Scottish Child Abuse Inquiry

Witness Statement of

Gillian ANDERSON

Support person present: No.

1. My name is Gillian Marlin Anderson. My date of birth is [redacted] 1967. My contact details are known to the Inquiry.

Background

2. I have a BSc Honours in psychology and a Masters of applied science in clinical psychology. From 1989 to 1990, I was an assistant psychologist in what's now NHS Forth Valley. From 1990 to 1992, I was a trainee clinical psychologist employed by Greater Glasgow Health Board and was attending the University of Glasgow. From 1992 to 1994, I worked as a clinical psychologist in Forth Valley. From 1994 to 1995, I worked as a clinical psychologist in Greater Glasgow Health Board. From 1995 to 2022, I worked as a clinical psychologist in NHS Lanarkshire. All my posts involved working with adults with learning disabilities, including my assistant post.

NHS Lanarkshire – Lead Psychologist Learning Disability Services

3. From 2001 until I retired in 2022, I was the lead psychologist in learning disabilities in NHS Lanarkshire. That role was across the whole health board area, which includes North and South Lanarkshire council areas. When I started in that role, there were only three of us in the team. When I finished, there were about fifteen of us. It therefore varied from three to fifteen staff providing services from Kilsyth down to practically England. We went as far south as Abington. It was from Shotts in the east to East

Kilbride in the west. South Lanarkshire is very rural so it covers a huge geographical area.

4. My responsibilities were to manage, develop and ensure that the clinical psychology service for adults with learning disabilities living in the NHS Lanarkshire area was implemented according to the needs of the people within that area. We were also tasked with ensuring that we were doing the most appropriate interventions and assessments for people. That was a lot of what my job involved. We did quite a lot of implementation of new interventions over the time that I was there. There's quite a lot of that still going on. There was a lot to do over the piece.

5. We had to take about five or six trainee psychologists every year. We were also involved in training nursing staff and care staff around the area, particularly in relation to people's support and needs. We had a multi-disciplinary team of psychiatry, nursing, psychology, physiotherapy, occupational therapy, dietetics, speech and language therapy. During the time that I was lead, both the hospitals in Lanarkshire, Birkwood and Kirklands, closed to long stay patients, although there is still an assessment and treatment service within Kirklands. We were involved in the discharge of people from those hospitals. We provided a lot of training around the people who were discharged into the community. My role therefore involved service development, implementation, providing actual psychological care and providing training to support the staff and other members of the team to maintain treatment within community settings.

6. I reported to the director of clinical psychology within NHS Lanarkshire. He and later she covered older people's psychology, all of the adult mental health psychological services, learning disabilities, neuropsychology, forensic psychology, the Ending Violence and Abuse against Women (EVA) services, and the V1P services, which provided mainly trauma services to ex-service people. It was a huge job and there were something like two hundred staff within those areas.

7. In our team, I was the lead but there was another consultant, who I suppose was like my deputy. We then had various people at various levels. There are bandings within the health service and five levels of psychologists. We also had assistant

psychologists, who worked with us on a temporary basis. They were looking to get into trainee roles. They supported our work and would do some of the work that didn't require a qualified member of staff. They might follow up on some work or go and do parts of the intervention for us. We had two teams, divided over North and South Lanarkshire. They were two different council areas that worked in different ways, which meant that we had to modify our systemic working. That made it easier in terms of how we linked with those authorities. The Scottish Government wanted mental health services to be co-led between NHS services and local authority social work services, but different social work departments worked in different ways.

8. Within Lanarkshire, there were ten localities. The localities were split between the psychologists and we provided care to those localities. Each of the psychologists also had specialisms. For example, I provided behavioural family therapy and 'Step Up and Beat It', which were interventions for anxiety. I oversaw those services along with a couple of other psychologists from across the teams. We would take referrals for those services from right across Lanarkshire. Similarly, there was a dialectical behavioural therapy service that took referrals from across Lanarkshire and had two or three of the psychologists working within it. We worked in geographical areas but we also had specific specialisms within the service that we all worked to.

