# Sexual Abuse Inquiry and Response: A New Zealand Training Programme

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Despite the high prevalence of child abuse amongst users of mental health services and the many long-term sequelae of abuse, it has been demonstrated, in New Zealand and elsewhere, that mental health professionals are frequently unaware of clients' abuse histories. In response an urban District Health Board has introduced policy guidelines that all mental health clients must be asked about sexual abuse and other trauma, and that all mental health staff must receive training designed to improve confidence and competence in relation to inquiring about abuse, and responding to disclosures. This paper summarises the New Zealand and international research that informed the design of the training programme, and presents an evaluation of the first seven administrations of the programme, to 85 mental health staff from a range of professions. The programme was highly valued by participants, was effective in improving confidence, knowledge and some of the relevant beliefs, and improved actual clinical practice for a proportion of the staff.

Child abuse has been shown to have a causal role in depression, anxiety disorders, PTSD, eating disorders, substance abuse, sexual dysfunction, personality disorders and dissociative disorders (Fergusson, Horwood, & Lynskey, 1996; Kendler et al., 2000; Lysaker, Wickett, Lancaster & Davis, 2004; Mullen, Martin, Anderson, Romans, & Herbison, 1993). Child abuse can also contribute to the development of psychosis later in life (Bebbington, Bhugra, & Brugha, 2004; Briere, Woo, McRae, Foltz & Sitzman, 1997; Janssen et al., 2004; Read, Goodman, Morrison, Ross, & Aderhold, 2004; Read, Agar, Argyle, & Aderhold, 2003; Read, Perry, Moskowitz & Connolly, 2001; Read, Rudegeair & Farelly, in press; Ross, Anderson & Clark, 1994). The more severe the abuse, the greater is the probability of mental health problems in adulthood (Janssen et al., 2004; Mullen et al., 1993; Read et al., 2003).

### *Prevalence and Effects of Child Abuse*

A recent review of 40 international studies of adult and adolescent female service users calculated that 50% had been subjected to childhood sexual abuse (CSA) and 48% to childhood physical abuse (CPA). The majority (69%) had been subjected to either CSA or CPA. The figures for men were CSA 28%, CPA 51%, CSA or CPA 60% (Read et al., 2004).

Service users who suffered CSA or CPA have earlier first admissions, longer and more frequent hospitalisations, spend longer in seclusion, receive more medication, are more likely to self-mutilate, and have higher global symptom severity (Briere et al., 1997; Goff, Brotman, Kindlon, Waites, & Amico, 1991; Mullen et al., 1993; Read, Agar, Barker-Collo, Davies & Moskowitz, 2001; Rose, Peabody, & Stratigeas, 1991). They also try to kill themselves more often than non-abused service users (Briere et al., 1997; Mullen et al., 1993; Read 1998). A New Zealand study found child abuse to be a more powerful predictor of adult suicidality than a current diagnosis of depression (Read, Agar, et al., 2001).

Furthermore, general population surveys in numerous countries find that the public believes that adverse life events, including childhood trauma, play a primary role in the causation of mental health problems (Dietrich et al., 2004; Read & Haslam, 2004). Unsurprisingly, therefore, when members of the public come into contact with mental health services they expect to be asked about bad things that might have happened to them as children (Lampshire, 2000; Lothian & Read, 2002).

### *Current Practice*

Given the research summarised above it seems essential that mental health staff know whether clients have been abused. Studies in the U.S. and the U.K., however, have found that clinicians fail to identify the majority of the abuse cases reported to researchers (Read, in press). The percentages identified by clinicians ranged from 48% to 0% (Craine, Henson, Colliver, & MacLean, 1988; Muenzenmaier, Meyer, Struening & Ferber, 1993; Rose et al., 1991;

Thompson & Kaplan, 1999; Wurr & Partridge, 1996). Four New Zealand studies also found low levels of abuse identification by mental health services (Agar, Read, & Bush, 2002; Lothian & Read, 2002: McGregor, 2003; Read & Fraser, 1998a).

