (Continued)

Organisation	Location	Relevance to Caranua Study?
Immigrant Counselling and Psychotherapy (ICAP) www.icap.org.uk	London and Birmingham, UK.	Yes. They provide specialist training to professionals working with survivors of institutional abuse. They are also in the process of publishing a toolkit of sensitive practice for practitioners working with survivors of institutional childhood abuse.
Survivors UK www.survivorsuk.org	London, UK.	No. The training they provide is to members of the public working in a variety of settings to raise awareness of male sexual violation. They recommended ICAP for training in this area.
Adults Surviving Child Abuse (ASCA) www.asca.org.au	Sydney, Australia	To some extent, although their work focuses on the broader topic of trauma. They have published a manual on *Practice Guidelines for the Treatment of Complex Trauma* and a range of Factsheets for different stakeholders.
Survivors of Institutional Abuse www.sia-now.org	California, USA	No. They do not have the funding to provide training or awareness raising. It is part of their future plans.
Public Health Agency of Canada www.phac-aspc.gc.ca	Canada	Yes. They have published a detailed handbook on sensitive practice for health care practitioners dealing with adult survivors of childhood sexual abuse.
Survivors Scotland www.survivorscotland.org.uk	Scotland	Yes. Part of their national strategy is to develop training and skills for frontline workers. They have worked with health professionals on how they can facilitate disclosure of abuse in clinics and surgeries, thereby increasing awareness levels and sensitivity. They have also explored in particular how tools and interventions can be adapted for people with learning disabilities.

Contact was also made with a number of other organisations, such as www.newzealandchildabuse.com. However, their aims or activities do not correspond with those of Caranua. A more comprehensive summary of the organisations listed above and their relevance to the Caranua study is presented below.

3.2 Dublin Rape Crisis Centre

The mission of *Dublin Rape Crisis Centre* (DRCC)[2] is to prevent and heal the trauma of rape and sexual abuse. They provide help and support to anyone who has experienced sexual violence of any kind. In addition to a national awareness campaign, which was launched in September 2012, they provide a wide range of services, including: a national 24-hour Helpline, training and education, one-to-one counselling, accompaniment to the sexual assault treatment unit, court accompaniment, campaigning and lobbying. Of most relevance to the present study is the work of DRCC's Education and Training Department, which provides services to professionals and volunteers who may come into contact with the issues of sexual violence, rape, sexual assault and child sexual abuse in the course of their work.

The DRCC *Education and Training Department* of DRCC has developed and delivered awareness raising and capacity building programmes to a wide range of professionals, including Gardaí; those working in homeless services, domestic violence services, addiction services, and with Travellers; school staff; youth work staff; consular staff; mental health professionals; staff of GSOC; prison staff; the Ombudsman for Children's office etc. They also provided training to the staff of the Commission to Enquire into Child Abuse when it was first initiated. The issues covered by their training include childhood abuse (neglect, emotional, physical and sexual and institutional abuse), rape and sexual assault, and trauma including intergenerational trauma. They also provide training on how to conduct sensitive interviews, on counselling skills, and vicarious traumatisation, for Helpline and SATU volunteers. While training programmes are provided in their offices in DRCC,

[2] www.drcc.ie

which an individual can attend, most of their training programmes are developed and delivered on request to meet the needs of specific roles and particular organisations (See Appendix A).

For the past five years they have received some funding from the European Refugee Fund to develop and deliver training programmes for those working with asylum seekers and refugees who have experienced sexual violence and other trauma. They developed a range of programmes including a 2-day introductory programme, a 2-day programme for Gardaí, a 3-day programme for Domestic Violence staff, a 2-day programme for those working in homeless services, a 4-day programme for those working with young children, a 4-day programme for family support workers, a half day programme for primary school staff etc. These projects have been comprehensively evaluated by an independent evaluator, which shows that this type of training does work in increasing sensitivity, capacity and confidence of staff (Copy of evaluation report available).