Adults with learning disabilities who had previously been in care as children

9. Some of the people I worked with had been in care as children. The referral system changed over the years. At the time I was seeing some of the people who had been in care, the disciplines worked independently of each other. Although we did work as part of teams, each individual discipline took their own referrals. We had an open referral system. At that time, Monklands/Cumbernauld was my locality. That covered Cumbernauld, Kilsyth, Airdrie and Coatbridge. All the referrals that came in from that area would come to me. There was a waiting list. When people reached the top of the waiting list, I would see them, assess them and decide what sort of interventions there should be.

10. Most of our input with people who were able to understand, as far as possible, what we were trying to do was one-to-one. Their carers would often be involved in that. There were some people for whom we needed to work more with their carers alongside them. Service provision was usually in their day centre or their home. After 1996, we moved into unitary local authorities. We had two teams set up for North and South Lanarkshire. When referrals came in, they came to the teams where they were screened by nurses. It was decided at that point whether they needed a service and which discipline or disciplines were required. They were then referred by the nurse who did the screening to the particular discipline/disciplines required and if one of those included psychology then they were added to our waiting list. It was a better system because there was a central database of all the referrals. There were specific times by which assessments had to be completed and interventions commenced. We also had waiting times targets. It also meant that people weren't getting referred to all disciplines at once and probably made the system more efficient. Previously, it could be the case that some people were referred to all disciplines at the same time.

11. We're one of the few services where we don't get many referrals from GPs. Referrals would come from social workers or care managers and sometimes from families, people could also self refer. They often came from day services and support services like Richmond Fellowship and Key Housing. At one point, we did do a breakdown and I think referrals from GPs were about 5%. Social workers were the biggest referrers to our service.

Disclosures of abuse in care by adults in my service

12. In the course of my work, I heard reports from people that had been referred to me that they had been abused as children in care. They reported all forms of abuse, physical, sexual and psychological. Secondary Institutions - to be published later

Secondary Institutions - to be published later

13. Secondary Institutions - to be published later

Secondary Institutions - to be published later The people that I saw were all people who might have been described as having a mild learning disability. They would probably have been thought of as a little bit slower than their peers but possibly not thought of as having a learning disability at that time.

14. Secondary Institutions - to be published later

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Secondary Institutions - to be published later

17. None of the people that made disclosures to me spoke about medical restraint, such as use of sedatives. The reason I don't think anything was said about that is that a lot of people with learning disabilities think that receiving medication is the norm. There are still a lot of people on what's called as required medication, which they would get if there was a particular reason they required it, for example if they're agitated. My opinion is that they would see that as part of the normal process. None of the seven people who spoke to me said that they were given medication. I'm sure that did happen as part of the process, but that wasn't reported as abuse to me. Nothing was reported to me about neglect of personal care or the health of these people.

Prevalence of abuse amongst and risk of abuse to children with learning disabilities

18. Although I have knowledge of seven people making disclosures of abuse in care, I'm sure there were other people with learning disabilities in our service who had been abused in care. It wasn't always reported, but there were places that we were concerned about over the time I worked there. We raised concerns about them or about people. All through my career, child abuse has been a massive elephant in the room. It was something that I would ask about in any kind of therapeutic situation. I would ask them if anything like that had happened or if they'd been harmed when they were younger. From what the research says, people with learning disabilities are one of the groups that are most likely to be abused. A lot of them can't tell on their abuser.

19. It's public knowledge that we were involved in a case at one of the local day centres in 1996, 1997. A man was accused of sexual offences against adults with learning disabilities in an adult day centre in Lanarkshire. He had said to some of the people that they were special to him. One person made a disclosure, but not because he thought it was something abusive. He was just talking about his relationship with this person and thought that it was very positive. That was another way of getting into the lives of people with learning disabilities.

20. I think children generally are at increased risk of abuse. They're smaller. Depending on their age, they're dependent on adults for physical care and other forms of care. People with learning disabilities are often very isolated. If someone shows an interest in them or shows them any affection, that could be seen as a positive by the person with learning disabilities. Some of them can't speak so they can't tell on their abuser. Not so much now, but in the sixties, seventies and eighties a lot of children with learning disabilities went to special needs schools. They weren't with their peers and they were often segregated. They were often in care so they were being looked after by people who weren't members of their family, although that doesn't mean that family members don't abuse because they do.

