

# Sexual abuse and therapeutic services for children and young people in Northern Ireland

The gap between provision and need

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# Contents

<b>List of figures</b> .....	<b>4</b>
<b>List of tables</b> .....	<b>5</b>
<b>Section 1: Introduction</b> .....	<b>6</b>
<b>Section 2: Policy and service framework in Northern Ireland</b> .....	<b>8</b>
Structures and service providers .....	8
Policy context.....	8
Tiers 1 and 2.....	9
Tier 3 .....	10
Tier 4.....	10
Statistics – the need for therapeutic services in Northern Ireland.....	13
Police statistics .....	14
<b>Section 3: Methodology</b> .....	<b>17</b>
Aims .....	17
Phase 1 .....	17
Phase 2 .....	18
Analysis.....	19
Ethics.....	19
Limitations .....	19
Report structure.....	20
<b>Section 4: Findings</b> .....	<b>21</b>
Type and coverage of service.....	21
In-depth interviews.....	25
Referral criteria and sources.....	26
In-depth interviews.....	28
Ability to meet demands .....	29
In-depth interviews.....	31
Models of therapy offered.....	33
In-depth interviews.....	34
Working with others.....	34
In-depth interviews.....	35
Staffing levels and funding .....	36
In-depth interviews.....	40
Service accessibility .....	40
In-depth interviews.....	44

Reviewing and improving service..... 45

In-depth interviews..... 47

Training and supervision..... 48

In-depth interviews..... 49

Number of referrals ..... 50

Gaps and challenges ..... 54

In-depth interviews..... 55

Commissioning process ..... 57

In-depth interviews..... 57

**Section 5: Summary of key findings ..... 61**

**Section 6: Discussion ..... 65**

Service coverage ..... 65

Service accessibility ..... 66

Meeting demands ..... 68

Models of service provision ..... 69

Training and supervision..... 70

Monitoring and review ..... 71

Gaps and challenges ..... 72

**Section 7: Key gaps and recommendations..... 73**

**Section 8: References ..... 76**

## List of figures

Figure 2.1: Percentage of children in Northern Ireland by health and social care trust area (2007 mid-year population estimates).....	13
Figure 4.1: Types of services providing therapeutic support (n=47) .....	24
Figure 4.2: Area of service provision (n=47).....	24
Figure 4.3: Age of children and young people who received a therapeutic service in relation to sexual abuse in 2006/07 .....	53
Figure 4.4: Numbers of children and young people who received a therapeutic service in relation to sexual abuse in 2006/07 by main reason for referral.....	53

## List of tables

Table 2.1: Sexual offences recorded against children and young people under 18 years 2002–2007.....	15
Table 2.2: Offences against the person and sexual offences involving victims under the age of 18 in 2006/07 by age.....	16
Table 4.1: Service eligibility criteria (n=47) .....	26
Table 4.2: Service referral sources (n=47).....	28
Table 4.3: Estimated typical waiting time between referral and therapy.....	29
Table 4.4: Capacity of services to meet the demand for therapy for children and young people who have been sexually abused .....	31
Table 4.5: Therapeutic models used by services (n=44).....	33
Table 4.6: Working with others (n=47) .....	35
Table 4.7: Numbers of professionals available to services (n=45).....	36
Table 4.8: Types of professionals available to all services (n=45).....	37
Table 4.9: Types of professionals available to specialist services (n=6).....	38
Table 4.10: Non-professional qualified staff available to services (n=45).....	38
Table 4.11: Additional experience and skills required for different professional groups.....	39
Table 4.12: Number of years for which funding is secure (n=47).....	40
Table 4.13: Access for service users with additional needs.....	42
Table 4.14: Ways of improving service quality (n=47).....	46
Table 4.15: Ways in which the services take into account children and young people's views and family/carer service users' perspectives in informing policy and practice (n=47).....	47
Table 4.16: Quantity and quality of staff training and supervision .....	49
Table 4.17: Numbers of children and young people services worked with in relation to sexual abuse.....	51
Table 4.18: Numbers of children and young people who received therapeutic service in relation to sexual abuse in 2006/07 by type of provision .....	52

## Section 1: Introduction

Research with young adults in the UK has found that 16 per cent (11 per cent of males and 21 per cent of females) reported experiences of sexual abuse in childhood (Cawson et al, 2000). Childhood sexual abuse has been associated with both short- and long-term mental health problems such as anxiety, phobic reactions, guilt, substance abuse, difficulty trusting others, low self-esteem and dissociation (Walker, 1988), and depression and even suicide (Briere and Runtz, 1987). *The Corston Report* (Home Office, 2007) highlights criminality as a very real potential consequence of these problems, revealing that a high proportion of female inmates have a history of sexual abuse. Research also suggests that individuals with a history of sexual abuse and victimisation are at a greater risk of re-victimisation (Messman and Long, 1996; Roodman and Clum, 2001). More recently Finkelhor et al (2007) found that a significant number of children experience more than one type of violence (referred to as “poly-victims”).

Therapeutic services aim to address the mental health issues arising from such abuse. However, across the UK there are significant information gaps in the area of service provision for child sexual abuse victims and little is known about the availability and accessibility of support and therapeutic services for this group. This research, which was generously funded by the Private Equity Foundation, aimed to address this gap in our current knowledge by mapping the availability of therapeutic services that support children and young people affected by sexual abuse across the United Kingdom.

A full UK report (Allnock et al, 2009) was published in July 2009. This report details the UK-wide findings from the research, as well as providing a comprehensive review of the research literature relating to sexual abuse and therapeutic service provision. A summary is available from [www.nspcc.org.uk/Inform/research/Findings/sexual\\_abuse\\_therapeutic\\_services\\_wda67007.html](http://www.nspcc.org.uk/Inform/research/Findings/sexual_abuse_therapeutic_services_wda67007.html)

The current report specifically examines the policy and service framework and research findings as they relate to the Northern Ireland context. The data collection for the Northern Ireland component of the research was conducted between February and July 2008, a period of huge structural change throughout health and personal social services in Northern Ireland. This change is still ongoing and the practical implications for therapeutic provision for children and young people remain to be seen. Nonetheless, the report for the first time provides insight into the nature and coverage of such provision, examining issues such as geographical coverage, referral criteria, staff numbers and qualifications, issues of accessibility, and training and

supervision. The implications of these findings are discussed within the current policy framework and broad recommendations are put forward for consideration.

## Section 2: Policy and service framework in Northern Ireland

### Structures and service providers

As in England, Wales and Scotland, therapeutic provision for children and young people who have been sexually abused involves a range of service providers largely from the statutory and private sectors. However, Northern Ireland differs from other health structures in the UK in that it has an integrated health and social care system. This integrated system has recently undergone significant changes under the review of public administration (RPA) launched by the Northern Ireland Executive in June 2002. Prior to the review, Northern Ireland had 19 trusts, which were responsible for the day-to-day running of health and social care services as commissioned by the four regional health and social services boards (HSSBs) and the local health and social care groups (LHSCGs). Under RPA the trust structure changed in April 2007 from 19 trusts to five health and social care trusts (HSCTs). The four HSSBs were replaced on 1 April 2009 by a single health and social care board. Under these new arrangements the five HSCTs are responsible for the provision of therapeutic services, which are currently commissioned by the Health and Social Care Board.

The Bamford review of child and adolescent mental health and learning disability services across Northern Ireland – Bamford Review of Mental Health and Learning Disability (Northern Ireland), 2006 – outlined a four-tier model of service delivery. While not specific to sexual abuse therapeutic provision, this model provides a useful overview of general mental health provision for children and young people in Northern Ireland (see pages xx8 for details of the tiers).

### Policy context

#### Children and young people who have been sexually abused

The central piece of legislation relating to child welfare and protection in Northern Ireland is the Children Order (NI) 1995. This enshrines two important principles: first, that in making decisions about children, the welfare of the child is the paramount consideration; and second, that wherever possible, interventions should focus on prevention and voluntary work with parents and others to support children and families in the community. Alongside this legislation, the Department of Health, Social Services and Personal Safety (DHSSPS) publishes guidance detailing how agencies should cooperate with each other to promote the welfare of and to safeguard children. The most recent version, entitled *Co-operating to Safeguard*, was last issued

in 2003. This provides definitions for sexual abuse and outlines child protection processes to be followed if a child is suspected to be at risk of significant harm.

However, the 2006 review of child and adolescent mental health and learning disability across Northern Ireland – Bamford Review of Mental Health and Learning Disability (Northern Ireland), 2006 – highlighted the lack of strategic oversight in relation to the development of post-abuse intervention services for children young people. It concluded that:

“...strategies for the provision of post-abuse intervention services for children and young people, and for the provision of assessment and treatment services for children and young people who display sexually harmful behaviour, should be developed and implemented. These strategies may need to include the contribution of CAMHS and set out how treatment and protection services will be co-ordinated and integrated across disciplines and agencies.” (p47).

### **Tiers 1 and 2**

Tier 1 offers interventions to children with mild to moderate mental health problems accessible across Northern Ireland, while tier 2 is the first line of specialist services, more often involving individual specialist practitioners rather than specialist teams. The Bamford review noted limited development of tier 1 and 2 services in Northern Ireland. Nonetheless, it acknowledged some tier 1 developments in the education and voluntary sectors, as well as tier 2 developments, such as services for children with attention deficit disorder (ADHD) and autistic spectrum disorder (ASD) in some areas, and a number of health visitors and clinical psychologists using a behavioural and family counselling model to address the developmental needs of young children up to final year in primary school.

Other service providers at tiers 1 and 2 were identified as:

- adolescent support services/projects provided by a range of professionals
- Sure Start early intervention programmes
- statutory and voluntary family centres
- education departments providing pastoral care and school-based counselling services
- educational psychologists, educational welfare officers, and emotional and behavioural support teams
- youth justice services
- a range of voluntary and community providers.

**Tier 3**

These services are more specialised and are staffed by specialist CAMHS professionals from tier 2 who become tier 3 workers when they function together as teams for particular children and families. There are specialist CAMH services across Northern Ireland in each of the board areas. These are delivered by psychiatrists, clinical psychologists, specialist nurse therapists, social work practitioners and, in some cases, family therapists and child psychotherapists.

**Tier 4**

Tier 4 services deliver very specialised interventions and care for the most complex or uncommon disorders or illnesses. At the time of the review they comprised mental health inpatient and secure residential care units. Inpatient psychiatric services and secure residential care services for children in the care system are delivered on a regional basis by separate providers in Northern Ireland.

More recently the government strategy on preventing sexual violence 2008–2013 (DHSSPS and NIO, 2008) has outlined plans to develop a more strategic approach to supporting victims, identifying the need to provide and deliver easily accessible, coordinated, quality support services for victims/survivors and their families as a key objective. A major element of the support component of the strategy is to provide a sexual assault referral centre (SARC) for Northern Ireland. A SARC is a one-stop location where female and male victims of rape and serious sexual assault can receive comprehensive forensic, medical and support services. It is planned that this new facility will be located in the Antrim Area Hospital and will provide services to children and young people as well as adults. The SARC will be operational by the end of 2010.

The strategy recognises that children who have been sexually abused or who display sexually harmful behaviour are often found among those who have the worst predicted life outcomes and that, given the very specific nature of child sexual abuse, therapeutic services should be provided by a specialist service rather than by general children's counselling services. A recent mapping of psychological therapies in Northern Ireland (Bolton and Rankin, 2008) commissioned by DHSSPS further supports the need for greater specialism in this area. The mapping identified a total of 99 relevant services across Northern Ireland, 39 of which reported being children's services, covering a wide range of specialist disorder areas or needs. Within mental health services, this included anxiety disorders, depression, trauma, psychosis, eating disorders, adult survivors of child sexual abuse, borderline personality disorder, child abuse, addiction, adult sexual assault, sexual offending and criminology/forensics. Overall,

the mapping identified a total of 392 disorder areas across 69 mental health services, giving a mean of six areas per service. This finding led the authors to question if the number of specialities evident in mental health service provision is currently spread too thin:

“...should we...not be moving to services specialising in fewer areas or needs, benefiting from the development of expertise and the scarce and skilled supervision and support arrangements required to optimise practice?” (p40)

In addition to advocating the need for specialist service provision in this area, the sexual violence prevention strategy also commits to:

- support counselling services in schools to ensure that children and young people who are victims of sexual abuse are identified and referred to appropriate support in line with the regional procedures on child protection
- develop and publish guidance for professionals on therapeutic support, to assist in ensuring that children and young people are not denied assistance in advance of a court case.