The two representatives of DRCC interviewed for this project believe that their training is an effective way to raise awareness and build capacity for professionals. Their public awareness campaign was very effective in increasing awareness of, and calls to their Helpline. Their training methods would also appear to be conducive to the work required by Caranua. Their training approach is participative and experiential. Methods used include group discussion, lectures, case studies, videos, audiotapes, role-plays, and experiential exercises. There is a strong theme throughout of the importance of developing resourcing strategies for the worker, and the prevention of vicarious traumatisation and burnout. The Education and Training Department of DRCC receives no funding apart from a small amount of project funding, and therefore a fee will apply for their services. They expressed an interest in working with Caranua in developing and delivering awareness and capacity building programmes. They will need to be briefed on the specific type of training that will be required by Caranua but that should not present too many difficulties for DRCC, given their experience and expertise in this area. .

3.3 Women's Aid

Women's Aid[3] is a national organisation that has been working in Ireland to stop domestic violence against women and children since 1974. They provide a range of services to women experiencing emotional, physical, sexual or financial abuse by a current or former husband, partner or boy friend. These services include a national Freephone Helpline, one-to-one support, court accompaniment service, and Dolphin House Support and Referral Service. They also provide specialised training and organisational support on ways of responding to domestic violence. They are the Specialist Support Agency on violence against women to the Local and Community Development Programme (LCDP) and to Family Resource Centres throughout the country. All their services offer free and confidential support to women and their children who are experiencing violence in the Republic of Ireland.

They employ a training and education manager who delivers a number of programmes to different audiences. One of these programmes is a training opportunity for continuing professional development (CPD) for childcare workers and trainees on how to respond to women and children experiencing domestic violence. The aim of the two-day programme is to help childcare workers/trainees/managers:

(a) To understand the dynamics of domestic violence and its effects on women and children;
(b) To recognise the impact of domestic violence on women and children and how to respond effectively;
(c) To make safe and appropriate domestic violence referrals;
(d) To provide them with information on safety considerations for childcare staff; and
(e) To fulfil their duties under Children First in the context of domestic violence.

Women's Aid has developed a range of resources, including training packs and

[3] www.womensaid.ie

DVDs, which they use in their training. They believe that their training is effective in raising awareness and responding to domestic violence. During the past number of years, they have offered courses to a range of health and social care professionals including, Family Resource Centre staff. These courses are often linked to professional development where participants receive CPD credits. Their experience and expertise would be a benefit to Caranua in its proposed work (See Appendix B).

3.4. ICAP (Immigrant Counselling and Psychotherapy, UK)

The Immigrant Counselling and Psychotherapy (ICAP)[4] is a registered charity in the UK providing counselling and psychotherapy to help people heal their lives and deal with emotional trauma, depression and risk of suicide. They were originally founded to meet the needs of Irish immigrants resident in Britain, but now they support people from a variety of communities and circumstances. They provide free counselling for survivors of institutional abuse and their families, and for former residents in the Magdalene Laundries.

In 2012, the London Irish Centre and Immigrant Counselling and Psychotherapy (ICAP) delivered training sessions for practitioners and volunteers on sensitive practice when working with survivors of institutional abuse. An evaluation of the workshop indicated that the training had a positive impact on participants' understanding of institutional abuse and that most people felt more confident in their ability to work sensitively with survivors of institutional abuse. In planning the training, the project team conducted research (4 focus groups) with survivors and experienced professionals to get their views on what constitutes good practice when working with Irish survivors of institutional abuse. The primary aim of the first training day was to improve practitioners' awareness of the needs of survivors of institutional abuse and provide workers with the tools to work sensitively with this group. An overview of a two-day training session planned for practitioners in Ireland is outlined below (Table 2.2).

[4] www.icap.org.uk

Table 3.2 ICAP Specialist Training: Working with Survivors of Institutional Abuse

Day One	Day Two
What is institutional abuse?	How does institutional abuse differ from other forms of abuse?
The background to institutional abuse.	What constitutes sensitive practice when working with survivors?
The effects of trauma.	Shared experiences of professionals working with survivors of institutional abuse.
How to manage disclosures.	
How to look after yourself when working with survivors of institutional abuse.	