21. There have been a number of reports about people with learning disabilities being abused in care settings in recent years. Going right back, Lennox Castle was exposed by a television programme. That led to a lot of new-builds and changes to systems. Abuse was also exposed by the BBC programme, *McIntyre Undercover*. There was also a school in Dundee exposed on a television programme around 2011. It was an NHS facility and the programme resulted in a massive inquiry. We had problems in Kirklands Hospital when I first started in my role. An ex-nurse was convicted of abusing patients and jailed. There was also physical abuse on one of the wards. It was reported in the media and led to a fairly lengthy programme of training and support for staff to ensure something like this didn't happen again. This process was led by the then medical director, Doctor Long.

Reporting and responding

22. Of the seven people I worked with who disclosed that they had been abused in care, I know that other members of my team were aware of the abuse some of them had experienced. They therefore had reported the abuse to other professionals. I don't know whether there were any reports out with that, for example to the police. I think some of the social work services also knew about what had happened [redacted] I don't know when they were told about that or whether any action was taken at that time.

23. I raised the disclosures of abuse [redacted] through my supervision and also within my team. I was told that people were aware of it and the school was closed. There was no information given to me about anything else that had happened as a result of that. There may have been something, but I didn't hear of it. When I took the disclosures to my team, we were fifteen years down the line from the abuse taking place. At that point, the limit for reporting abuse to the police was three years. My understanding at the time was that was the legislative time limit. By the time I was speaking to people, reporting the abuse was time-barred.

24. We would have multi-disciplinary meetings about people. For some people, there might only be a couple of us involved. We would meet and discuss what had been said. We wouldn't discuss everything because we were bound by confidentiality. If someone told me something and asked me not to discuss it with anybody else, I couldn't discuss it with anybody else. If somebody disclosed abuse to me that was not time-barred at that time, I would have disclosed it. We do let people know that. Only one person specifically said that I was not to share what they had disclosed. Another person told me that they had also shared it with their social worker and it was okay to speak to her about it. Another one I had picked up from my former boss. I knew that the disclosure of abuse was already part of their file. These were all things that were discussed and raised in my supervision. If there was anything else that I needed to do from that I would do it.

25. I didn't know the names of any of the people alleged to have carried out the abuse disclosed to me. I was therefore not in a position to determine whether those people were in positions where they could still harm children. It was mainly roles which were disclosed to me, such as being there at night or teachers. The people involved were night staff and one of the teachers [redacted] but nobody mentioned any names. It's possible the names had been forgotten or it was too traumatic to say the names. I probably would have asked people for names. If someone disclosed abuse, I would ask them who it was straight away. I don't think anybody did say a name to me. [redacted]

26. I'm aware that people reported abuse in care to others in my team, but I don't know particular people involved. [redacted] There have been other occasions when people might not have reported abuse, but we had strong suspicions. We tried to do everything we could to get to the bottom of it. Sometimes we managed but sometimes we didn't. There were situations when you thought that something wasn't right, but however much you dug you didn't get anywhere with it.

27. I didn't receive information from another team about an adult I worked with having experienced abuse as a child. I did see a file that I had requested and there were references to behaviours in childhood we'd now recognise as potential indicators of abuse, but had not been acted upon. That file would have been from the seventies into the early eighties.

28. I'm not aware of any reporting of the abuse the person had experienced in care. I wasn't working in Lanarkshire when the abuse was reported. I don't know if it was reported and what the response to that was. I do know that familial abuse had been identified and acted on. They were removed from the family home as a result of that. From then on, they were very well supported.

29. When I started working at NHS Lanarkshire, there was no formal guidance about receiving a disclosure of abuse. There is formal guidance now. Basically, any disclosure of abuse has to be reported immediately. We do not sit on any disclosures. I think that was brought in at some point in the 2000s. It was probably when I was lead, but I wouldn't be able to pinpoint an exact year.

30. I think the biggest factor that prevents people with learning disabilities from reporting abuse is that they can't report. They either don't have the language or they're not able to report. I also think that the experiences they've had may well discourage them from reporting. If they're not taken seriously about other things, they might believe that they won't be taken seriously if they report abuse. They may also think that they're in a positive relationship with their abuser and don't think that they've got anything to report. I think communication issues for people with learning disabilities and how much they are generally believed are probably the biggest factors that prevent them from reporting.