The strategy also stresses the ways in which victims/survivors of sexual violence and abuse access services depend upon their own individual circumstances: formal pathways (usually beginning with the police) and informal pathways with friends and family. As such, the support strand of the 2008/09 action plan for implementing the strategy requires HSSBs and HSCTs to specify how ongoing support services will be delivered in conjunction with statutory, voluntary and community sector partners, and included in budget agreements with trusts, service delivery plans and service level agreements with voluntary and independent sector providers. It also aims to:

- produce guidance on therapeutic support for children and vulnerable adults pending criminal investigation in relation to their cases
- develop and implement regional standards for recruitment, management, training and support of staff (including access to staff care services) dealing with victims and survivors of sexual violence and abuse.

Furthermore, the recently published *Standards for Child Protection Services* (DHSSPS, 2008) establishes an overall framework to deliver continuous improvement and strengthening of such services in Northern Ireland and their associated accountability arrangements. Standard 7 of the publication stipulates that:

“There are agreed protocols, structures, staffing, management and auditing arrangements in place for ensuring effective interfaces and joint working arrangements for children in need of residential care, across fieldwork, CAMHS, adult mental health services and other agencies. These facilitate the comprehensive assessment, risk management and care planning process and the provision of the appropriate therapeutic interventions and supports that are required for children and families.”(p24)

The standards also indicate that, across health and social services boards (HSSBs), health and social care trusts (HSCTs) and agencies, there should be an agreed, planned programme of audit for the full range of child protection services. This should include the regular review and audit of therapeutic interventions and professional practice, and their effectiveness in achieving specified outcomes for children.

### **Children and young people who display sexually harmful behaviour**

*Co-operating to Safeguard Children* (DHSSPS, 2003) also provides the policy framework for working with children and young people who display sexually harmful behaviour. The 2003 guidance, implemented in conjunction with regional area child protection committee procedures (Eastern ACPC, Western ACPC, Northern ACPC, Southern ACPC, 2005) places an emphasis on early multi-agency intervention and assessment of risk, together with access to specialist services. The Southern Area Child Protection Committee (SACPC) has also developed specific policies and procedures for working with young people who engage in sexually harmful behaviour. These require all cases to be referred to a specialist NSPCC project, the completion of a full multi-agency assessment and set out the components of treatment.

However, despite these developments, Yiasouma, Gossrau and Leonard’s (unpublished) audit of case files and interviews with professionals working with this group notes that current ACPC policy and procedures are not sufficient to support or guide assessment and interventions with children and young people who display sexually harmful behaviours. To this end, their research recommends “the introduction of an over-arching and comprehensive NI-wide policy and procedures when working with children and young people who display sexually harmful behaviours” and suggests that “the impending Safeguarding arrangements must give clear (mandatory) regional protocols with regard to the decision making processes, including a specific category assigned to these children and young people.”

The sexual violence prevention strategy (DHSSPS and NIO, 2008) develops much of this, stipulating that:

- each trust must ensure that any such child identified as engaging in sexually harmful behaviour is considered as a child in need
- any assessed risks are managed through child protection processes with the child and their carer(s) being offered therapeutic counselling.

The action plan also gives an undertaking to explore existing tools to determine the best method of assessing risks posed by children and young people who display sexually harmful behaviours.

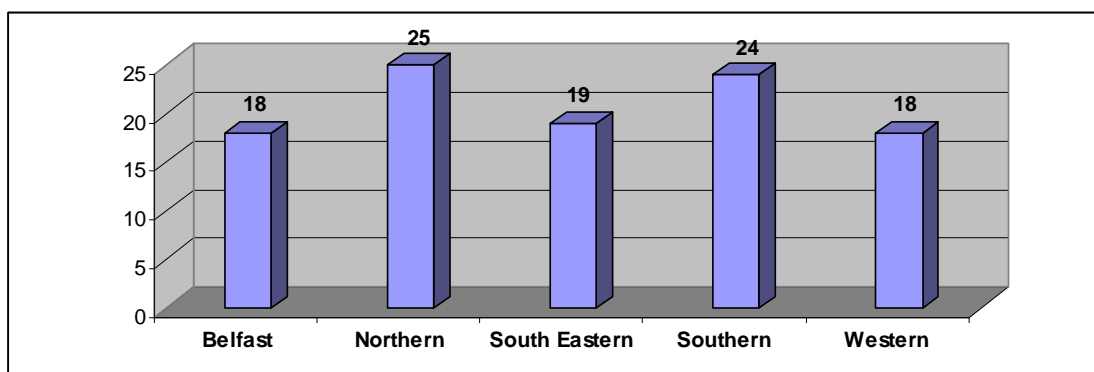
**Statistics – the need for therapeutic services in Northern Ireland**

**Population estimates**

The mid-year population estimates for 2007 (NISRA, 2007) indicate that the population of children aged under 18 in Northern Ireland is 431,867. Based on this estimate, children equate to approximately 25 per cent of the total population.

The Northern HSCT has the highest proportion of children, accounting for a quarter of the Northern Ireland child population, followed by the Southern HSCT at 21 per cent, the South Eastern HSCT at 19 per cent and then the Belfast and Western HSCTs, which both have 18 per cent of the Northern Ireland child population residing within their boundaries (see figure 2.1).

**Figure 2.1: Percentage of children in Northern Ireland by health and social care trust area (2007 mid-year population estimates)**



Source: DHSSPS (2007)

**Child protection statistics**

During 2006/07, 21,456 (approximately one in 20) children were referred to social services a total of 31,930 times (some children were referred more than once) (DHSSPS, 2007). This

resulted in a total of 2,320 investigations completed under child protection procedures. It is not known what the concerns were in these child protection cases.

However, there were 1,305 registrations to the child protection register during this time period and, overall, the number of children placed on the register for sexual abuse in 2006/07 (whether alone or in conjunction with another form of abuse) was 221. Figures (215 in 2005/06 and 243 in 2004/05) suggest a fair amount of annual variation, although this equates to a rough annual figure of approximately 225 child protection registrations involving sexual abuse of some kind. This group would form the core group who enter the child protection system each year who are likely to be in need of therapeutic support services with regard to sexual violence.

Children who are looked after by the HSCTs will also form part of the core group of children and young people who have experienced sexual abuse and require support services. Statistics for 2006/07 indicate that there were 833 admissions to care during that time. While some overlap between those children and young people on the child protection register is to be expected, most of the looked after children (LAC) who were on the register will be removed shortly after entering the care. Furthermore, at the end of March 2007, a total of 2,356 children were looked after, 80 per cent of whom had been looked after for more than one year. While the exact numbers of children in long-term care who have experienced sexual abuse are not known, a proportion of this group will likely require ongoing support and therapy in relation to sexual abuse experiences.

### **Police statistics**

Statistics collated by the Police Service for Northern Ireland (PSNI) provide a much broader overview of sexual abuse cases that are reported to the criminal justice system. There were 855 recorded sexual offences against children and young people aged under 18 years in 2006/07. Of these offences, 55 per cent were classified as indecent assault, 20 per cent as rape/attempted rape, 11 per cent as unlawful carnal knowledge, 7 per cent as indecent exposure, 4 per cent as indecent conduct towards a child and 3 per cent as other sexual offences (PSNI Central Statistics Unit, 2007). Almost three in five (58 per cent) sexual offences were recorded against teenagers, while the remaining 42 per cent were recorded against children up to 12 years of age.

Current guidance stipulates that, where a victim is a child, “joint protocol” investigation procedures involving PSNI and social services should be implemented. Although child protection statistics are not available for the number of joint protocol investigations undertaken specifically in relation to sexual abuse, the overall figure of 316 presented in the

2006/07 child protection statistics is clearly considerably lower than the total number of sexual offences recorded against children and young people in the same year. Reasons for this disparity are not clear: it may be that many cases do not have child protection concerns (for example, a one-off sexual assault/rape by non-family members may account for much of this disparity); or discussion may take place between police and social services without a full joint protocol investigation being implemented.

Together, these statistics provide an overview of sexual violence cases involving children and young people, which are known to statutory agencies and service providers. However, as the findings from the UK prevalence study (Cawson et al, 2000) demonstrate, the actual incidence of abuse within the child population is substantially higher. At any given time there are a considerable number of children and young people who have experienced sexual abuse and who need therapeutic support but have not made any disclosures or accessed a support service in relation to this.

**Table 2.1: Sexual offences recorded against children and young people under 18 years 2002–2007**

<b>Sexual offences</b>					
Rape (including attempts)	164	170	166	154	178
Indecent assault (males and females)	424	541	454	494	474
Unlawful carnal knowledge of a girl	44	68	65	67	86
Buggery	25	23	13	0	0
Indecent conduct towards a child	33	24	15	34	33
Indecent exposure	144	172	188	88	61
Other sexual offences	17	14	27	31	23
<b>Total</b>	<b>851</b>	<b>1,012</b>	<b>928</b>	<b>868</b>	<b>855</b>

Source: PSNI Central Statistics Unit (2007)

**Table 2.2: Offences against the person and sexual offences involving victims under the age of 18 in 2006/07 by age**

	Age																	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
<b>All sexual offences</b>	5	3	9	28	27	35	38	52	30	38	33	26	57	84	101	132	102	55
Rape (including attempts)	2	1	1	2	4	3	8	8	5	7	6	3	14	18	22	27	29	18
Unlawful carnal knowledge of a girl under 14	0	0	0	0	0	0	0	0	0	0	0	1	3	9	0	0	0	0
Unlawful carnal knowledge of a girl 14 and under 17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21	32	20	0
Indecent assault on a female	3	0	6	15	15	19	16	18	16	20	17	15	23	32	43	46	38	27
Indecent assault on a male	0	2	2	8	2	11	8	15	4	4	5	6	7	2	4	13	6	6
Indecent exposure	0	0	0	0	1	1	1	5	2	2	3	0	7	16	7	6	7	3
Other sexual offences	0	0	0	3	5	1	5	6	3	5	2	1	3	7	4	8	2	1

Source: PSNI Central Statistics Unit (2007)

## Section 3: Methodology

### Aims

Across the UK there are significant information gaps in the area of service provision for child sexual abuse victims and little is known about the availability and accessibility of support and therapeutic services for this group. The project aimed to address these gaps in knowledge and feed into current policy developments in Northern Ireland through:

- mapping the current availability of therapeutic services for children and young people who have been sexually abused, raped or sexually exploited, including those who have also displayed sexually harmful behaviour
- evaluating the accessibility and approachability of services to children and young people
- considering the provision of services in relation to the identifiable demand and need
- interviewing professionals working in therapeutic services about the accessibility of services, interagency working and how to deal with any areas of unmet need.

### Phase 1

Phase 1 of the Northern Ireland component of the mapping project involved a telephone survey with managers of statutory/voluntary-based therapeutic services and using a national questionnaire to map the provision of services geographically in order to identify the range of services available and any gaps in provision.

### Identification and eligibility of services

Initially, potentially relevant services were identified through contact with NSPCC services as well as directories of services provided on HSCT websites. The director of children's services (or equivalent) in each HSCT was contacted in relation to the mapping and each appointed a HSCT link person to assist with further development of the service list. Relevant managers/practitioners in each HSCT were also contacted to confirm service locations and details within their catchment area. The final contact list comprised a total of 67 potentially relevant services, including voluntary and statutory sector specialist provision, child and adolescent mental health services, family centres, looked after children therapeutic services, a small number of criminal justice projects and a range of non-specialist voluntary sector

services. Each of these services was then individually contacted to ascertain if they were relevant to the mapping exercise and, if so, asked to participate.

In order to ensure that the appropriate range of services was represented, a broad, self-labelling definition for therapeutic services was adopted, which sought to include all services, mainstream and specialist, which considered themselves to be providing a therapeutic service to children and young people who had experienced sexual abuse. Where services were unsure if they were relevant or not, managers/practitioners were asked if they had any service users who were victims of sexual abuse and, if so, if they worked therapeutically with them in relation to their abuse experiences or if they tended to refer on to another service. Where the service engaged in some level of direct therapeutic work with the children and young people, it was included in the mapping. In total, 47 services participated in the mapping and provided information. In a majority of cases the information was provided in relation to one specific service by a service manager or team coordinator. In four cases, a senior manager provided information on more than one service provided by the agency or organisation. Twenty of the services were found not to be relevant and one relevant service refused to participate.