There has been surprisingly little research on what mental health professionals do after a client discloses child abuse. Two New Zealand studies (Agar & Read, 2002; Read & Fraser, 1998b) and a U.S. study (Eilenberg, Fullilove, Goldman, & Mellman, 1996) found low levels of response in terms of: offering information or support, referring for counselling, documenting the abuse in files, asking about previous disclosure or treatment, including the abuse in summary formulations or treatment plans, and considering reporting to legal or protection authorities.

### Barriers to Asking and Responding

For an array of understandable reasons service users rarely spontaneously disclose abuse (Craine et al., 1988; Eilenberg et al., 1996 Lampshire, 2000; McGregor, 2003; Read & Fraser, 1998a). It is therefore incumbent on mental health staff to take the initiative and ask.

Barriers to inquiry, and appropriate response, include:

- concerns about offending or distressing clients (Mitchell et al., 1996; Young, Read, Barker-Collo, & Harrison, 2001)
- fear of vicarious traumatisation (Eilenberg et al., 1996)
- fear of inducing 'false memories' (Briere et al., 1997; Young et al., 2001)
- the client being male (Finkelhor, 1993; Lab, Feigenbaum, & De Silva, 2000.; Read & Fraser, 1998a, 1998b)
- the client having a diagnosis indicative of psychosis (Read & Fraser, 1998a, 1998b), particularly when the clinician has strong bio-genetic causal beliefs (Young et al., 2001)
- the clinician being a psychiatrist (Agar & Read, 2002; Lab et al., 2000), especially a psychiatrist with strong bio-genetic causal beliefs (Young et al., 2001)

### Training

Neither including an abuse section in admission forms (Read & Fraser, 1998a), nor simply mandating that staff ask about abuse (Dill et al., 1991) is, in the absence of training, effective. A U.S. study found that previous training was the best predictor of case identification and initiation of appropriate care (Currier, Barthauer, Begier & Bruce, 1996). A New Zealand survey of psychologists and psychiatrists found that having received training was positively correlated to self-reported probability of taking a trauma history (Young et al., 2001). U.S. mental health staff who received a one-hour lecture, on prevalence, impacts and issues around sensitive assessment, identified significantly more sexual and physical violence than those who did not receive the lecture (Currier & Briere 2000).

### Policy and Guidelines

Only 15% of New Zealand psychologists and psychiatrists report that their workplace has a policy addressing abuse inquiry (Young et al., 2001). In 2000 Auckland District Health Board (DHB) added to its Mental Health Service Policy and Procedure Manual a 'Recommended Best Practice' document for 'Trauma and Sexual Abuse'. The two guiding principles of this document are '1. Assessment of mental health clients must include questions about possible trauma/sexual abuse to ensure that appropriate support and therapy is made available. 2. Clinicians should routinely ask about history of trauma, especially occurring during the client's childhood' (p.2). It also states: 'Clinical staff are required to undertake a one day skill based training to ensure that questioning techniques are appropriate' (p.5) and recommends that the training covers: "Prevalence and effects of abuse; Cultural and consumer perspectives; Learning to ask about abuse; How to respond to a disclosure of abuse; Notetaking; Legal obligations; Resources available within Auckland DHB mental health services; Resources available in the community; Vicarious traumatisation/staff safety" (p.5).

### A New Zealand Training Programme

To implement the goals of Auckland DHB a community-based sexual violence education group (Auckland Rape Crisis) worked, for more than a year, with the DHB's mental health staff, consumer consultants and management, and the psychology department of the University of Auckland, to develop a one-day training programme. It teaches the skills thought necessary for effective inquiry and response (focussing on sexual abuse but also covering physical abuse) within a framework of the research summarised above and a survey of service users undertaken to help design the training (Lampshire, 2000). See Table 1 for a list of the programme's components. The programme is described in more detail elsewhere (Read, in press; Young et al., 2001). This study reports the outcome of an evaluation of the training programme.

The evaluation criteria included satisfaction with the programme. However, it is possible to value the content and process of a training programme without the programme producing the changes for which it was designed. Therefore the evaluation criteria included changes, approximately six weeks after the training, in confidence (about asking and responding), knowledge, beliefs (including those identified as barriers to asking – see above), and – most importantly – actual clinical practice.