31. I hope it's not the case nowadays, but I think there might have been a time when children, not just children with learning disabilities, were not taken seriously when they reported abuse. They were told not to be ridiculous and that what they said was nonsense. Children with learning disabilities may have reported abuse and not been taken seriously. The issue may not only be about not reporting.

32. When I did my training and started work as a psychologist, I was aware that child abuse happened but I didn't ask anybody about it. Asking is the first step. I think most places do now have it as part of the initial assessment. People will be asked whether they were harmed as children. It's very much part of our training as psychologists now that if the patient says that they were harmed, this is taken seriously, and reported. I think those things have been helpful in supporting people to report abuse. If I think of the seventies, eighties and nineties, there were some abuse cases. There have been more and more reported cases in recent years. I think that the fact we ask and that we take disclosures seriously now has helped. We believe people who report abuse and we take the reports forward. I think the next stage is about what happens in the criminal justice system. That's still a difficult one for people. The challenges are that any kind

of abuse is usually one on one so corroboration is still required. Additionally, people with learning disabilities might not be viewed as competent witnesses. They can then be denied access to justice because of their learning disabilities. There have been some measures put in place for witnesses with vulnerabilities, but I think there's still a long way to go. The adversarial nature of the system continues to be traumatic for victims, whether or not they have a learning disability.

33. We were getting people from the age of sixteen to eighteen onwards. I would say that there were a lot more people coming to us towards the end of my career who had reported abuse or abuse had been discovered in childhood. They'd either been removed to places of safety or taken into care. We were aware of their histories. I think children are definitely reporting more or staff are recognising signs of abuse more. Staff are investigating things more readily. I think it varies in adulthood. People had often already disclosed or had abuse identified in their childhoods. They were coming to us with us being aware of the abuse as part of their history.

34. I think there are more disclosures nowadays. When certain television programmes are on, you tended to get more disclosures across the board. I don't think that's a bad thing. Sometimes it takes something to push people to report abuse. When I was a trainee, I worked in the Southern General for my adult mental health placement. There was a *Panorama*-type programme on television about sexual abuse. The following week, two women I saw for the first time both disclosed abuse. They had seen that programme and it was the first time either of them had ever spoken about their abuse. People with learning disabilities will see these programmes too. However, there are still a number of people who can't disclose. They don't have the understanding, communication or language to disclose.

35. I might be a bit off with my stats, but about 2.6% of the population will be defined as having a learning disability because of their IQ. About 50% of those people will have a mild learning disability. About 25 to 30% of them will have a moderate learning disability. These will all be people who probably have some language. People with a mild disability won't be that different from their peers. They might be less able academically, but they will have language and vocabulary. Some people with

moderate learning disabilities will have language and vocabulary too. The other 20 to 25% of people with learning disabilities will have very limited communication skills and will struggle to disclose abuse. What they do have is behaviours. Staff training and an ability to pick up on what people might do as a result of abuse is any area where I think we are getting a bit better. Previously, that would just have been perceived as "bad behaviour".

36. I think that each health board and social work area has guidance on how to respond to disclosures of abuse. As far as I'm aware, it's not national guidance. The Scottish Government's policy, 'One for Scotland', is currently being implemented. All our policies and procedures will eventually be national. Some of them are national now. They're gradually working their way through them. Every social work department and health board should have a procedure on dealing with disclosures of abuse, whatever the nature of that abuse. It was just before the Covid-19 pandemic that the Government started One for Scotland. We should all be using the same system. In the 1980s, Wales introduced the All Wales strategy, which covered health, social care and social work. It was amazing. It worked so well. Why don't we have something like that?

37. I've been employed during the times of various governments. There have been attempts to make everyone respond the same way to reports of abuse. Governments tend to want all health boards to do the same thing, but also expect each health board to meet their population's health needs. Each health board's initial task is to identify what the health priorities are within their area. That might be different across different health boards. There might be different demographics in different areas with different levels of health need. Health boards have to respond to the identified need in a way that's suitable for the population.

38. There have been increasing demands on returns of various statistics. For example, how many people are getting better, how many people are getting worse, how many people have a particular disease or disorder. There is a desire for health boards to be returning the same quality of statistics so that comparisons can be made across health boards. Different health boards differently resource the health services within their area. Some are fairly well resourced in mental health, but poorly resourced in other

areas or vice versa. The health board decides where the resources go according to the health needs within their population. It has to fit within the budget.