### **Questionnaire design**

The questionnaire developed for the first phase of the mapping was primarily quantitative in design and covered a wide range of service provision issues, including staff qualifications, models of therapy and numbers of referrals. It was initially designed and developed by the research team, in consultation with NSPCC and external practitioners. The questionnaire was piloted among NSPCC staff across each of the UK jurisdictions.

### **Phase 2**

The second phase involved follow-up interviews with a small sample of service providers and commissioners to obtain their views on needs and service availability. In total, 10 in-depth interviews were completed involving six service managers (identified from phase 1) and four commissioners across two HSCT areas (one urban, one urban/rural). It was intended that interviews in each HSCT would involve:

- one commissioner at board level (since completion of the research the HSSBs have been replaced by one regional health and social care board)
- one commissioner at HSCT level
- one manager of a mental health based service

- one manager of a statutory project
- one manager of a voluntary project

However, as it was not possible to interview CAMHS practitioners in one HSCT location, two CAMHS practitioners were interviewed in the other HSCT area, giving a breakdown of four interviews in one HSCT and six in the other. All interviews were recorded, fully transcribed and lasted an average of 40 minutes.

## **Analysis**

Data from the telephone interviews was inputted using the statistical software package SPSS (version 14) and descriptive statistics produced. The qualitative data collected from the interview phase of the projects was analysed using the software package N\*UDIST 6. The analysis made use of the structured question format provided by the interview schedules, as well as identifying common themes and issues emerging from the data.

## **Ethics**

Ethical approval for the mapping research for all four jurisdictions was given by the National Research Ethics Service (NRES), as well as the NSPCC and Edinburgh University ethics committees. In addition, permission to contact relevant services and managers was obtained via the research governance approval processes in operation in each of the five HSCTs in Northern Ireland. Additional research governance approval was granted by the two HSCTs selected to take part in the in-depth interview phase.

## **Limitations**

While all efforts were made to include as many relevant services as possible, some may not have been appropriately identified and included in the project. For example, two services, one statutory and one voluntary, came to the attention of the mapping team after the research was completed and are not included in the final analysis (see pages 14–15 for details). Nonetheless, given the various mechanisms used in identifying services, the researchers are confident that this represents the vast majority of relevant statutory and voluntary services across Northern Ireland. It should also be noted that private sector services were not explicitly targeted in the Northern Ireland mapping, although a small number were identified but found not to be relevant when contacted.

## **Report structure**

This report presents the findings from the Northern Ireland component of the mapping project. Quantitative findings from the first phase of the mapping are presented together with relevant qualitative findings gathered from the interview with service managers/practitioners and commissioners in phase 2 (highlighted in text boxes).

## Section 4: Findings

Findings from phases 1 and 2 of the mapping project are presented under the following headings:

- type and coverage of service
- referral criteria and sources
- ability to meet demands
- models of therapy offered
- working with others
- staffing levels and funding
- accessibility
- reviewing and improving the service
- training and supervision
- numbers of referrals
- gaps and challenges
- commissioning process.

### **Type and coverage of service**

Of the relevant services identified, 11 per cent (five) are NSPCC-based services. Almost two-thirds (66 per cent) are statutory and one-third voluntary (34 per cent).

In total, six services (13 per cent) identified themselves as a specialist service specifically focusing on post-abuse therapeutic work with children and young people (see figure 4.1). Three of these projects specialised in sexual abuse and three in all types of child maltreatment. Three of these projects were NSPCC projects with the remaining three comprising specialist statutory provision in the form of one dedicated centre, as well as specialist/dedicated provision within two family centre locations.

In terms of geographical coverage, a specialist post-sexual abuse assessment and treatment service covered both the Belfast and South Eastern HSCTs. The Belfast HSCT also provided therapeutic support in the form of a post-abuse therapeutic project covering part of the trust area. There are two services in the Southern trust area, one a voluntary sector specialist post-abuse treatment project covering the entire HSCT area and the other a specialist sexual abuse service based in a family centre covering part of the Southern HSCT (formerly the Newry &

Mourne HSST). In the Western HSCT, there is one voluntary sector specialist post-sexual abuse project, which covers one-half of the Western HSCT (formerly the Foyle HSST). In the Northern HSCT, there is a specialist post-abuse provision based within a family centre, which covers part of the HSCT area (formerly the Causeway HSST). There appear to be gaps in specialist provision in relation to the former Altnagelvin HSST and the Sperrin and Lakeland HSSTs, which now comprise substantial parts of the Western HSCT, as well as the former Homefirst HSST area, which is now part of the Northern HSCT.

Two services that work specifically with young people who display sexually harmful behaviour (SHB) reported providing some degree of victim work with young people<sup>1</sup>. Both of these were voluntary sector projects.

Other services (83 per cent) comprised a range of statutory and voluntary services which, while not specialist post-abuse services per se, by the nature of their remit carry out some degree of therapeutic work with children and young people who have been sexually abused<sup>2</sup>. This includes inpatient psychiatry services (tier 4) and tier 3 child and adolescent mental health services (n=12). Together these provide a regional service for children and young people experiencing severe emotional and psychological problems across Northern Ireland, a number of which will have experienced sexual abuse. In some trusts, therapeutic support for looked after children was reported as being provided within tier 3 CAMHS provision. However, three separate services providing therapeutic support specifically for looked after children were also identified during the course of the mapping. Given that many children and young people enter the care system because of abuse, it could be argued that these form an element of statutory specialist provision, although for a specific group only.

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<sup>1</sup> It should be noted that there was an additional, statutory-based project in the Western HSCT, which provided therapeutic support to young people who had displayed sexually harmful behaviour in relation to their own sexual abuse experience. This was identified after the mapping was completed and does not appear in the findings.

<sup>2</sup> It should be noted that an additional voluntary sector project came to the attention of the mapping team after the research was complete. This service offered short-term applied psychotherapy for children and young people aged between four and 18 years. GPs, social workers, educational welfare officers, CAMHS and other relevant agencies could refer and the service covered Larne, Newtownabbey, Enniskillen, Omagh, Strabane, Coleraine and various sites within the Northern board area. The service was provided through health centres, family centres, CAMHS and various GP practices. It was not a specialist service but accepted referrals in relation to children and young people experiencing a range of emotional difficulties. In 2006/07 the service worked with 320 children and young people, 24 of whom were treated in relation to sexual abuse.

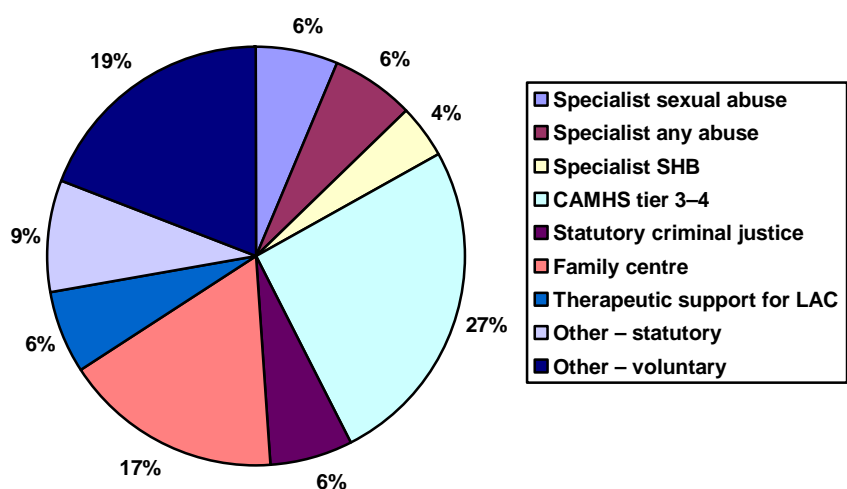
In addition to the two family centres that reported specialist work in relation to child abuse, a further eight also indicated that they provided some therapeutic support to children and young people in relation to sexual abuse.

The mapping also identified three statutory criminal justice services that reported providing some form of therapeutic support to sexually abused children and young people, often those who had engaged in sexually harmful behaviour themselves. Other sources of therapeutic support for children and young people who have experienced sexual abuse include:

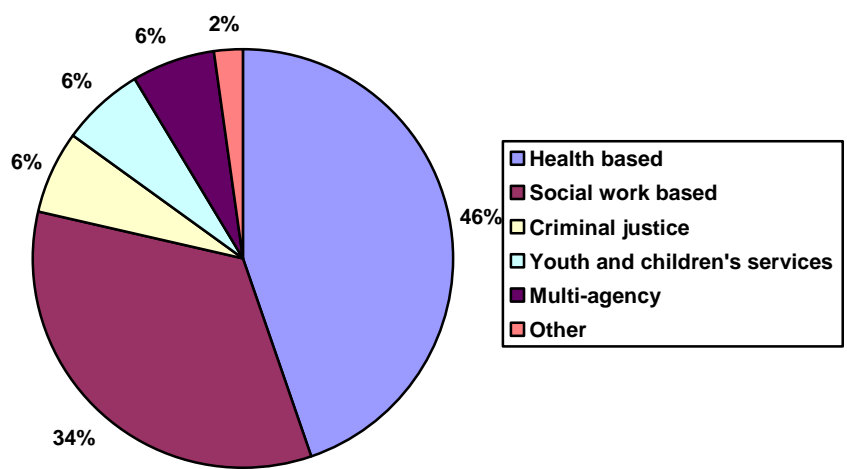
- a statutory social work based project working with marginalised youth and young people at risk
- statutory secure accommodation and intensive support units
- a voluntary sector project providing a number of support services to children and young people at risk of offending or who have been involved in the CJS
- a voluntary sector project providing a range of support and counselling services on both a regional and local level, including a collaboration with CAMHS
- a voluntary sector project providing support to children and families who have experienced psychological trauma.

Overall, 45 per cent of all relevant services reported being a health-based service, a third (34 per cent) social work based, 6 per cent criminal justice based, 6 per cent youth and children's services based and 6 per cent as part of a multi-agency initiative (see figure 4.2).

**Figure 4.1: Types of services providing therapeutic support (n=47)**



**Figure 4.2: Area of service provision (n=47)**



Seventeen per cent (eight) of services covered the whole of Northern Ireland, with the rest covering or partially covering HSCT areas. Regional services tended to be statutory in the form of inpatient psychiatric services, criminal justice system accommodation and secure accommodation. Some voluntary sector provision was also provided on a regional basis in the form of a helpline, counselling provision in schools and work with young people in contact with the criminal justice system. These services were aimed at specific groups of young people or did not focus specifically on sexual abuse. There was no regional specialist post-

abuse service and, as noted above, provision at the time of the research did not cover all geographical areas of Northern Ireland.

In addition to providing therapeutic support to children and young people, 55 per cent (n=47) of services reported providing a service to families/carers.

### **In-depth interviews**

Those HSCT-based commissioners interviewed as part of phase 2 of the project confirmed that current provision takes the form of a range of specialist/non-specialist and statutory/voluntary provision, which operates at various levels to meet the differing needs of the children and young people referred to them:

“There are services that directly provide service to a child where sexual abuse would be the main issue and that would be the \*\*\*\*\* or that dedicated worker, at \*\*\*\*\*,... but we’ve got other services that undertake family work where children are receiving a service but it’s not solely because of child sexual abuse. Domestic violence could be a feature so, for example, \*\*\*\*\* could be delivering a service to women and children. It’s not specific to the child sexual abuse but the child and the family are still receiving a service. We have the \*\*\*\*\* which works with families with regard to parenting or where there could be issues of domestic violence or where there are parenting alcohol issues or mental health issues and they work with children and families but once again sexual abuse could be a factor. So you could have direct services, for example, like the \*\*\*\*\*. Also our own social work staff undertake specific pieces of work with children who have been sexually abused.” (Trust commissioner)

“We would also have a child and adolescent mental health service. Now they don’t specifically accept referrals for the primary reason of sexual abuse but they would work with children who have suffered trauma or there would be attachment issues or issues surrounding their emotional health or mental health. The primary reasons for those issues could be that a child has been sexually abused so there would be therapeutic workers within the CAMH service, which is a trust service and that would be made up, for example, from consultant psychiatrist, consultant psychologist, a lead nurse, therapist with a social work background and they would work with young people who have emotional health/mental health problems but sexual abuse may have contributed to that.” (Trust commissioner).