## Method

### Participants

The 85 mental health staff who attended the first seven sessions of the training programme participated in the study. Seventy three percent were women. The age distribution was: under 30 – 24%, 30 to 39 - 32%, 40 to 49 - 31%, 50 or older – 13%. Seventy eight percent identified as European/Pakeha, 14% as Maori, 5% as Pacific Islander, 2% as Indian and 1 % as Jewish. Just over half (53%) were nurses. Other 'occupations/ professions' were: therapist/ psychotherapist – 14%, psychologist – 10%, social worker – 7%, occupational therapist – 7%, psychiatrist – 5%, and support worker – 4%. Eighteen percent

had less than three years of clinical experience, 39% had 3–9 years and 43% ten or more years.

### Materials and Procedure

Permission to conduct the research was obtained from the DHB management and the regional ethics committee. On the day of the training, immediately prior to the training session, the participants were asked to complete, anonymously, a 'Sexual Abuse Inquiry and Response Questionnaire'.

Section 1 gathered demographics, information about prior training, and knowledge of the D.H.B.'s policy guidelines. Section 2, 'Asking Clients About Sexual Abuse', asked 'In approximately what percentage of your clients do you know whether they have been sexually abused.' It also asked whether clients' diagnoses, age and gender influenced their decisions whether to ask about sexual abuse. Section 3, 'Responding to Disclosures of Sexual Abuse', listed five responses to disclosures (See Results) and asked participants to estimate the percentage of disclosures in which they use each of the five responses. It also asked 'Of all reports of sexual abuse made to mental health professionals in general, I believe that: __% are true, __% are the result of psychotic delusions, __% are imagined (i.e. the client believes them to be true but they are not), and __% are deliberate false allegations (i.e. the client knows the allegations to be untrue)'. Section 4, 'Causal Beliefs', asked participants to estimate the percentage contribution of 'bio-genetic' and 'psycho-social' factors to the causation of depression, PTSD and schizophrenia. The final section measured agreement, on a Likert scale, from 1 – 'strongly agree' to 6 – 'strongly disagree', with the four items about confidence and attitudes listed in Table 2.

Approximately six weeks after the training the participants were posted a post-training questionnaire. This was the same as the pre-training questionnaire, but began with: 'Please consider your work since you attended the training', and ended with a measure of agreement (6 – 'strongly disagree', 1 – 'strongly agree') with the statement: 'The training session I attended a few weeks ago has changed my clinical practice'. Participants who agreed (i.e. responded 1, 2 or 3) were asked to give up to three examples.

Participants were also asked to complete a short, anonymous 'Training Evaluation Sheet' on the day of the training. Likert scales were used to assess agreement with three general statements about the training and to evaluate the perceived usefulness of its individual components (see Table 1). Space was made available for open-ended comments about what might be added to the programme, what aspects were considered 'effective', and 'ineffective', and for 'Additional Comments'.

### Data Analysis

Independent samples t-tests (two-tailed) were used to test for differences between participants who completed the post-training questionnaire and those who did not (to ascertain generalisability from the former to the latter). Independent samples t-tests (two-tailed) and correlation coefficients were used to ascertain relationships and differences relating to variables within the total sample prior to the training. Because of the large number of these pre-training analyses the significance level, for these analyses only, was reduced from the traditional $p < .05$ level to $p < .025$, in order to reduce the

Table 1. Evaluation of Programme and Its Components Immediately After Training

| **Overall Programme**<br>*1 = strongly agree, 6 = strongly disagree* | Mean |
|---|---|
| I benefited from the training today | 1.06 |
| The programme increased my confidence in my ability to inquire about sexual abuse | 1.65 |
| The programme increased my confidence in my ability to respond to disclosures | 1.61 |
| **Programme Components**<br>*1 = very useful, 2 = somewhat useful, 3 = slightly useful, 4 = not at all useful* | |
| *Morning - Asking* | |
| Small group activity on pros and cons of asking; and why clinicians sometimes don't ask | 1.50 |
| Research summary – prevalence and effects | 1.54 |
| Research summary – how often clinicians are asking | 1.49 |
| Consumer perspectives on whether, and how, to ask, and how to respond to disclosures | 1.27 |
| Maori perspectives, from Maori practitioner | 1.96 |
| Observing role play about asking about abuse | 1.44 |
| Participating in role-play about asking about abuse | 1.45 |
| *Afternoon - Responding* | |
| Summary of handouts on agency policy, community resources and how to respond to disclosures | 1.33 |
| Group activity on best and worst ways to respond to a sexual abuse disclosure | 1.65 |
| Research summary on current practice regarding response to disclosures | 1.50 |
| Observing role-play about responding to a sexual abuse disclosure | 1.45 |
| Participating in role-play about responding to a sexual abuse disclosure | 1.55 |