39. Through my work, I have been involved in specific cases where there was police involvement. They all went through the process. One of the cases was where abuse had occurred in childhood, but the case wasn't heard until the person was eighteen. They hadn't been a patient of mine at the time the abuse occurred. There have also been cases where abuse has been reported to the police and we've been present at interviews. We weren't acting as appropriate adults, but we were known to the individual and the police wanted someone they knew and who would be supportive. I've never been approached by the police asking me about allegations of abuse in general.

Impact

40. I don't even think you can start to measure the impact of abuse in care on adults with learning disabilities. I mentioned one person who I think had the worst level of abuse I've ever been aware of. The outcome for that person was that their life was never going to be remotely close to ordinary. Across the other people I saw who had been abused in care, I saw them because they were seen as being difficult people. My view is that a lot of these "difficult behaviours" were a response to the abuse they had experienced.

41. If you want to do health economics, all of those people cost the government, the health service, the forensic system, the penal service and social work services a lot of money. All of them required a lot of additional support. They were in and out of hospitals and low secure settings. One person has a 24 hour, very expensive care package which isn't going to change. If we can stop people being abused or do something about that, we might not be spending so much later on. That's from a purely economic point of view and that's not my main concern. I think their lives have gone down a particular path that they wouldn't have gone down if they hadn't been abused. If you talk to anybody who has been abused, they'll tell you how major the impact has been.

42. I did see the impact of abuse on the family of one of the people who went to the children's home [redacted] The family thought that they were doing the right thing when their child went into the children's home. They were absolutely devastated by the abuse. [redacted] We were thirty, forty years on from when the abuse had happened. The mother, who was in her late seventies, cried about what happened every time I went into that house. That's the impact.

43. Of the people who had gone to the school, three of them were estranged from their families and had been out of the home since they were teenagers. Two of them were supported in their own accommodation. One of them didn't have a great deal of contact with their family. The other's mother had died and they didn't have contact with their dad. That meant that I didn't have contact with their families.

44. I think the impact could be mitigated by these people receiving a big sorry for a start. These are people in their fifties and sixties now. I think it's important to acknowledge that what happened to them was not okay and that it's had an effect on them. I think that financial redress often speaks louder than words for some people. It could make their lives easier. One person has a good level of support and money is not going to do much to change their quality of life. Another is pretty much living hand to mouth. Financial compensation would make a big difference to their life.

Helping the Inquiry

45. I think there are things that might help people with learning disabilities come forward to the Inquiry. The Scottish Consortium for Learning Disabilities (SCLD) would be somewhere that the Inquiry could go. There are also places like Enable. There is a whole host of organisations, like Key Housing, the Richmond Fellowship and Cornerstone, whose main focus is the support of people with learning disabilities. They may be places to go to spread the word about the Inquiry. SCLD might be able to help in getting it out to people in a form that they understand, through a medium that they understand and with people who know them very well and know the best way to do

things with them. I think the Inquiry needs to start at an organisational level. If it's online or on the TV, I don't think that people with learning disabilities will necessarily see that and be able to take steps to make contact or apply.

46. I attended something about the Inquiry for health workers and social workers around 2017, 2018. It came from the health board and was for people working in mental health services. It was to tell us about the remit of the Inquiry and how evidence was being taken. I did think at the time that we were the wrong people to be there. I think it needs to be people who are working with people with learning disabilities day to day, directly, spending time with them and talking to them all the time. That's the people who support them.

Lessons to be learned

47. I think awareness of abuse is a massive thing. Professionals need to be aware that abuse is something that can happen and does happen. The vulnerable people are people like children, disabled people, people who have communication difficulties and learning disabilities. Training for professionals is important. Abuse does happen in families, but most of the abuse I was aware of took place in institutions or services and paid staff were the perpetrators. We need to make sure that from an early stage everybody has an awareness and knows what to look for. People looking after our children, whether that be nursery workers or foster carers, must be paid, trained and vetted appropriately.