“...so principally we would commission from the trust and voluntary sector providers who have an expertise in this area. And within the trust that involves both obviously main stream child and family care services, the child and family clinic, which fits within the CAMHS arena but CAMHS, as you may be aware is fitting with the children services directly and the director of children’s services has that responsibility and the principal voluntary sector organisation are \*\*\*\*\* and \*\*\*\*\* but there would also be some other smaller voluntary sector providers who have specific expertise and particularly may be around family therapy interventions but also where an individual has particular expertise and knowledge in child sexual abuse.” (Board commissioner)

**Referral criteria and sources**

A variety of eligibility criteria for accessing services were reported (see table 4.1). Eighty-three per cent reported taking referrals only from professional groups, such as social workers, education, criminal justice, CAMHS and the voluntary sector. Services which reported also taking referrals from children and young people included one specialist post abuse project as well as a range of voluntary sector based counselling services (some generic and some aimed at suicide prevention, drugs, alcohol and so forth). Two residential criminal justice services also reported taking referrals from children and young people or parents/carers themselves, although this was obviously limited to those who were resident within the units.

**Table 4.1: Service eligibility criteria (n=47)**

Eligibility criteria	No	Percentage
Referral source	39	83
Catchment area	39	83
Age	26	55
Gender	0	0
Assessment of need	23	49
Abuse type	4	9
Sexually harmful behaviour (SHB) only	2	4
Specific stage of child protection proceedings	2	4
Other	8	17

As noted above, a majority of services (83 per cent) were provided to a specific catchment area, usually covering or partially covering HSCT boundaries. Five (11 per cent) of these services reported covering/partially covering more than one HSCT area and a further 17 per cent were regional services covering all of Northern Ireland.

Fifty-five per cent of services reported some kind of age restriction. Five out of six specialist services reported age restrictions, with lower age limits generally around 3–5 and upper age limits around 17–18. One specialist service covered 3–13 year-olds. Among other services a variety of age ranges were apparent, some covering older teenagers (13 and over), some up to the start of adolescence (12 and under), others from middle childhood to early adolescence or young adulthood (10–17, 8–13 and so forth). A small number of projects reported taking young adults aged 18 and over, usually those who had previously accessed the service or whose intervention continued past their 18<sup>th</sup> birthday.

No services reported gender restrictions. Half (49 per cent) reported requiring an assessment of need, although a majority of services mentioned carrying out their own assessment as part of service provision.

The three specialist sexual abuse services reported restrictions around the type of abuse, while the two services specialising in sexually harmful behaviour (SHB) were the only services to report accepting SHB cases only. Only two services reported accepting cases at specific stages of child protection proceedings: in one service, an investigation must be completed and no outstanding child protection issues can be present; in the other, social services must have completed an investigation or assessment.

Some services specified additional referral criteria: one specialist project indicated that they only accepted referrals in which a complaint had been made to social services or police; others indicated that their service was only open to specific groups, such as looked after children or those with mental health difficulties (this would be common to all CAMH services and looked after children services).

When asked specifically about referral sources, 90 per cent of services indicated that they accepted referrals from social care professionals, 77 per cent from health professionals, 68 per cent from education professionals and 64 per cent from youth justice professionals (see table 4.2). Fifty-seven per cent also accepted referrals from the voluntary sector. Just under a third took referrals from children and young people (32 per cent) and just over a third accepted referrals from parents/carers – these figures are higher than for those reported when services

were asked if they had any referral source criteria. While not specifically excluding referrals from these sources, it is likely that services focused on the primary referral sources in their responses. As such, the figures of 32 per cent accepting referrals from children and young people and 36 per cent from parents/carers are likely to be more accurate.

**Table 4.2: Service referral sources (n=47)**

Referral source	Number	Percentage
Social care professionals	42	90
Health professional	36	77
Youth justice professionals	30	64
Education professionals	32	68
Voluntary sector	27	57
Parent	17	36
Child	15	32
Other	13	28

Other referrals sources mentioned included the police, courts, community groups, family members, the prison service and the Northern Ireland Public Prosecution Service.

### **In-depth interviews**

Service providers/managers who took part in in-depth interviews tended to be happy with the eligibility criteria for their service, indicating that it provided structure and guidance in terms of the work and the type of referrals accepted. Although there was a general consensus that services should be able to take referrals from children and young people and parents/carers directly, those interviewed also highlighted the resourcing implications associated with this, as well as the implications of dealing with child protection concerns. Some services indicated that they accepted such referrals but under the proviso that child protection policies and procedures would be followed and appropriate agencies notified where necessary.

“I feel that children and families have the right to make referrals but all services need to be adequately resourced. It’s OK saying we can take a referral but what do you do with the referral? It would be a falsehood to say we’ll take a referral, for any agency to take a referral, if they don’t have the capacity and depth because at the end of the day what we are talking about is vulnerable children and vulnerable families and the

last thing we want to do with these groups is further isolate them...” (Manager of CAMH service)

“I suppose it depends on the type of referral and the type of abuse, for example if it’s inter-familial abuse or there are potential child protection issues obviously that case would need to be assessed by a social worker, so therefore those referrals couldn’t come directly from children or families, they would need to come via the social services. I think it’s appropriate that cases are assessed by social services before they come to me. However on saying that I think, I suppose, more work could be done in promoting the services and encouraging young people to tell for example through educative mediums, school, youth clubs, etc so through those mediums perhaps you could get the message out to young people and parents that it’s OK to tell and I suppose in an ideal world if there were services you could be saying there are services here that you could avail of. I suppose we’re not in an ideal world and there aren’t the services there to address those needs.” (Manager of specialist service)

### Ability to meet demands

Only 15 per cent have no waiting time, although 66 per cent report treating children and young people within three months (see table 4.3). Nevertheless, nine projects (19 per cent) reported waiting times of over three months, ranging from four, six, nine and even 12 months. Eight of these services were statutory based and included a number of family centres, therapeutic services for looked after children, CAMHS and specialist projects.

**Table 4.3: Estimated typical waiting time between referral and therapy**

Typical waiting time	Number	Percentage
None	7	15
Up to 1 month	6	13
Up to 2 months	8	17
Up to 3 months	17	36
Up to 4 months	2	4
Up to 6 months	5	11
Up to 9 months	1	2
Over 12 months	1	2

A vast majority of services (92 per cent) reported that they did not have a maximum waiting time after which they stopped accepting referrals. Those that did reported a maximum waiting time of one (n=1), three (n=2) and nine (n=1) months. Only two services stated they had had to stop accepting referrals in the past 12 months. Nonetheless, just over a quarter (26 per cent, n=12) thought this would be likely or very likely to happen in the next 12 months.

Close to three-quarters (72 per cent) of services reported that demand for services exceeded capacity to supply them (see table 4.4). Similarly, 72 per cent felt that there were insufficient other therapeutic services to help meet demand in their catchment area. Almost 90 per cent reported that all staff in the service had a full caseload with 85 per cent reporting that demand would be more fully met by extra members of staff. Almost three-quarters indicated that demand would be more fully met by the provision of one to three extra staff members, with a small proportion reporting greater staffing needs in the form of five, six, nine and even 10 additional posts.

Fifty-seven per cent thought that demand would be better met by a greater skill mix of staff, 60 per cent by better capacity planning and management, and 50 per cent by better training and development of staff.

Other suggestions for meeting demand more fully included:

- more joined-up working and planning
- better links between providers
- reduction in numbers of inappropriate referrals
- more resources
- better training within tier 1 and 2 provision
- making child sexual abuse a priority
- providing art therapy and non-verbal therapy
- developing a satellite service for traumatised children.

**Table 4.4: Capacity of services to meet the demand for therapy for children and young people who have been sexually abused**

Capacity issues	N	Yes	
		Number	Percentage
Demand for services is fully met by capacity to supply them	47	12	27
Demand for services exceeds capacity to supply them	47	34	76
Demand is well-met by the availability of other therapeutic services in this catchment area	47	10	23
There are insufficient other therapeutic services to help meet demand in this catchment area	47	34	78
All staff in this service have a full caseload	47	42	89
All staff do not have a full caseload	47	5	11
Demand in this service would be more fully met by extra members of staff	45	40 1–3 extra staff = 74% 4–6 extra staff = 26%	85
Demand would be more fully met by a greater skill mix of staff	45	27	57
Demand would be more fully met by better capacity planning and management	44	28	60
Demand would be more fully met through more/better directed training and development opportunities for staff	44	24	51
Demand would be more fully met in other ways	47	20	43

**In-depth interviews**

Managers who took part in in-depth interviews reported a variety of waiting times ranging from one to six months. Most took the view that having no waiting lists at all would be preferable in terms of service provision. Nonetheless, one manager with a relatively short waiting time (two months) emphasised the quick response that was provided by their service. They took the view that a waiting list was not necessarily a bad thing if they could respond to

a referral fairly promptly, liaise with families appropriately and advise them when the intervention would be able to start; offering reassurance and maintaining “holding contacts” with the family enabled this service to alleviate parental anxieties in the interim.

A number of interviewees commented on having to prioritise referrals so that particularly vulnerable children and young people were seen as quickly as possible. A manager of a specialist project highlighted the age of the child as a key consideration, stressing the potential negative impact of long waiting times on very young children’s ability to recall what had happened to them. A practitioner within CAMHS commented on the frustrations caused by new departmental guidance, which stipulated that they must now prioritise based on time on the waiting list rather than the previous practice of prioritising on the basis of clinical need:

“Ideally I don’t think there should be a waiting time. However I don’t have a team. I’m one person who provides the service and at any given time there is a six-month waiting list for referrals....ideally what I think is needed is a team because if there was a team there wouldn’t be a waiting list, because what happens is when people are sexually abused initially they are very much in the stage of trauma, the stage of crisis and what they need is someone in there at the very beginning just helping them make sense of what is happening. They may not necessarily be ready to engage in therapeutic work at that point in time, but they need someone supporting them and supporting their family and quite often there’s nobody there to do that...” (Manager of specialist service)

Reduction of waiting times was clearly linked with making increased resources available to the project.

All of those interviewed were unanimous that more staff were required to deliver a better service and most were adamant that such services should only be provided by appropriately trained and qualified staff. Most also thought that staff with a wider mix of skills would be beneficial, referring to multidisciplinary teams and access to psychotherapists, play therapists, psychologists, family therapists and other “specialist” professional groups. One specialist service manager was of the view that a social work qualification was essential, because so many cases involved child protection issues and that this should form the basis for further development and specialism in areas, such as cognitive behaviour therapy and systemic family therapy.

## Models of therapy offered

There was evidence of a broad range of therapeutic models in service responses with cognitive behavioural therapy (CBT), creative therapies and family therapy being the most common, each used by roughly 50 per cent of services (see table 4.5). This was followed by counselling models and the use of attachment theory/work, narrative/story-based therapies and group work. More than four in five services (82 per cent) reported using more than one type of therapeutic model with the mean average being 3.6 (n=44, SD=2).

**Table 4.5: Therapeutic models used by services (n=44)**

	Number	Percentage
Cognitive behavioural therapy	24	55
Creative	23	52
Family therapy	22	50
Counselling	20	46
Attachment	17	39
Narrative/story	10	23
Group work	8	19
AIM assessment <sup>3</sup>	5	11
Psychodynamic	5	11
Sensory	2	5
Transactional analysis (TA)	1	2
Other	22	48

Other therapeutic models/approaches discussed included eye movement desensitisation and reprocessing (EMDR), psychotherapy, systemic therapy, Gestalt, solution-focused therapy, hypnotherapy, humanistic approaches, psychodynamic approaches, resilience models, self-regulation therapy, multimodal therapy, person-centred therapy, play therapy, child development behaviour therapy and non-directive therapy. Some managers also discussed doing self-esteem work, anger management, and personal change and planning.

<sup>3</sup> Procedure introduced by the Assessment, Intervention and Moving-on (AIM) project to assess children and young people who display sexually harmful behaviours.

Sixty-four per cent (30, n=45) reported an extra specialist qualification being required to deliver the therapy and 13 per cent (6, n=45) reported contracting out some aspect of the therapeutic work.