They are currently in the final stages of developing a manual on '*Principles of Sensitive practice*' for volunteers and professionals working with survivors of institutional abuse (Moore et al., 2014 (forthcoming)). The toolkit comprises nine separate sections:

Chapter One:	Introduction: how to use the toolkit.
Chapter Two:	Institutional childhood abuse in Ireland: an overview.
Chapter Three:	Experiences in care: what childhood in an institution was like.
Chapter Four:	The impact of institutional childhood abuse: statistical information.
Chapter Five:	Developing sensitive practice.
Chapter Six:	Dealing with disclosures: a guide for the practitioner.
Chapter Seven:	Self-care: a necessity for the practitioner
Chapter Eight:	Enhancing resilience.
Chapter Nine:	Further information and advice.

Chapter five is possibly of most relevance to Caranua within the context of the present study. This chapter sets out some principles, which form a

framework for developing sensitive practice. It is based on a sample of emigrant survivors of institutional child abuse about their experiences seeking professional help. The following themes are addressed in the chapter.

- Taking time.
- Building rapport.
- Sharing control.
- Respecting boundaries, including privacy and confidentiality.
- Demonstrating understanding of institutional abuse.
- Understanding the complex traumatic effects of institutional abuse.
- Sensitivity about literacy and educational attainment.
- Sensitivity to identity loss.
- Moving on and building resilience.

The final report is due for publication in 2014.

3.5 The Public Health Agency of Canada[5]

A Handbook on sensitive practice for health care practitioners dealing with adult survivors of childhood sexual abuse was published by the *Public Health Agency of Canada* (Schachter et al., 2009). The Handbook is divided into nine chapters:

Chapter One:	The Handbook as a tool for Clinical Practice.
Chapter Two:	Background information about Childhood Sexual Abuse
Chapter Three:	What Childhood Sexual Abusers Bring to Health Care Encounters.
Chapter Four:	Principles of Sensitive Practice.
Chapter Five:	Guidelines for Sensitive Practice: Context of Encounters.
Chapter Six:	Guidelines for Sensitive Practice: Encounters with Patients.
Chapter Seven:	Guidelines for Sensitive Practice: Problems in Encounters.
Chapter Eight:	Guidelines for Sensitive Practice: Disclosure.
Chapter Nine:	Summary and Concluding Comments.

[5] www.phac-aspc-gc.ca

The Handbook is quite specific in the detail it provides. For example, in chapter five, which deals with guidelines relating specifically to the context of health care encounters, it makes the following recommendations:

- Administrative staff and assistants should receive training in sensitive practice so that they will have some understanding of the dynamics and long-term effects of interpersonal violence.
- Create waiting areas that are warm and welcoming, with clearly identified washrooms. Also, provide printed materials related to interpersonal violence, and give survivors a realistic estimate of the length of their wait time.
- Privacy is an important aspect of safety, where survivors can speak in confidence to a clinician. However, they should be aware that some survivors may opt for a more public place or a private area in the presence of a support person who accompanies them.
- Patients should be prepared for the appointment by the sharing of relevant information, written in clear and plain language.
- Practitioners should consider encouraging the presence of a support person or 'chaperone'.
- Health care should be culturally sensitive to take account of different ethnic and cultural groups in society.
- Collaboration between practitioners should be encouraged but care needs to be taken that survivors do not feel abandoned if their care is transferred to another practitioner.
- Practitioners should take care of themselves.
- Practitioners working in agencies that serve abuse survivors should prominently display posters and brochures for programmes. This would give survivors the message that the practitioner is aware of the prevalence and potential long-term problems associated with sexual, physical and emotional abuse.

The tone and content of the Canadian Handbook is similar to the ICAP Handbook. Its primary focus is on helping health care practitioners practice in a manner that is sensitive to the needs of adult survivors of childhood sexual

abuse and other types of interpersonal violence. Conversely, the ASCA Handbook is more concerned with childhood trauma generally.

3.6 Professional Development Education in Ireland

The increasing popularity of Continuous Professional Development (CPD) in Ireland should provide some potential avenues for the development and provision of a module on institutional abuse. It would appear that many of these opportunities are based in third level institutions. A recent report commissioned by the Mental Health Commission of current education and training available for professionals working in the mental health services in the Republic of Ireland found that 31 educational institutions provided 227 courses for professionals working in mental health service i.e., psychiatrists, nurses, social workers, psychologists, occupational therapists, and speech and language therapists (Higgins et al., 2010). The majority of these courses were offered at post-graduate level. Many of these courses were developed to meet a specific health service need or to respond to policy initiatives or to enhance practitioners' skills. There may be some opportunities for Caranua to work in partnership with one or more third level institutions to provide a module on institutional abuse. A module is most likely to be included in a college's curriculum if they perceive a demand from students and/or if funding is provided to offset some or all of the costs of the course. The majority of courses in the Mental Health Commission study were self-financed, with others being either completely or partially subsidised by the HSE, the Department of Health and Children, the Department of Education and Science, or other sources.