48. There have been step changes over the years. I'm giving evidence to the Inquiry because it's now being taken seriously. That's a massive leap from a point where people were not believed and sometimes ridiculed. Abuse does happen and it happens everywhere. People are more aware and more willing to talk about it. That's already happened. Now we have to look at the support for people, and their families, who have experienced abuse. We need to support the people who are supporting those who have been abused. Listening to accounts of abuse has an effect on supporters as well. In a perfect world, abuse wouldn't happen and we would have

those things in place from the day somebody is born onwards. We would be trying to prevent abuse rather than dealing with the consequences. The consequences are really expensive. If we can put money into prevention, which is about training and supporting staff across all the care sectors and pulling it all together, then we can make it work from day zero onwards.

49. The risk of people with learning disabilities experiencing abuse could be minimised by making sure the people caring for them are not going to abuse them. I don't know how you do that. Some people get themselves into these roles and positions to do just exactly that. Some of the things that happen are cultural. I'm not excusing that, but people can go into a situation where there's already a fairly toxic culture. They then get pulled into those cultures. Good training and good support helps to break those cultures. People also need to be paid well to do the work that they're doing. Within the care sector, the sort of pay people get is appalling. People are paid better to work in Lidl than they are to look after people with learning disabilities. If you're not valued, how can we expect you to value the people you're caring for? I think we need to radically overhaul our care services.

50. I think we also need to value the people we're caring for. If we're saying that it's okay to pay people the minimum and give them no training, we're not valuing the people they care for. Within the NHS, we used to be able to provide a lot of training to care staff as part of our input to individuals. To give care staff training now, they have to use the hours they're supposed to give to the person being cared for to get the training. They're only paid for the amount of time they spend with the person. That means that person loses support so we can train their carer. What does that say we think about the people we're caring for?

51. It's about choosing the right people to do the work, paying them appropriately and changing our attitudes towards the people they're caring for. It's systemic. At the moment, recruitment into care services is very difficult and there is also a big turnover partly because the pay is fairly poor. Organisations are desperate to recruit. A lot of care organisations are having to use agency staff, which costs a lot more. The way it's

all set up is just wrong, in my opinion. There's no wriggle room to do anything differently.

52. I know that people with learning disabilities have been a group that haven't been very forthcoming when it comes to reporting abuse. I think that's for a variety of reasons. I'm on the board of Key Community Supports. I've spoken to the CEO there. I think there are people they support who would be willing to speak to the Inquiry but just don't know how to do it. They would need support. Within Key, every individual has a team of workers who know them very well. The head of support is looking at ways that they can help people to apply to the Inquiry. I think that they would need to have their support workers with them. The people involved are unlikely to be teenagers or in their twenties. It's likely to be people in their thirties, forties, fifties and sixties. They are people who will have been with Key for a long time so their support workers know them very well. They've usually been working with them for a fairly lengthy period of time. They'll need support because of what they went through in care, but also from the point of view of aiding understanding of the process and why it's happening now when the abuse occurred such a long time ago. They would need more specific support than people who don't have learning disabilities.

53. Those who don't have the language to communicate are extremely vulnerable because abusers are aware of that. A minority of people do get into positions to perpetrate particular acts. They're seeking out people to abuse. I'm not sure what we do about that. I think we can do some of the other things through training, changing the way that we pay people and changing how we regard the care sector. I think there are things that can help, but I don't know what you can do about the few people who set themselves up to abuse vulnerable people.

54. When I started working in learning disabilities, if you started seeing somebody then they remained on your caseload throughout your working life. You can't actually cure a learning disability so why not? The argument was that if a person had a mental health difficulty or a behaviour that was perceived as challenging then you should be able to provide intervention that would help ameliorate the condition and then discharge them. We were more focused on through-put. People would be discharged after specific

interventions. All this means is that people keep coming back, almost like a revolving door. I don't think we should be doing that. I think we should be providing support continuously. If you go to a mental health service, you're seen for a period of time and then you're discharged. I think for people with learning disabilities and probably a lot of mental health issues as well that support should remain ongoing, but it doesn't. I'm not suggesting that we go back to hospitals and large centres for people with learning disabilities, but we need to try and make sure people aren't falling through the cracks or getting dropped too quickly.

55. I have no objection to my witness statement being published as part of the evidence to the Inquiry. I believe the facts stated in this witness statement are true.

Signed.........[redacted]..

Dated.......................8|4|24..