### **In-depth interviews**

In keeping with the findings from phase 1, those who took part in the in-depth interviews discussed a range of different approaches and models, including CBT, play and creative therapies, rational emotional theory and counselling. Multimodal therapy and treatment tailored to fit the assessed needs of the child and their family emerged as the preferred approach:

“We don’t offer one particular type of therapy like family therapy, like cognitive behavioural therapy. Because we work with very young children we offer a mix for that particular child that suits their needs. A three-year-old child we would work with them through play. An eight-year-old child would be a mix of play therapy, psycho-educative work, may be some sort of behavioural work with their families helping them manage and may be CBT as well. I suppose is what we say is that we offer a multimodal type of therapy and it’s based on the individual needs of the child and their family.” (Manager of specialist service)

“We would...pull together a sort of formulation of the problem and we would then discuss with the young person and obviously the family what thoughts we had about treatment and then we would use a number of different treatments. I can’t say a particular one.” (CAMHS clinician)

“...we would also determine what this child is comfortable with, which technique? Is it arts, is it sand, is it clay, is it questions, is it verbal? So those are the nuances that you are actually picking up when you do therapeutic need.” (Manager of specialist service)

### **Working with others**

Almost all services reported routinely working with other agencies (98 per cent) and making referrals/signposting to other agencies (96 per cent). Ninety per cent reported sharing delivery of therapeutic services, 87 per cent provided specialist consultation to other professionals and 96 per cent reported the provision of specialist consultation by other professionals to service

staff (see table 4.6). Others alluded to relationships and referral pathways with specific agencies to support children and young people.

**Table 4.6: Working with others (n-47)**

Working with others	Number	Percentage
Works routinely with other agencies	46	98
Makes referrals/signposts to other agencies	45	96
Shares delivery of therapeutic services	42	90
Provides specialist consultation by service staff to other professionals	41	87
Provides specialist consultation by other professionals to service staff	45	96
Other joint work	4	9

### In-depth interviews

All those who took part in the in-depth interviews rated their service as fairly effective in working with other relevant services. One non-specialist, voluntary service stressed the importance of working well with others, because they did not have expertise in child sexual abuse. Another specialist voluntary service suggested that, while working relationships were generally good, maintaining these could be something of a balancing act, given different personalities and approaches.

All discussed sharing information with relevant agencies within the confines of confidentiality. Many talked about seeking consent before passing information on to other agencies, but recognised that this was necessary where child protection concerns existed. Having clear agreements and boundaries around the limits of confidentiality from the outset, particularly with children/young people, families/carers and contracting agencies, was considered key.

“Well, we have to be very careful about confidentiality and we would routinely ask for permission to contact other services where we know somebody’s been there. If we

are making a referral we would seek the consent of the family even to the extent to say ‘is it OK to ring your school?’ and if they say no we wouldn’t unless there were some overriding issue and the overriding issues involve child protection. We start very much with a boundary of confidentiality at the first interview and then knowing that what they say is confidential with the two ifs: if you tell us you’re being abused or you have been, we have to tell; and equally, if you tell us information that we are aware that you are going to put yourself or somebody else at risk, we can’t keep quiet about that.” (CAMHS clinician)

One manager of a specialist voluntary sector service, in particular, stressed that information passed on to social services should pertain only to child protection issues and should not involve discussion of the actual therapeutic work carried out with the child or young person.

### Staffing levels and funding

The mapping identified a total of 584 professionals available to the services with each service having a mean average of 13 (SD =20) professionals. However, it should be noted that these figures are heavily skewed by three services, which reported in excess of 50 members of staff (see table 4.7). Both of these were regional services, one criminal justice and one voluntary counselling, which did not focus specifically on child maltreatment. Likewise, five services reported 20–50 professionals. Again these involved non-specialist, often regional services operating in criminal justice, CAMHS and the voluntary sector. As such, the figures provided by these services reflect the full staff complement of the service rather than the numbers of professionals who work specifically with children and young people in relation to their abuse experience.

**Table 4.7: Numbers of professionals available to services (n=45)**

Number of professionals	Number of projects	Percentage
1–3	6	13
4–6	19	43
7–9	9	20
10–20	3	4
21–50	5	11
51+	3	7

Taking account of the skewed nature of the data, the median average provides a more realistic figure of six professionals per service. Examination of professional staffing levels in the specialist services also indicates that a total of 36 professionals were available to these services, giving a mean average of six professionals available to each project.

In terms of the type of staff available, table 4.8 shows that social workers were available to over 80 per cent of services, psychologists to almost two in five services (38 per cent), nurses to one-third of services and psychiatrists to 29 per cent of services. Psychotherapists were available to 27 per cent of services, counsellors to 17 per cent and health visitors to 11 per cent. Examination of the specialist provision (see table 4.9) reveals this to largely social work endeavour, with a total of 26 social workers available to the six services. Two specialist services also reported having a psychotherapist available: one a health visitor and one a nurse.

**Table 4.8: Types of professionals available to all services (n=45)**

Professional	Available to service		Number available
	Number	Percentage	
Counsellor	8	17	123
Social worker	37	82	211
Psychologist	17	38	24
Psychiatrist	13	29	20
Psychotherapist	12	27	24
Health visitor	5	11	9
Nurse	15	33	66
GP	-	-	-
Youth offending team (YOT) worker	-	-	-
Teacher	4	9	30
Youth worker	7	18	28
Community worker	-	-	-
Other	16	36	35

Other professionals included assistant psychologists, project workers, family therapists, support workers, occupational therapists, art therapists, intensive treatment workers and paediatricians.

**Table 4.9: Types of professionals available to specialist services (n=6)**

Professional	Available to service		Number available
	Number	Percentage	
Counsellor	-	-	-
Social worker	6	100	28
Psychologist	-	-	-
Psychiatrist	-	-	-
Psychotherapist	2	33	3
Health visitor	1	17	1
Nurse	1	17	1
GP	-	-	-
Youth offending team (YOT) worker	-	-	-
Teacher	-	-	-
Youth worker	-	-	-
Community worker	-	-	-
Other	2	33	3

Overall, 14 services reported having non-professional workers available to assist with the provision of therapeutic support (see table 4.10). Eleven per cent of services indicated that they had non-professionally qualified social care workers and, in a number of cases, these appear to have been student social workers or trainees. Thirteen per cent of services reported using volunteers and 26 per cent other non-professionally qualified staff. Other professionally qualified staff available to the service were composed mainly of administrative staff, cleaners and drivers. No specialist services reported using non-professionally qualified health or social care workers.

**Table 4.10: Non-professional qualified staff available to services (n=45)**

Non-professionally qualified staff	Available to service		Number available
	Number	Percentage	
Social care	5	11	5
Health	1	2	5
Volunteers	6	13	74
Other	12	26	47

In more than two-thirds of cases, social workers, psychologists, psychiatrists, psychotherapists, teachers and youth workers required additional experience and skills to work in the service (see table 4.11). Sixty-four per cent of nurses, 50 per cent of counsellors and 40 per cent of health visitors were reported as requiring additional experience.

**Table 4.11: Additional experience and skills required for different professional groups**

Professional	N	Experience	Skills
Counsellor	6	50	50
Social worker	34	85	79
Psychologist	17	77	71
Psychiatrist	13	77	69
Psychotherapist	11	73	66
Health visitor	5	40	40
Nurse	14	64	47
GP	-	-	-
Youth offending team (YOT) worker	-	-	-
Teacher	3	67	67
Youth worker	6	67	67
Community worker	-	-	-
Other	11 and 9	36	33

Almost all services (45) reported having a policy of providing access to continuing training and development in therapeutic work for professional workers. Of those services that had non-professional workers, 58 per cent (27) reported having a policy of providing access to continuing training and development.

Seventy-two per cent of services reported having funding for an indefinite period of time and 11 per cent funding for 3–5 years (see table 4.12). Three services had funding for less than one year and five had funding for one year. All eight services with funding for a year or less were voluntary sector services, which included two voluntary sector family centres and a range of counselling-based services.

**Table 4.12: Number of years for which funding is secure (n=47)**

Less than 1 year	3	6
1 year	5	11
2 years	-	-
3 years	4	9
5 years	1	2
Indefinite	34	72

Eight services reported more than one source of funding. Seven of these were voluntary sector projects, of which three were specialist post-abuse projects.

### **In-depth interviews**

As noted earlier, all managers/practitioners interviewed were unanimous that more staff were required to deliver a better service and most took the view that such services should only be provided by appropriately trained and qualified staff. The in-depth interviews also confirmed that funding for specialist post-abuse provision and CAMHS was generally considered to be secure. Nevertheless, one voluntary, non-specialist service manager highlighted that uncertainty with regard to funding was an issue for the voluntary sector generally:

“...of course in the voluntary sector the short-term funding is the big one. You’re not guaranteed any long-term funding and long-term funding should be three to five years. Some of the services go from year to year, some are only six months. So really part of the manager’s job is always to try and secure funding. It’s a big one in the voluntary sector.” (Non-specialist service manager)

### **Service accessibility**

More than 80 per cent of services reported being wheelchair accessible, accessible by public transport and having access to foreign language interpreters and sign language interpreters (see table 4.13). Between two-thirds and three-quarters reported having an adapted toilet, providing advocacy for people with mental health difficulties, providing information in other languages and providing transport and transport costs.

Only 17 per cent of services reported having a lift, 17 per cent induction loops to assist those with hearing difficulties and 37 per cent information available in Braille. Access to home based therapeutic support was provided by less than half of the services (47 per cent) and disability support workers were available in 40 per cent of services<sup>4</sup>. During the course of phase 1 interviews, respondents often indicated that these services were not available directly to or provided by the service itself but, where necessary, could be made available by the HSCT in which the service was located. Other types of support included the provision of outreach if a young person was unable to attend the centre, advocacy for parents, information leaflets and facilitating family contact where appropriate.

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<sup>4</sup> In addition to questions about service accessibility, respondents were also asked about any separate therapeutic support (eg group or outreach work) they provided for a wide range of potentially marginalised categories of sexually abused children and young people (such as black and minority ethnic groups). This question was widely misinterpreted and has not been included as answers appeared to be based on the groups with whom services generally worked rather than the provision of any separate service to these groups.

**Table 4.13: Access for service users with additional needs**

	<b>N</b>	<b>Number of services</b>	<b>Percentage of services</b>
Wheelchair access	47	38	81
Alarm system	47	28	60
Service accessible by public transport	46	43	94
Lift	42	7	17
Adapted toilet/bathroom	47	34	72
Information in Braille	47	18	38
Information in other languages	47	32	68
Induction loop (assists those with a hearing aid to hear more clearly)	47	8	17
(Written) translation facilities	47	33	68
Foreign language speech interpreters	47	39	83
Sign language interpreter	47	37	79
Trained disability support worker	47	19	40
Home-based therapeutic support	47	22	47
Telephone counselling	47	26	55
Advocacy for people with learning difficulties	47	26	55
Advocacy for people with mental health problems	47	32	68
Transport provision	47	32	68
Transport costs	47	31	66
Other types of support	47	4	9

Thirty-eight per cent (17, n=45) of services reported additional categories of children and young people to whom they were unable to provide a service. These included children and young people with severe mental health problems, learning disabilities, young offenders, those who had displayed sexually harmful behaviour, those with addictions and isolated children and young people who were difficult to access through schools and community-based projects. One respondent also noted the difficulty in providing a therapeutic service to incarcerated young people because of uncertainties around how long the young person would be incarcerated and the length of time spent in cells. None of the specialist services reported any restrictions in terms of groups of sexually abused children and young people to whom they could provide a service.

None of the services reported charging children or families for the services and 70 per cent (32, n=46) reported that the service opening hours were advertised. Almost all who reported not advertising were statutory services and three were specialist post-abuse services.

Ninety-eight per cent (45, n=47) reported being open at least 9am–5pm Monday to Friday (n=46). One service was school based and was open at allocated hours within the school setting. Half of the services (23) reported being open one or more weekday evenings, 17 per cent (eight) reported weekend coverage and 22 per cent (10) emergency out-of-hours coverage.

Thirty per cent of services (14, n=47) reported that their service/organisation had tried to raise awareness of the service to enhance its appeal to harder-to-reach children and young people who have been sexually abused, such as ethnic minorities, the homeless and others who may have had negative experiences of other services. Only one specialist service reported doing this, indicating that they had built up relationships with representatives from the travelling community as well as youth workers and school refusers through the local education and library board. Other services tended to comment on efforts to raise awareness about their service generally, rather than sexual abuse specifically. Actions included making links with schools, promoting the work of the service to other organisations/agencies, providing information/ literature, sitting on panels/forums, outreach work and targeting specific groups, such as those in the care or criminal justice system.