Some organisations, such as the Nursing & Midwifery Board of Ireland have published a CPD directory which lists approved training courses e.g., recognising and responding to elder abuse, recognising and responding to elder abuse in residential care settings, recognising and responding to elder abuse in the community, and protection from abuse and neglect with services for people with intellectual disabilities. Other professional organisations, such as Social

Care Ireland, are moving in this direction and they hope to introduce a CPD endorsement process. Other organisations, such as the Psychological Society of Ireland, depend on people applying to offer courses. To the best of my knowledge there is no comprehensive list of CPD courses and none of the organisations contacted in the course of this study were aware of any modules on institutional abuse.

3.7 Concluding Comments

This chapter has identified a number of organisations that provide training and education to different groups of professionals. The Dublin Rape Crisis Centre, for example, has developed and delivered awareness-raising and capacity building programmes to a wide range of professionals, including Gardaí, workers in homeless services, domestic violence and addiction services, Travellers, school staff, youth workers, mental health professionals, and prison staff, amongst others. Women's Aid has also provided training and awareness raising programmes to social care professionals. The experience and expertise of these two organisations suggests they would be a significant asset to Caranua in the provision of awareness-raising and capacity-building programmes. Their staff are experienced, professional and successful in providing similar programmes to professional workers. In addition to their role as trainers, both organisations would be able to integrate their experience of working with vulnerable groups into the programmes.

ICAP would also appear to be very well positioned in the provision of specialised training to professionals working with survivors of institutional abuse. They have worked with groups of survivors in the UK and they have plans to provide similar training in Ireland. Furthermore, their specialist knowledge and commitment to this vulnerable of survivors is evident from the time and resources they have committed to the publication of a *toolkit* of sensitive practice for practitioners working with survivors of institutional childhood abuse. Subject to further discussion with Dublin Rape Crisis Centre, Women's Aid and ICAP, I would recommend that the three organisations are

commissioned to give an appropriate training module to different groups of professional workers, and that the effectiveness of their training is independently evaluated for its diverse strengths and weaknesses. It is possible, for example, that the three groups would attract different groups of workers to their training, or that one group may have greater access to some categories of professionals than the others. The success of their training and the difficulties they encounter would inform Caranua in making more long-term decisions concerning the provision of awareness-raising and capacity-building. In addition to providing support to one or more of these organisations that specialist in sensitivity awareness, it is recommended that Caranua consider funding one or more courses in third level institutions, especially those which provide training and accreditation to a range of health and social care professionals.

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APPENDIX A

DUBLIN RAPE CRISIS CENTRE

SELECTED TRAINING PROGRAMMES,

Case Study 1: Working with issues of Child Sexual Abuse

A Dublin Rape Crisis Centre 3 Day Training Programme

Participants
This training programme is for those working in various roles with clients who have experienced child sexual abuse and other childhood trauma

Aims
To increase the participants' understanding of the dynamics and impact of child sexual abuse, and to enhance their capacity to deal with this issue.

Objectives
Participants will

- Be aware of the myths and attitudes existing in society regarding child sexual abuse
- Be informed about the actual incidence of sexual abuse, and about research into causes and effects
- Be aware of the impact of child sexual abuse on the internalised beliefs of the client
- Be aware of the effects of child sexual abuse, and the strategies employed by children in order to survive
- Be informed as to the long term impact of child sexual abuse, and issues that may arise for their clients
- Develop their understanding and skills in facilitating a disclosure of child sexual abuse or other trauma, while avoiding re-traumatisation of the client
- Have an overview of the counselling process with victims of child sexual abuse
- Develop skills and strategies for supporting clients who are experiencing symptoms of post traumatic stress
- Develop an understanding of how the dynamics of abuse impact on the worker/client relationship, and on the organisation and staff relations
- Develop an understanding of how to identify and develop the internal and external resources of the client
- Be aware of their own issues regarding listening to stories of abuse and witnessing its impact on the lives of their clients
- Understand the impact of vicarious traumatisation, and develop strategies to prevent and deal with this

Training is provided with two facilitators to ensure an appropriate level of support for participants when working with sensitive issues. The training approach is invitational, with the sensitive nature of the issues being covered and the fact that they may resonate for participants acknowledged. Participation is encouraged but without pressure. Each day begins with a mindfulness exercise so that participants

have an opportunity to assess how they are on the day and to resource themselves, and to take part in the day in the light of this.