probability of Type One (false positive) errors. Paired samples t-tests (two-tailed) were used, on those who completed both the pre- and post-questionnaires, to ascertain change following the training. Not all participants answered all the questions, resulting in variable sample sizes for different items.

## Results

### Previous Training

Thirty three percent stated that they had 'received any training about how to inquire about sexual abuse' and 39% that they had 'received training on how to respond to disclosures of sexual abuse'. Age was positively correlated with having received inquiry training ($r = .30$, $p < .01$). There was no significant relationship with gender or ethnicity. Fewer medical staff (26%) had received training in asking about abuse (28% of the nurses, none of the psychiatrists,) than the non-medical staff (48%), a difference that did not reach the $p < .025$ level of significance set for the pre-training analyses ($\chi^2$ (1) = 4.49, $p = .034$) Compared to untrained participants, those with prior training in inquiry were more likely to believe they knew how to ask ($\chi^2$ (6) = 22.57, $p < .001$) and how to respond ($\chi^2$ (6) = 30.30, $p < .001$), and to provide information on abuse to a greater percentage (76% vs. 48%) of abused clients ($t$ (1,66) = 2.60, $p < .025$). Those with prior training in responding to disclosures were more likely to believe they knew how to ask ($\chi^2$(6) = 15.77, $p < .025$) and to respond ($\chi^2$ (6) = 21.34, $p < .005$), and to believe that it is important to offer all abused clients abuse-related counselling ($t$(1,73) = 2.32, $p < .025$).

### Immediate Evaluation of Training

In the evaluation completed at the end of the training day 94% or more agreed to some extent with each of the three questions about general benefit from the training, increased confidence in ability to inquire and increased confidence in ability to respond. Table 1 records the mean Likert scale scores for these questions and for the perceived usefulness of the individual components of the programme. All components were found to be between 'somewhat useful' and 'very useful', with the consumer perspectives component perceived as the most useful.

In addition, 50 participants wrote comments in response to one or more of the four open ended-questions. In terms of what participants would like to see added to the programme ten recommended more time (including a second, follow-up day) and five suggested more input on Maori/Pacifika issues. In terms of what they found 'effective' 22 commented on the style of facilitation, including: relaxed/informal/fun, clear structure, collaborative, and the fact that the teaching modality varied throughout the day from didactic to participatory. Other frequently mentioned aspects were: role plays (16), the written handouts (11), and the research summaries about prevalence, effects and current practice (i.e. low levels of asking and responding) (9). Only seven participants found any aspect of the programme 'ineffective, the most common (two each) being the venue and the instant coffee. Under 'Additional Comments' the only two negative comments were: '*Felt a little rushed – more time*' and '*Needs another day*'. Seventeen praised the programme with comments such as:

*'Great day – learned much and gained new interview techniques and knowledge to take away'*

*'Thank you, useful training. Good practical skills and good info. to take away'*

*'An extremely useful programme, highly recommended'*

*'A very well constructed day – one of the best learning days I have attended – thanks'*

*Extremely useful workshop. Wish I had had it years ago! Invaluable'*

*'Thank you. Would look forward to attending updates/further courses'*

### Comparison of Participants Who Did and Did Not Return the Post-training Questionnaire

There were no significant differences in terms of age, gender, ethnicity, profession or years of clinical experience, between the 31 staff (36.5%) who completed the follow-up questionnaire and the 54 who did not. There were no significant differences between the two groups on the attitudinal items about the importance of asking about abuse and offering counselling and information to abused clients, the percentage who knew