Eighty per cent (37, n=46) reported having a specific strategy to help sexually abused young people transfer to adult services.

### In-depth interviews

Generally, managers/practitioners were happy with the levels of awareness of their service in their catchment area. However, their rating tended to be in terms of professionals knowing about the service and making referrals appropriately rather than directly advertising the work of the service. In particular, specialist service managers indicated that they did not advertise as such (although information was available on HSCT websites and so forth) and raised concerns about meeting demands if their service were to be more widely promoted:

“I think it’s down to a question of finance because the difficulty then with promoting the service is that you can’t set people up to fail. There’s no point me providing this great educative input and promoting the service and all these referrals coming to me and not being able to take them on.” (Statutory specialist service manager)

Almost all managers/practitioners interviewed were satisfied with the ability of their service to provide for the special needs of sexually abused children and young people, such as black and minority ethnic groups and those with a disability. While none reported providing specific services to such groups, they considered the services they provided to be non-discriminatory and talked about them being open to all groups of children who might need support. However, while one specialist service manager highlighted the diversity of their client group, another pointed to low numbers of such groups within their caseloads as a cause for concern:

“We have Chinese, we have Lithuanian, we have Portuguese, we have Portuguese African. Yes, children with learning disability, autism, children that have got educational needs that maybe haven’t been identified and we have pursued that. I think we’re actually quite good at that...” (Manager of specialist service)

“I think those groups are very under represented in the kids that we see. We see some children with a disability but I feel generally that there’s probably a lot more disabled children that experience abuse that are not referred through because of may be lack of awareness or whatever. I also think that in Northern Ireland there’s also quite a big Eastern European congregation. We have never seen one Eastern European child yet. I don’t believe that there’s no abuse in that population but they’re not being referred through.” (Manager of specialist service)

Another statutory specialist service manager took the view that they did not really provide services for these groups because this hadn’t been an issue in Northern Ireland

previously. This was acknowledged as a rapidly changing area, which necessitated the development of services to embrace a more diverse population:

“I think that the minority groups, with the exception of the travellers, haven’t been a major issue in Northern Ireland but they are going to become so. They are becoming so with the migrant workers and if we actually look a few miles south. In the south they are ahead of us in terms of asylum seekers, migrant workers and they are having to very much reconfigure services to take in ethnic diversity. I think again when you have even services for the hearing impaired we can get people to help us out with signing. I mean I have done that and we know how to access interpreters if we need interpreters for people say from the Polish or Lithuanian community but there’s something more to it than that. It’s not just the language, it’s an understanding of the culture as well and it’s training ourselves. Now there are some training but I think there needs to be more training on working with ethnic minorities and working with disability. I remember years ago going to a workshop, somebody called Mark Kennedy I think in Dublin, who was talking about working with victims of abuse with disabilities and that was a very long time ago and there was something called the A, B, C, D pack or something like that, which I’ve nearly forgotten about because it was so long ago, but that’s the sort of thing we should actually be getting updates on all the time.” (Manager of statutory service)

Likewise, a manager within CAMHS also highlighted the need to make better links with black and minority ethnic groups.

### **Reviewing and improving service**

Regular case assessment/review by responsible worker, feedback from children and young people and monitoring returns to an internal data collection body were the three most common ways services reported improving the quality of the service offered (see table 4.14). Service outcome measures and the use of internal and external research were the least common methods of service improvement. Other ways of improving service quality included the introduction of a specific module of care into statutory accommodation for looked after children.

**Table 4.14: Ways of improving service quality (n=47)**

	Number	Percentage
Children and young people's feedback	42	89
Children and young people's (non-abusing) family feedback	35	75
Regular case assessment/review by responsible worker	47	100
Client outcome measures	28	60
Service outcome measures	20	43
Monitoring returns to internal data collection body	38	81
Monitoring returns to external data collection body	37	39
Internal evaluations/audits, fed back to services	30	64
Evaluation reports by external body, fed back to services	24	51
Other internal research	23	49
Other external research	10	21
Action by services based on evaluation/other research reports	2	4
Other	2	4

Of the options provided, the most common ways of taking into account the views of children and young people and families/carers were provision of a complaints procedure, regular reviews involving feedback from children and young people, and referrer feedback (see table 4.15). The least common were involving children and young people in staff recruitment, provision of a suggestions box and regular consultation with a children and young people's user group. Other ways of taking into account service user perspectives included evaluation, consultation (both informal and formal), provision of a compliments book and advising service users to access their records.

**Table 4.15: Ways in which services take into account children and young people’s views and family/carer service users’ perspectives in informing policy and practice (n=47)**

	Number	Percentage
Regular reviews involving feedback from children and young people	43	92
Children and young people’s feedback form	31	66
Exit interview/questionnaire	32	68
Referrer feedback	35	75
Family/carer feedback	33	70
Children and young people’s involvement in staff recruitment	1	2
Regular consultation with children and young people’s user group	18	38
Suggestions box	13	28
Complaints procedure	46	98
Other	9	19

### In-depth interviews

Those interviewed supported the findings from the phase 1 interviews, reporting a variety of mechanisms by which their work was monitored and evaluated, such as feedback from services, evaluations, annual reports, attendance at various forums and adherence to standards. However, some were sceptical about how these processes actually improved the service offered to children and young people, voicing concern that such processes had become too number and target orientated, to the detriment of provision:

“I feel it’s very much driven by targets and government targets and so on. I’m not sure that the powers that be understand the reality of what children need. I think it’s very much a theoretical approach in terms of children. Families that come here shouldn’t wait longer than half an hour in the waiting room. Yes, that’s important but I don’t know, I wouldn’t want them to wait longer than that but, in terms of therapeutic service that they receive, I don’t know that they have the available statistics to gather that information. I think probably the health service management are very much driven by government in terms of achieving that and it’s a very quantitative approach to a qualitative approach and looking at the kind of service etc that the children get.” (Manager of specialist service)

“How do they do it? They evaluate it by numbers. Numbers of new people meeting waiting list targets, face-to-face contact. They don’t look at an awful lot of the other things we do like consultation to other services like advice, teaching, training...I think the way the trust do it, it’s counterproductive. It actually makes the service worse not better.” (CAMHS clinician).

Many of managers/practitioners interviewed indicated that they took account of the views of children and young people and their families through review meetings and feedback once the intervention was finished. However, there was recognition by some that this was an area requiring further development with one interviewee identifying a tendency to pay “lip service” to user involvement rather than to address the issue in a meaningful way. Using service user perspectives to influence service and policy development outside or inside the service itself was also considered to be an area of frustration for one specialist service manager.

### **Training and supervision**

Eighty-seven per cent (41, n=47) reported that the service facilitated access to clinical supervision for practitioners in their own discipline. Of the six services that said no, five were voluntary sector services, including four specialist post-abuse services.

Over half reported the quantity of staff training provided by the organisation/service to be good or excellent, 27 per cent average and 16 per cent poor or very poor (see table 4.16). No services perceived the quality of training available to them as poor or very poor, with 80 per cent perceiving this as good or excellent and 21 per cent average.

Eighty-nine per cent of services reported the quantity of staff supervision as good or excellent and 97 per cent reported the quality as good or excellent. It should be noted that in many cases this involved managers reporting on the supervision they themselves provided.

**Table 4.16: Quantity and quality of staff training and supervision**

Area	Very poor/poor	Average	Good/excellent
Quantity/amount of training	16	27	55
Quality of training	-	21	80
Quantity/amount of supervision	2	9	89
Quality of supervision	2	2	97

### In-depth interviews

All those interviewed cited staff supervision as one of the ways they satisfied themselves that staff correctly carried out the therapy offered by their service. Generally they considered the amount and quality of supervision provided by the service as satisfactory or good, although one reported it as variable and indicated that they themselves did not receive supervision. Another indicated that supervision could be improved by the provision of clinical supervision:

“The quality of supervision from my trust line manager it’s of a good quality, but again the only criticism of that would be...I feel that I need something more, clinical supervision because child sexual abuse. It’s a very difficult subject. You are working in this field. It can on occasions impact on you individually even though we all try to be professional and sometimes for me I feel it would be more beneficial to me if I had more clinical supervision but that’s not available. It’s like counselling for the counsellor and that’s something that would have to be paid for by the trust and again there’s a lack of funding. I’m not able to access that anywhere.” (Manager of specialist service)

When asked about the amount and quality of in-house training, two managers of specialist services indicated that it was fairly poor. Both highlighted the specialist nature of work with child abuse victims and the current lack of in-house specialist training to help develop the service. Both talked about lack of funding and talked about members of staff paying for specialist courses out of their own pocket. Even those who reported being satisfied with the amount and quality of in-service training acknowledged that training provided by their agencies/organisations tended to be more general and there was a general lack of more specialist training with which to develop expertise in this field. As such, managers often looked to external training services to address these gaps:

“It’s probably a difficult one to answer because we are a very specialist service and there’s a lot of in-service training available to social workers within the trust. Not all of it is relevant to us because our work is very specific, so we would always be looking for courses, in service training whatever is relevant to us but it wouldn’t be relevant to other people in the Trust so we would probably have more outside training rather than in-service training, because it has to be a specialist nature.” (Manager of specialist project)

Responses in relation to qualifying and post-qualifying training needs acknowledged that practitioners in this field came from a range of different disciplines. Half of those interviewed were generally happy with current training provision, while half indicated that this could be improved through more training that specifically focused on sexual abuse or through specialist training that enabled practitioners to develop their skills and expertise:

“...because we do work with such high levels of child protection and they do need to deal with that environment, need to be aware of that legislation...because I have spoken to in the past, say to art therapists who have provided a service to children who have been abused but they had no idea about pre-court restrictions, they had no idea about the recording, they had no idea about the impact of case conference and having to make their contribution there. They had no concept on the constraints on confidentiality and that concerns me because as a manager. If I knew that my staff didn’t have any insight into that that would be very difficult and that would have to be raised. I think that some of that is learned through their experience in social work. I do think there needs to be a development of training for people in therapeutic teams because it is very specialised, it is very intense.” (Manager of specialist service)

### **Number of referrals**

In total, 39 of the services were able to provide figures or rough estimates for the numbers of sexually abused children and young people accepted after referral in the year 2006/07. In total, services reported some degree of therapeutic work with 895 children and young people, ranging from one to 77 young people per service. Almost a quarter (23 per cent) of services reported working with less than 10 children and young people in relation to sexual abuse, 28 per cent with 10–19 children and young people and 23 per cent with 20–29 children and

young people (see table 4.17). Five per cent reported working with 30–39 children and young people and 21 per cent with 40 or more children and young people.

**Table 4.17: Numbers of children and young people services worked with in relation to sexual abuse**

Number of children and young people	Number	Percentage
Less than 10	9	23
10–19	11	28
20–29	9	23
30–39	2	5
40+	8	21

Not surprisingly, the specialist projects/services accounted for a substantial proportion (251) of referrals (see table 4.18). This number reflects those children and young people who received therapeutic support in 2006/07 specifically in relation to sexual abuse from services specialising in this area of work (either sexual abuse or abuse generally).

CAMH services also reported providing therapeutic support to a substantial number of children and young people in relation to sexual abuse. It should be noted that these cases involved those children and young people who were experiencing severe mental, emotional and psychological difficulties. This was the key reason for referral and many of the CAMHS professionals who took part in the mapping were keen to point out that sexual abuse was not a key focus of their work. Nonetheless, teams reported contact with significant numbers of children and young people who had experienced sexual abuse and these figures reflected those with whom they had engaged in some degree of therapeutic work. A number of managers also highlighted that they would often refer aspects of treatment or co-work such cases with specialist services where available. As such there was likely to be a degree of overlap between those children and young people being treated through specialist provision and those in receipt of CAMH services.