For staff working in various roles with clients who have experienced child sexual abuse

Day One

Session One:	Introductions and the Concerns of the Group The impact of Internalised Beliefs and Attitudes: Small Group Discussion and Feedback Definition of Child Sexual Abuse The SAVI Report: Sexual Abuse and Violence in Ireland
Session Two:	The Impact of Child Sexual Abuse Video and Discussion The Effects of Sexual Abuse on the Child
Session Three:	Issues in Disclosure of Child Sexual Abuse Guidelines on Facilitating a Disclosure of Sexual Abuse Maintaining Safety and Resourcing the Client Role Play: Facilitating a Disclosure
Session Four:	Feedback from Role Play and discussion of the issues arising Debriefing and Closing

Day Two

Session One:	The Impact of Sexual Abuse The Impact on the Worker
Session Two:	Overview of The Counselling Process Stabilisation and Creating Safety
Session Three:	Creating Safety for the Client: Case studies and feedback Techniques for coping with symptoms of post-traumatic stress
Session Four:	Vicarious Traumatisation and self care Developing strategies for self care: Small group work Debriefing and Closing

Day Three:

Session One:	Issues for Survivors of Child Sexual Abuse Small Group work and Feedback
Session Two:	The Dynamics of Abuse Transference and Counter transference
Session Three:	Creating Safety and Developing Resources: Lecture
Session Four:	Resourcing: Exercise Evaluation and Closing

Case Study 2: Working with Victims of Sexual Violence
A Dublin Rape Crisis Centre Workshop
For
General Practitioner Training

Aims: To increase the participants' understanding of the impact of rape and sexual assault, and to enhance their capacity to support the patient in the crisis situation immediately after rape or sexual assault, and with the long term impact.

Objectives: Participants will

- Be aware of the myths and attitudes that exist in society concerning rape and sexual assault, and how these are internalised by the victim of sexual violence.
- Be aware of the incidence of sexual violence in Irish society.
- Be informed as to the impact of rape and sexual assault, both immediately and in the longer term.
- Be provided with guidelines as to how to sensitively offer support in the immediate aftermath of rape and sexual assault
- Be aware of the possible impact on the General Practitioner of working with these issues, and the importance of identifying resources and strategies to maintain their own well-being.

Methodology: The training approach is participative. Methods used include group discussion, lecture, video.

<u>Outline of Programme</u>

- Introductions
- The Myths and Beliefs in Society about Rape and Sexual Abuse: The Impact of these on the Victim of Rape or Sexual Assault, and on the Professional

Participants are asked to identify some of the myths, beliefs and attitudes that exist in society towards rape and sexual assault, and to consider how these impact on those who have experienced rape or sexual assault.

- **Incidence of Sexual Violence in Ireland: The SAVI Report**

The SAVI Report provides information about the level of incidence of sexual violence in Ireland. It will be useful for the General Practitioner to be aware of the proportion of patients who will have had these experiences.

- **The Impact of Rape: Video**

A short video of an interview with a rape victim who describes the attack and its impact. A discussion and lecture after the video focuses on the impact on the victim, and on the impact on the participants of watching the video and hearing about rape.