Table 2. Pre- and Post Training Attitudes and Confidence in Clinical Skills

| | All Participants (n = 82) | Participants Completing Pre-and Post-Training Questionnaires (n = 28) | | |
|---|---|---|---|---|
| *1 = strongly agree, 6 = strongly disagree.* | | Pre | Post | *t* |
| It is important that all clients be asked about sexual abuse | 2.42 | 2.39 | 1.79 | *2.01* |
| It is important that all clients who disclose sexual abuse be offered counselling to deal with the effects of that abuse | 1.73 | 2.05 | 1.43 | *1.70* |
| I have the knowledge and skills to inquire about sexual abuse in a sensitive and effective manner | 3.18 | 3.27 | 2.29 | *4.49** |
| I have the knowledge and skills to respond appropriately to disclosures of sexual abuse | 3.27 | 3.30 | 2.14 | *4.78** |

* p < .001, paired-sample t-tests (2 tailed) comparing means on pre- and post-training questionnaires.

about the DHB policy, or in causal beliefs. It was therefore assumed that those who completed the post-training question-naire were a representative sub-sample of the total sample for the purposes of the analyses presented next.

### Changes in Knowledge, Confidence and Beliefs Six Weeks After Training

At the time of the training 51% knew that the DHB has a policy about trauma and abuse, but only 23% reported that they had read it. Of those who completed the post-training questionnaire 60% had read it.

Table 2 shows that confidence in ability to ask about sexual abuse increased significantly following the training ($t$ (1,27) = 4.49, $p < .001$), as did confidence in ability to respond ($t$ (1,27) = 4.78, $p < .001$). The strengthening of beliefs in the importance of asking all clients about sexual abuse ($t$ (1,27) = 2.01, $p = .054$), and offering counselling ($t$ (1,27) = 1.70, $p = .093$), did not reach statistical significance.

At the time of the training the total sample believed, on average, that in 64% of client cases they knew whether or not the client had been sexually abused. There was no significant change following the training.

Prior to the training the total sample believed, on average, that 84.1% of disclosures to mental health professionals are true, 7.3% were psychotic delusions, 5.9% were imagined and 2.9 were deliberate false allegations. The percentage considered true was positively correlated with believing that all clients should be asked about abuse ($r = .37$, $p < .005$), and with the percentage of clients for whom the participant knew whether or not their clients had been abused ($r = .35$, $p < .005$). Among those who completed both questionnaires the increase in the percentage believed to be true, from 89.0% to 92.9%, was not significant. However there was a significant decrease, from 5.5% to 2.8% in the proportion of disclosures believed to be 'the result of psychotic delusions' (t (1,22) = 2.25, $p < .05$).

At the time of the training the average causal contribution of 'bio-genetic' factors were estimated as: Depression – 38%, PTSD – 22%, Schizophrenia – 52%. There were no significant differences in these beliefs following training, although all three scores fell slightly.

Prior to training there was a negative relationship between strength of belief in a bio-genetic etiology for schizophrenia and belief in the need to offer counselling ($r = .35$, $p < .05$).

### Changes in Self-Reported Behaviour Six Weeks After Training

Twenty out of 30 participants (67%) agreed with the statement 'The training session has changed my clinical practice'. Seventeen of these 20 provided examples. The majority of these related to increased knowledge, awareness and confidence: '*more confident about enquiry*', '*raised my awareness of need to ask*', '*now believe its OK to ask all clients*', '*more confident that it must be explored in initial assessment*', '*I know what to offer people*', '*more confident in my ability to respond appropriately*' and '*increased awareness of need to address abuse in therapy*'. Ten (33%) reported specific behavioural changes, including: '*check files more closely for abuse*', '*now I ensure that either myself or someone else working with the client asks about abuse*', '*document abuse*', '*I tend to ask the question quite early on in therapy*', '*phone abuse agencies to update my referral information*' '*give advice, especially about support networks*', '*I follow through re appropriate service*', and '*more able to support colleagues*'. Two of the ten who reported that their clinical practice had not changed wrote: '*current role limits opportunities to practice with this focus*' and '*with my client contacts new disclosures occur very rarely.*'