Two therapeutic services for looked after children also reported substantial contact with 85 looked after children who had experienced sexual abuse. Family centres that did not identify themselves as specialising in this area reported varying degrees of therapeutic support provision in relation to sexual abuse ranging from four to 22 cases. Other voluntary sector provision accounted for 150 children and young people, while the criminal justice system reported

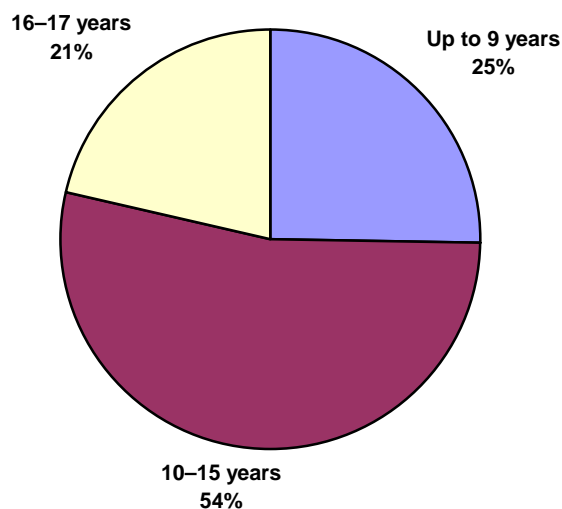
working with 72 children and young people across Northern Ireland, some in relation to their sexual abuse to some degree. Other statutory provision and therapeutic work with young people who display sexually harmful behaviour accounted for 20 children and young people.

**Table 4.18: Numbers of children and young people who received therapeutic service in relation to sexual abuse in 2006/07 by type of provision**

Provision type	Number
Specialist (n=6)	251
CAMHS (n=9)	225
Family centres (n=7)	72
Therapeutic support for looked after children (n=2)	85
Statutory criminal justice (n=3)	72
Other voluntary (n=9)	150
Other statutory (n=1)	10
Sexually harmful behaviour (n=2)	10

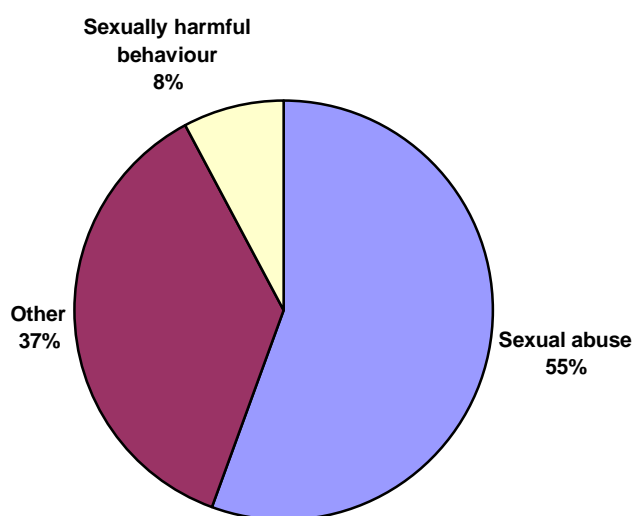
Services were able to provide information on the gender of 758 children and young people (n=35), reporting work with 263 males (35 per cent) and 495 females (65 per cent). In terms of age, work with 10–15 year-olds accounted for 54 per cent of children and young people, up to nine years 25 per cent and 16–17 years 21 per cent (see figure 4.3).

**Figure 4.3: Age of children and young people who received a therapeutic service in relation to sexual abuse in 2006/07**



As can be seen from figure 4.4, in a majority (55 per cent) of cases, sexual abuse was the main reason for referral. However, 37 per cent involved referrals for other reasons, while 8 per cent were referrals for sexually harmful behaviour.

**Figure 4.4: Numbers of children and young people who received a therapeutic service in relation to sexual abuse in 2006/07 by main reason for referral**



Respondents were also asked about ethnic breakdown of children and young people accepted after referral in relation to sexual abuse. However, as only 10 services were able to provide such data, overall figures in relation to therapeutic services are not available.

### **Gaps and challenges**

In total, 94 per cent of services<sup>5</sup> (44, n=47) commented on gaps/limitations in either their own or their catchment area's service provision, including:

- waiting lists and slow response of services
- general lack of services
- facilitative work around disclosure
- lack of resourcing
- need for more training
- need for more strategic planning and interagency working
- lack of out-of-hours coverage
- lack of specialist psychological/psychiatric provision
- court proceedings not helping children and young people
- lack of prevention and awareness raising
- lack of services for parents/carers
- lack of provision for specific groups such as those with autism or learning disability, Eastern Europeans, female juvenile offenders, young people in rural areas, young men and the hearing impaired
- need for more staff, better staff retention
- need for school-based services
- need for better links with the police
- need to listen more to voices of children and young people
- need for a more proactive approach.

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<sup>5</sup> Comments made by respondents who provided information on more than one service were taken as applying to all services.

### In-depth interviews

Those interviewed identified a wide range of gaps and challenges in relation to the provision of services for children and young people who had been sexually abused in Northern Ireland. These mirrored much of what came out of the phase 1 interviews and included:

- general lack of staff and resources as well as specialised services
- no services for parents of abused children
- need for better services for looked after children
- lack of drop-in services for children
- difficulties with the criminal justice system/judicial system not dealing appropriately with this group, impacting on therapeutic support and making matters worse
- current mental health service structure not being able to deal flexibly with children who need help
- need to develop confidence and capacity within social services to do self-protection work and facilitative interviewing
- services not being listened to by social services
- lack of information for children and young about available services
- lack of therapeutic services for the 18–25 age group
- difficulties in placing young people who have sexually offended who cannot go home.

“I think there’s a gap for parents first of all because I believe that children who have been sexually abused, their recovery is aided or not by the care they receive from their parents. I think the therapeutic service like ourselves is important in helping them recover from sexual abuse but, because they are young children that we work with, the main kind of recovery is within their family and, if parents aren’t dealing well with that sexual abuse, then their child is not going to deal well with it and we can’t offer the kind of service to parents that we would like...We’ll advise parents etc in relation to managing their child’s behaviour but we haven’t any resources to offer to parents themselves and that’s a big gap.” (Manager of specialist service)

“I think children in the care system, looked after children, also lose out, particularly when they get to their teens and start maybe going off the rails a bit and I think they do lose out in a lot of ways and I think you need very specialist services configured in a different way for them. There are a lot of young people who do not want to come to a clinic and sit in a chair and talk to a therapist. It’s not the way they work and it’s

not meeting their needs but that's how we have to work.” (Practitioner in non-specialist service)

“I think as I said and I started off saying there aren't enough services, ie I am the only trust specialist social worker in this area and while management recognise the need, I think the majority of the management would recognise the need for the service to be developed, there isn't the funding for it and again I suppose it's not only looking at the victim now but it's really recognising the benefits of therapy because therapeutic intervention at an early stage can really reduce long-term impact and, as we all know, as research tells, us long-term impact of child sexual abuse can result in psychiatric problems later on, function in relationships, may be alcohol and drug abuse...”

(Manager of specialist service)

“I suppose the big thing for me, and it is probably for them, is an environment that makes it easier for children to tell their story without there being a focus on how credible. I think in terms of the criminal legal system I think it doesn't do young children a service as they are viewed as not credible, there's a lot of scepticism about. That whole adversarial system, a child's word against an adult's, that's a very unequal system and the jury system that we have currently, I'm not sure that that's the best way of dealing with the criminal system. I think juries need to be more educated about how young children tell. It's not the same as adults in that there's a discrepancy and a disparity there.” (Manager of specialist service)

“And I suppose, just on the subject of formal complaints, as well the number of young people who do decide to proceed with a formal complaint and then, the prosecutor, the PPS directs no further action or it goes to court and it's thrown out of court or there's plea bargaining and the assailant gets a very minimal sentence or may be a suspended sentence...quite often, families think what was this for because there is this misconception out there that when a child or young person makes a formal complaint that oh, we have told our story to the care unit, the perpetrator is going to be arrested now, he's automatically going to go to prison...they are not told that by the care unit and sometimes that's what they hear then you have the whole delay in that it can take up to two years in cases to get to court and as I've said the outcome in court isn't always conducive to the young person's recovery and it's not what they want or what they thought was going to happen.” (Manager of specialist service)

“You need experience, you need skills, you need time to do it properly, do it right, to think, to reflect, very often work together with the young people and the families too. You provide what they need in a flexible accessible way. What we are made to do, it goes completely against that. Most of the challenges I would have are with the whole structure of the service, with the managements, the waiting list targets, and with all that it makes it impossible to meet the needs of these kids, you know the ones that need it. So I mean it’s that tension between those two things.” (Practitioner in non-specialist service)

## Commissioning process

### In-depth interviews

Commissioners across both areas confirmed that services for children and young people who had experienced sexual abuse in Northern Ireland were provided by a range of different providers and at a number of different levels. In the main, boards commission HSCTs who, in turn, provide services directly themselves in the form of CAMHS, family centres, child and family social work, and specialist statutory services, as well as commissioning services from the voluntary and community sector. Boards also reported some degree of direct commissioning with some voluntary providers, for example one HSSB indicated that it directly commissioned 30–40 services through their family and child care programme, although this was highlighted as something of an anomaly.

Services were commissioned to meet the identified needs of children and young people in the locality and support their families. The choice of service provider was influenced mainly by ability of the service to meet local demands with issues such as staff qualifications, skills and expertise, as well as costs, being central to decision making. At the time of the research the length of contracts offered to service providers appeared to vary between the two areas: one used three-year contracts with specialist projects and the other used one-year contracts, although the intention was to move to three-year contracts also.

Board commissioners discussed having contracts with HSCTs around the nature of services to be provided and HSSB expectations, and HSCTs then being responsible for drawing up service level agreements with voluntary service providers. Where boards directly commissioned, they also used service level agreements with providers. Service providers

were expected to provide some degree of outcome measurement to commissioners. One board commissioner took the view that the focus was more on outputs (how many, how much, how often) rather than outcomes, linking this to more of a health-based model:

“In terms of our direct service providers we are still more output focused than we are outcome focused. Output – contracts, volumes, how many, how much, how often as opposed to what does it actually achieve. And I have to say that’s partly a health service thing that would compare us to the equivalent local authority type services in England. They moved to a much more outcome-focused thing – the local authorities and Every Child Matters whereas the health service both there and here is still very much around waiting lists and numbers and that kind of stuff, so we haven’t moved as quickly as perhaps we should into the outcome stuff around child and family care services.” (Board commissioner)

However, both board commissioners interviewed highlighted the ongoing development of outcome indicators for children’s services as a positive development.

All those interviewed reported reviewing service level agreements on at least an annual basis using a combination of annual reports and meetings between commissioners and service providers. Monthly information returns relating to activity levels, quarterly meetings and biannual reviews were also mentioned by HSCT commissioners.

Responses as to whether access to therapeutic services should be offered as a matter of course to children and young people who had disclosed sexual abuse were somewhat mixed. Three commissioners thought that, in principle at least, this should be the case and two of these highlighted the importance of meeting the assessed need of the children and timing any intervention appropriately:

“If that’s what is deemed to meet their assessed need and the time is right for it, because many young people, if they have been abused or are in a period of crisis the time’s not right to offer them so it really has to be at a time when the young person is able to take on board and to use that therapeutic service. So it wouldn’t be right for all young people but it may well be right for some people.”  
(Trust commissioner)

One board commissioner took the view that some form of intervention should be on offer but felt that offering a full therapeutic service would not be appropriate if the child showed some resilience to what had happened to them:

“My experience of direct work with children and families is that the most effective use of therapeutic information is that when it’s needed not necessarily when it’s available. I think a child going to see some sort of therapeutic social worker once a week for six months or 12 months is not particularly effective, is not particularly cost effective and I don’t think it actually works for children. But I think the response or a child’s ability to deal with an issue depends particularly on the child and the circumstances that they find themselves in and the whole family background, the whole nature of the abuse, and sometimes as a child gets older the issues come back and that’s when they need the therapeutic intervention and often I don’t think we respond in that particular way until the kind of wheel’s come off and sometimes it’s too late. So it’s not a simple yes or no.” (Board commissioner)

This commissioner, in common with the others, indicated that services were generally accessed through professional referral and assessment rather than directly by children and young people. He went on to comment that he did not necessarily consider the development of such drop in services as the best way forward.