- **Issues when Supporting a Victim of Rape or Sexual Assault**

Guidelines as to how to sensitively support the victim in the immediate crisis situation

- Issues for the General Practitioner
- Debriefing and Evaluation

Case Study 3: Working with Issues of Child Abuse

A Dublin Rape Crisis Centre Workshop for The Commission to Inquire into Child Abuse 12th, 13th December 2000 and 10th January 2001

9.30 - 11.00:	Introductions and the Concerns of the Group Societal Myths and Attitudes about Child Abuse: The impact of external and internalised beliefs Small Group Discussion and Feedback Definitions of Child Abuse
11.00 - 11.20:	Break
11.20 - 1.00:	The Client Profile: Impact of Child Abuse Video and Discussion The Effects of Abuse on the Child and on the Adult Debriefing and Closure

Day Two:

9.30 - 11.00:	Check in Issues in Disclosure of Child Abuse Guidelines on Listening to a Disclosure of Child Abuse Skills Practice: Role-Plays
11.00 - 11.20:	Break
11.20 - 1.00:	Boundaries of the Role Structuring the Interaction Debriefing and Closure

Day Three:

9.30 - 11.00:	Check-in Hearing about Child Abuse: Awareness of Personal Impact Vicarious Traumatisation
11.00 - 11.20:	Break
11.20 - 1.00:	Support for the Listener Self Care Support and Supervision Debriefing and Closure

APPENDIX B

WOMEN'S AID

SELECTED TRAINING COURSE

Training Women's Aid - Day One

Trainers:

10.00 (40mins)	Intro and set up • Welcome and intro trainers • Brief participant intro (opening round) • Housekeeping • Context of this training- Code of practice • Mention C1st • Intro WA + Gendered nature of dv (stats) • Hopes and concerns (1 per person) • Group contract • Park sheet • Agenda – day 1 & 2 • Reflective question(possibly on flipchart) Who do you think is responsible for the effects of the violence on the children?	Ensure the following in the contract -One voice at a time -Equal /mindful participation -Respect topic/ each other/everyone's views/ trainers -Trust learning process and agenda -mobile off/silent, no texting/calls in room -time keeping -all this applies to small groups	RD
10.40 (50mins)	Dynamics (before and after break) • Show NI DVD • Small groups - 3Qs Q1 re the forms of abuse ag. the woman Q2 re impacts on the woman Q3 re how the woman copes • Feedback		ML
11.30 (15mins)	BREAK		
11.45 (50mins)	Dynamics (contd) • Show Family DVD • Distribute 3 Qs (same groups) Q4 re abuse of the children Q5 re impacts on the children Q6 re how the children cope • Feedback		ML
	• Flipchart Q7. Woman's Protective Parenting • Trainer summary (drawing points re woman and children together)	Link between DV +CA Collective victims UK children at risk register stat	RD
12.35 (30mins)	Intent behind the abuse • Flipchart Q re intent • Link to DVD • Structure and origin of wheel, DAIP • Non-physical tactics (avoid repetition)	Ensure using the children is understood as a tactic to control the woman	RD

1.05 (55mins)	LUNCH		
2.00 (50min)	Common Beliefs • Intro module • Visualisation • Flipchart Qs re what is said about the woman and the perpetrator • Case studies x3 Common Beliefs • Feedback Trainer clarification/summary re case studies as given and include culture and mental health	Case studies: Abused as a child, anger management, alcohol. Issue of culture.	ML
2.50 (45min)	Liz Kelly: Crisis Intervention Model • Introduce model & LK • Woman's scripted journey • Explain processes & application of model • Flipchart 'Who can stop the violence'	In concluding LK ask 'Who can stop the violence?'	RD
3.35 (15min)	BREAK		
3.50	Influence of the perpetrator • Intro theme, reference source • First date scenario • Explain set up and grooming • Provide definition of grooming • Explore who can be groomed and to what end • Ask participants if they recognise this, share examples (from their work)		ML
4.15	Closing round		RD
4.30	CLOSE		

Ask ML re Common beliefs material (used in June delivery).

Day Two

Trainers:

10.00 (20mins)	Intro • Opening round, check in • Re-cap on day 1 • Agenda for day 2 • Link between DV and CA (note only cover if feel needed as will be mentioned at end of dynamics)	Note: if not covered in day 1, mention WA as SSA and tally CoP with information covered in tx	ML
10.20 (40min)	Obstacles • Intro module • Read scripted journey • Facilitate discussion and trainer summary Capture on flipchart (5min) Q. 1 What kind of support needs might the woman and children have as a result of experiencing DV?	Tiles and cards to be placed on the floor Step into role and de-role after Keep brief, focus on their needs (medical, housing , financial, protection, support)	RD
11.00 (25mins)	Effects on Parenting • Brainstorm re Positive Parenting, • Barnardos definition • Small groups (10mins) - 4Qs Q1. What impact does being abused have on the woman's parenting? Q2. What impact does being abusive have on the man's parenting? Q3. How do the children view their mother? Q4. How do the children view their father?	Either 4 small groups with 1 Q each (10mins) or 2 groups with 2 Q's each (15/20mins). This format takes 65/70mins. Adjust timeline on the day if needed.	ML
11.25	Break		
11.40 (35mins)	Effects on Parenting cont. • Feedback from group work (20mins) • trainer summary • Facilitate large group Q on flipchart (5mins) Q5. Who do children mainly get support from in relation to dv? (informal + formal supports) • Quotes from Stop hitting Mum (optional) • Repeat reflective question asked earlier, inviting feedback Q. Who do they think is responsible for the effects of domestic violence on the children?	Keep Q5 for use later in child protection in DV Changed Q5 to support mention of mother. Key learning: his abuse of their mother is not separate from his parenting. He is responsible for all effects on W + C (short + long-term)	ML
12.15 (45mins)	Child Protection in DV (WP=CP) • Draw attention to related learning from other modules (5mins) (see across)	Intro module, how to protect the children in DV Earlier learning:	RD

	Naming that responses in society to protecting children in the context of DV can be categorised under the following 3 headings 1. Tasking the woman to protect the children. 2. Putting children into care 3. Partnering with the woman to protect the children. • Explore the pros and cons for each option, (look at partnering with the woman last) Support understanding of partnering with the woman as best option. Name as WP=CP. • Cite L. Kelly WP=CP and D. Mandel models. • Trainer summary of WP=CP. (WP=CP can be looked at further in implications for practice)	Q1.What did the women in the DVDs do to protect the children? (extensive effort) Q2. Who can stop the violence? (the state/him) Q3. Who children mainly get their support from? (mother)	
1.00 (60mins)	LUNCH		
2.00 (30mins)	Custody and access • Display large P+C wheel • In pairs (if time is short just ask large group, this way takes only 5mins) Q1 What do you think happens to the perpetrator's P+C post-separation? Q2. What do you think is likely to be the perpetrator's response to the change in his P+C? Feedback • Large group flipchart question Q3. What are the risks when the perpetrator has diminished contact with the woman but has child contact? • Stats re post separation violence towards the woman and risks to children in contact. (Optional) Facilitate discussion on custody and access in DV, eliciting their experiences of this through their work	This can be done in 20mins if needed (review on the day) Rem: Post separation P+C wheel? Collect appropriate stats, mostly stats to be conveyed in handouts, only necessary in training as context	ML
2.30 (35min)	Disclosures • Briefly ask wider group what may be some of the barriers to disclosure for; the woman; for the worker • Display flipchart and talk through Principles of taking a disclosure (from Women's Health Council) • Acknowledge obligations re C1st here, expanded on in next section (when to report and how to do this with the woman)	C1st table Note: this is where we specifically address C1st + the responsibilities etc.	RD
3.05 (15mins)	BREAK		

3.20 (35min)	Referral options • Relate to Q earlier in Obstacles exercise, i.e. What support needs may the woman and children have as a result of the DV? Display flipchart as starting point for info on services. • Input on services: What is FL, describe WA services HL+ 1:1, refuge, legal options, housing, financial -V. brief re Safety planning	Focus of learning on need to refer to WA/ other FL Only essential info on other services needs to be shared e.g. what is refuge; what will it be like for a woman; Dublin/ rural areas.	RD
3.45 (20mins)	Implications for practice (focus on key learning WP=CP) Divide group in two and ask each group to look at Q1. What practices are based on this model of supporting the woman and child together? / What do you do that stems from understanding that by protecting the woman you can protect the children. Q2. What are the challenges to doing this in practice? Q3. Can you identify a possible solution to each of the challenges named in Q2.	Quick version: Ask large group when might WP=CP be difficult in practice? (E.g. if have no contact with woman; if know him; if reporting necessary and woman feels betrayed) As each challenge is named explore solutions to address this difficulty. Continue in this way- challenge + possible solutions.	ML
4.05 4.15	• Evaluations • Closing round	Evaluation forms need review	RD
4.30	CLOSE		