Of the total sample 35 (41%) had answered '*yes*' to 'Do diagnoses sometimes influence your decision whether or not to ask about sexual abuse?' All 35 identified one or more diagnoses which 'increase the probability of asking', most frequently: borderline personality disorder – 17 (20%), depression – 17 (20%), PTSD – 14 (16%), anxiety disorders – 8 (9%), alcohol/drug abuse – 6 (7%), and dissociative disorders – 5 (6%). Among the 31 participants completing pre- and post-training questionnaires the reduction, from 39% to 32%, for whom at least one diagnosis increased probability of asking was not significant. Eight (9%) of the total sample had identified diagnoses that decreased the probability of asking, most frequently: schizophrenia – 3 (4%) and bi-polar disorder – 2 (2%). There were no significant changes following the training.

Of the total sample 36 (42%) had reported that client gender sometimes influences whether they ask about sexual abuse, with 33% reporting that they were more likely to ask when the client was a female and 25% that they were less likely to ask if the client was male. Among the 31 completing both pre- and post-training questionnaires the slight reduction in the overall proportion influenced by gender following training (42% to 35%) was not significant Prior to the training five of the 23 male clinicians (22%), but no female clinicians, had been less likely to ask if the client was a female ($\chi^2$ = 14.10, $p < .001$). Three males (13%), and no females, had been more likely to ask if the client was a male ($\chi^2$ = 8.25, $p < .005$). These relationships remained significant following the training. The opposite pattern was true for female clinicians, although the relationships did not reach significance prior to the training. After the training six (30%) of the women, but none of the men, were less likely to ask if the client was a male ($\chi^2$ = 4.09, $p < .05$). Seven (35%) of the women, but none of the men, were more likely to ask when the client was a female ($\chi^2$= 6.04, $p < .05$).

Of the total sample 27 (32%) had reported that the client's age sometimes influences whether they ask about sexual abuse. Twenty-two (26%) had reported being more likely to ask if the client was between 20 and 40 years old, with the same number (26%) being less likely to ask a client who was over 60 years old. Among the 31 completing both questionnaires 29% were influenced by age at both pre- and post-training. Thus the training failed to change reported probability of asking in relation to either the clients' gender or age.

Prior to training the participants were asked to estimate, on a checklist, the percentage of times they responded to disclosures in the following ways:

- Offer to refer on for abuse-related counselling – average = 79% of disclosures
- Offer to provide abuse-related counselling yourself – 12%
- Provide information about sexual abuse – 58%
- Provide information about sexual abuse agencies – 78%
- Record disclosure in client's file – 86%

Only 17 participants completed this checklist in the post-training questionnaire (with several indicating they had had few or no disclosures since the training). There were no significant differences between pre- and post-training frequencies of responses.

For the first two training sessions (n = 25) the questionnaires included an open-ended item asking participants to list up to five things they would do immediately in response to a disclosure. (This item was discontinued to shorten the questionnaire). Prior to the training the most common responses were offering to refer for, or giving information about, counselling (17, 68%), affirming that it was a good thing that the client had disclosed (14, 56%), checking whether the client was now safe from abuse (14, 56%), and asking the client's views about a possible connection between the abuse and their current difficulties (8, 32%). Among the 11 who responded to both the pre- and post-training questionnaire the mean number of responses increased from 3.2 to 3.9, ($t$ (10) = 2.64, $p < .05$). The largest increases were for affirming that it was a good thing that the client had disclosed (from 36% to 82% of participants), asking how the client felt about having disclosed (from 27% to 45%), and checking whether the perpetrator posed a current risk to any one (from 0% to 36%).

## Discussion

### Study Limitations

Self-report, even under circumstances of anonymity, is open to social desirability and other biasing influences. Furthermore the period between the training and administration of the post-training questionnaire, while adequate for measuring attitude and knowledge changes, may have been insufficient to permit an accurate assessment of changes in actual behaviours (as indicated by several of the participants).

### Programme Limitations

Ten participants felt that the programme was either too short or required a follow up session. The latter would clearly be desirable, to consolidate learning and discuss the outcome when the new skills were deployed. One might also wonder whether there is an ethical issue about a one-day programme teaching staff to ask about abuse when there may not always be the resources within an agency to deal with the disclosures in terms of ongoing counselling. However, this was precisely why time was devoted to educating participants about community resources (including New Zealand's government subsidised and monitored abuse counsellors) and how to assist clients to access those services.

Only four of the 85 participants were psychiatrists. No psychiatrists have attended the four sessions since data collection ceased. Previous studies have also found this profession particularly unlikely to receive training in abuse issues (Lab et al., 2000; Currier et al., 1996). Given that psychiatrists are key members of multi-disciplinary teams and are frequently responsible for initial assessments and treatment plans it is important that incentives be developed, or barriers reduced, to facilitate their presence at such training programmes.

### Prior Training, Knowledge, Beliefs and Confidence

The training was clearly very well received by almost all the participants on the day. Furthermore it had a significant positive impact on confidence, and self-perceived abilities, in relation to both asking about abuse and responding to disclosures. The study provided additional support for the utility of training. Those who had previously received training scored significantly better on some key variables, which is consistent with previous studies (Currier et al, 1996; Currier & Briere, 2000; Young et al., 2001). The finding that age was positively correlated with previous training suggests that the staff were gaining training after gaining their professional qualifications and that relatively few recently qualified staff had received any training in how to ask about abuse during their formal training.

The finding that strength of bio-genetic causal beliefs, especially in relation to schizophrenia, was related to low belief in the importance of offering abuse counselling is consistent with a previous New Zealand study (Young et al., 2001). Young et al. also found that clinicians who believe a relatively large number of disclosures to be untrue are less likely to perform competently with abused service users, a finding confirmed by the current study in terms of belief in the importance of asking, and percentage of clients whose abuse histories are known.

The decrease, following training, in the percentage of disclosures thought to be delusions is important. The belief that abuse histories provided by service users diagnosed psychotic should not be believed is not supported by the relevant research (Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995; Dill, Chu, Grob, & Eisen, 1990; Read, 1997; Read et al., 2003).

### Changes in Self-reported Clinical Practice

Two-thirds reported, after six weeks, that the training had impacted their clinical practice. One third offered specific examples of actual behavioural changes. The training had no impact on the tendency of a significant minority of clinicians to be influenced by diagnosis, gender or age when deciding whether to ask. Nor did the training improve the percentage of clients for whom clinicians knew whether or not they had had been abused. There was some improvement in affirming clients for having disclosed and checking how they were feeling about having disclosed. Other desired responses

had not become more frequent. This is partly explicable by the high base-line frequency of some of the responses prior to training and partly, perhaps, by our not allowing enough time before administering the post-training questionnaire. Nevertheless it must be concluded, on the evidence available, that the training was highly successful in terms of improving confidence in one's abilities but achieved only moderate improvement in actual clinical practice within the six week follow-up period.

## Conclusion and Implications

It appears that the combination of skills-based and knowledge-based approaches, and the clearly structured but informal, collaborative and varied style of the facilitators were appreciated by participants. The consumer perspectives, role-plays, research summaries, and handouts were all experienced as valuable parts of a programme which, six weeks later, had a significant impact on confidence and a moderate impact on some aspects of clinical practice. The training should therefore be continued with minor refinements being made in accordance with feedback. The poor attendance by psychiatrists to date is a serious limitation that needs to be addressed by the trainers, senior psychiatrists and management. The programme should be considered by other mental health agencies, with variations according to local context and needs, which could be assessed by questionnaires to managers and clinicians about the specific barriers to asking and responding operating in a given locality (Young et al., 2001). Professional training institutions for mental health disciplines need to ensure that abuse inquiry and response is included in their curriculum.

Future evaluations of such programmes require a longer follow up period to allow for greater opportunities to deploy new knowledge and skills. It is suggested that between three and six months might be optimal, beyond which time period staff turnover might render the response rate too low for meaningful analysis. Interviews might be a useful adjunct to written questionnaires at follow up. An additional source of data would be a review of client files for staff that have, and have not, received the training.

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