On the whole, commissioners felt the services they commissioned met the needs of children and young people in terms of quantity and quality. They often referred to the board/HSCT figures available to them in monitoring the demand for the service and identifying unmet need, as well as the lack of large waiting lists. One board commissioner was less certain about the quantity and quality of service provision, as the board area had only recently introduced monitoring in this area. In terms of accessibility, one commissioner took the view that services were open to all who had been abused, while one suggested potential gaps in accessibility with regard to outreach work and ability of those with disabilities to travel. Another thought that services might not be sufficiently accessible given the changing population in Northern Ireland and the fact that, as there were no drop-in services in this field, accessibility was more about thresholds than location.

Population, demand, unmet need, waiting lists and available resources were all identified as key factors influencing the level of service provision, although it was recognised that there

would be a number of children and young people in the service areas who would be in need of a service but were not known to providers. Demand for services was assessed through a number of mechanisms, including referral rates, feedback from professionals and waiting lists, with some commissioners stressing that these services were a response to identified and assessed needs. As such, commissioners raised legitimate concerns about advertising and campaigns increasing the numbers of referrals to services and stretching current resources and provision. One commissioner queried to whom exactly would services be advertised and promoted, again stressing that services were not provided on a drop-in basis and were, rightly, accessed through professional assessment referrals.

“I don’t think we could meet the needs of any service if we went out and canvassed and promoted it. We are really responding to presenting need or assessed need. Obviously there are, for services that we provide, we would have brochures, we would have leaflets for our whole range of services and we would respond as best possible to that. That’s not to say that if a new service came on stream, or an extension of the service, that there wouldn’t be a demand for it.” (HSCT commissioner)

Overall, commissioners were positive about current levels of provision, highlighting appropriate levels of skills and expertise from a range of providers, and generally taking the view that such services were able to meet identified needs in the area. Nonetheless, they were able to identify a number of challenges and needs, including increased funding, increased capacity, using secondments to build up skills, more flexible service structure, joined-up working and greater clarity about the level of need (cases involving looked after children, family support and so forth).

## Section 5: Summary of key findings

- The mapping project identified a total of 47 relevant services across Northern Ireland. Of these, six (13 per cent) were projects/services specialising in therapeutic work with victims of sexual abuse or child maltreatment; and two (4 per cent) were projects specialising in sexually harmful behaviour, which reported doing some degree of victim work.
- Almost two-thirds of the 47 services (66 per cent) were statutory and one-third voluntary (34 per cent).
- Specialist provision did not cover all geographical regions in Northern Ireland and there appeared to be gaps in relation to parts of the Western and Northern HSCTs.
- Other provision comprised 83 per cent of services and took the form of CAMHS, a number of family centres, looked after therapeutic support services, criminal justice services and voluntary-based non-specialist services. These were services that did not specialise in sexual abuse, but reported carrying out some degree of therapeutic work with sexual abuse victims.
- Thirty-two per cent of all services accepted referrals from children and young people and 36 per cent from parents/cares, while the rest accepted professional referrals only.
- Services accepted referrals from a broad range of professional groups with social care, healthcare, education and youth justice professionals being the most common.
- Fifty-five per cent of services reported some kind of age restriction with specialist services generally covering 3–5 and 17–18 year-olds.
- Eighty-five per cent of services had a waiting time although 66 per cent reported being able to begin treatment within three months; 19 per cent reported waiting times of more than three months.
- Although a vast majority of services (92 per cent) reported that they did not have a maximum waiting time after which they stopped accepting referrals, just over

a quarter (26 per cent) thought this would be likely or very likely to happen in the next 12 months.

- Seventy-two per cent of managers/practitioners reported that demand for the service exceeded capacity to supply it.
- Seventy-two per cent felt that there were insufficient other therapeutic services to help meet demand in their catchment area.
- Almost 90 per cent reported that all staff in the service had a full caseload with 85 per cent reporting that demand would be more fully met by extra members of staff.
- Services made use of a wide range of therapeutic models and methods, depending on the age and needs of the child. Cognitive behavioural therapy, creative therapies and family therapy were the most commonly reported therapy models.
- Almost all services (98 per cent) reported routinely working with other services in the delivery of therapeutic support.
- On average, each service had six professionals available to it: social workers were the most common, followed by psychologists, nurses and psychiatrists. Specialist provision was mainly social work based.
- Fourteen per cent of services indicated that they had non-professionally qualified workers available to assist with the provision of therapeutic support. These were all non-specialist services.
- Ninety-eight per cent of services reported having a policy of providing access to continuing training and development in therapeutic work for professional workers.
- Seventy-two per cent of services reported having funding for an indefinite period. All services with secure funding for a year or less were voluntary sector services but none were specialist services.

- Wheelchair access, accessibility by public transport and foreign language interpreters were the three most common ways services provided access to users with additional needs. Lifts, induction loops and information in Braille were the least common.
- Thirty-eight per cent of services reported additional categories of children and young people to whom they were unable to provide a service, including children and young people with severe mental health problems and learning disabilities, young offenders, those who had displayed sexually harmful behaviour, those with addictions and isolated children and young people who were difficult to access through schools and community-based projects
- Ninety-eight per cent reported being open at least from 9am to 5pm on Monday to Friday. Weekend and emergency out-of-hours cover were reported by 17 per cent and 22 per cent of services respectively.
- Regular case assessment/review by responsible worker, feedback from children and young people and monitoring returns to an internal data collection body were the three most common ways services reported improving the quality of the service offered. Service outcome measures and use of internal and external research were the least common methods of service improvement.
- The most common ways of taking into account the views of children and young people and families/carers were the provision of a complaints procedure, regular reviews involving feedback from children and young people, and referrer feedback. The least common were involving children and young people in staff recruitment, provision of a suggestions box and regular consultation with a children and young people's user group.
- Eighty-seven per cent reported that the service facilitated access to clinical supervision for practitioners. Almost all those who did not provide clinical supervision were voluntary sector services.
- Over half reported the quantity of training provided to staff by the organisation/ service to be good or excellent, 27 per cent average and 16 per cent poor or very poor. Eighty per cent perceived the quality of such training as good or excellent and 21 per cent average.

- Eighty-nine per cent of services reported the quantity of staff supervision as good or excellent and 97 per cent reported the quality as good or excellent.
- Thirty-nine of the services were able to provide figures or rough estimates for the numbers of sexually abused children and young people accepted after referral abuse in the year 2006/07. In total, services reported some degree of therapeutic work with 895 children and young people.
- Twenty-eight per cent of these children and young people received support from a specialist service.
- Roughly two-thirds of service users were female and one-third male.
- In terms of age, work with 10–15 year-olds accounted for 54 per cent of children and young people, up to nine years for 25 per cent and 16–17 years for 21 per cent.
- Most services (94 per cent) commented on gaps/limitations in either their own service or provision in the wider catchment areas. A general lack of services, more funding and staffing, more specialist training, better joined-up working and planning, and the development of services for families/carers were raised as key issues.

## Section 6: Discussion

### Service coverage

Overall, the mapping project identified a total of 47 relevant services who reported providing some degree of therapeutic support to children and young people who had been sexually abused in Northern Ireland. Eighty-three per cent of these services were able to provide figures or rough estimates for the numbers of children and young people they had worked with therapeutically in relation to sexual abuse in 2006/07, indicating that, together, they provided a service to some 895 children and young people. A quarter of these children were under the age of 10, over half were aged 10–15 years (54 per cent) and just over one in five were aged 16–17.

These therapeutic services for children and young people were provided in a variety of ways and at varying levels. Specialist provision accounted for only a minority (13 per cent) of available therapeutic services for children and young people who had been sexually abused in Northern Ireland. They are provided by both the voluntary and statutory sector in the form of specialist dedicated projects and family centres, which offered a specialist post-abuse/sexual abuse service. Of the 895 children and young people who received a service in 2006/07, only 28 per cent were in receipt of a specialist service. The mapping results also showed that not all children and young people across Northern Ireland were able to access a specialist service, highlighting gaps in both the Western HSCT and the Northern HSCT.

In addition to specialist support, children and young people could potentially access a range of other non-specialist services, which were able to provide some degree of therapeutic support in relation to their abuse experiences. Many of these services were specialist services in their own right in that they targeted specific issues or populations, such as statutory tier 3/4 children and adolescent mental health services (CAMHS), statutory therapeutic support for looked after children, statutory services for young people within the criminal justice system, or voluntary services for marginalised and at-risk youth. Given that many children and young people enter the care system because of abuse, it could be argued that therapeutic services for looked after children form an element of statutory specialist provision, although for a specific group only. Nevertheless, although these services provided much-needed support for very vulnerable groups many of whom would have sexual abuse histories, support specifically in relation to sexual abuse was generally not a particular area of specialism.

Similarly, a number of statutory family centres and a small number of voluntary counselling-based services reported some degree of therapeutic work with the victims of sexual abuse. These differed from the services discussed above in that they did not tend to target specific issues or groups and would generally be considered to operate around the tier 2 level of provision and be open to a broader range of referrals. Again, working with sexual abuse victims was not a specialist area of practice.

The sexual violence prevention strategy (DHSSPS and NIO, 2008) indicates that the very specific nature of child sexual abuse means that services should be specialist in nature rather than provided by general children’s counselling services. The recent mapping of psychological therapies across Northern Ireland (Bolton and Rankin, 2008) also questions whether areas of specialism are spread too thinly across current mental health provision:

“...should we...not be moving to services specialising in fewer areas or needs, benefiting from the development of expertise and the scarce and skilled supervision and support arrangements required to optimise practice?” (p40)

Certainly, many of those who took part in the in-depth interviews took the view that therapeutic support for child victims of sexual abuse was a specialist area of practice, with managers of specialist services highlighting how their services had developed skills and expertise in this field over time.

**Whether or not therapeutic support to children and young people should be provided only/mainly by specialist or dedicated services in Northern Ireland is a key issue requiring further discussion and debate in order to inform decision making around future service development.**

### **Service accessibility**

The mapping also highlighted that provision was mainly accessible through professional referral. While there was some disparity between responses to questions on service eligibility and those on referral sources, the mapping findings indicated that roughly only a third of services accepted referrals from children and young people and/or parents/carers.

It would be expected that a majority of children and young people who had disclosed sexual abuse, particularly younger children, would be in contact with social services and the police, and that referrals from these professionals would provide the point of entry into therapeutic

provision. Nonetheless, there were likely to be older teenagers who had experienced sexual abuse of some kind who did not formally enter the child protection or criminal justice system; either because there were no ongoing child protection concerns (eg the victim of a one-off stranger assault) or because they did not wish to disclose their experiences within these contexts. These young people would have been able to access only a limited number of specialist and non-specialist services, which were available in some areas but not others. Those who took part in in-depth interviews took the view that children and young people should be able to access services directly, providing these were adequately resourced and any child protection concerns addressed through the appropriate channels.

School-based counselling services and other more universally based, generic services offered children and young people an opportunity to directly access advice and support on a range of issues. Indeed, evaluation of the impact of the NSPCC school-based counselling service in Northern Ireland identified self-referral as an important service pathway, often chosen by children and young people exhibiting the highest levels of distress and resulting in the greatest treatment benefits (Adamson et al, 2006). If, as the sexual violence prevention strategy for Northern Ireland suggests, service development is to move away provision of support for sexually abused children within more generic counselling services, young people would then need to be referred on to more specialist provision (as would often be the case currently). **This has implications for the availability and capacity within specialist provision across Northern Ireland. It also suggests the need for agencies working with children and young people to have a common understanding of referral pathways, as well as the need to develop self-referral mechanisms generally.**

While all services reported being open to male and female children and young people, more than half (55 per cent) reported some kind of age restriction. Wide variation in age groups catered for was apparent among other, non-specialist services. Overall, specialist post-abuse services covered children and young people from two/three to 18 years of age, with some projects allowing for continuing work and re-referrals from older age groups. Nonetheless, one service did not work with young people older than 13 years. **Recent developments in neuropsychiatry and social neuroscience have provided insight into the impact of trauma on very young children (Goleman, 2007), potentially suggesting the need to develop specialist therapeutic work with infants and children under three.**

All services were provided free of charge and almost all were available during working hours from Monday to Friday. Although half reported being open one or more weekday evenings, weekend and emergency out-of-hours coverage was much less common and was rare within

specialist provision. Seventy per cent reported advertising the service opening hours. However, three specialist services did not advertise and the in-depth interviews indicated that, although services were well known among professionals in their catchment areas, there was some concern among managers about promoting the service and then not being able to deal with the ensuing demand. **This further highlights the importance of making resources available to develop capacity if wider groups of children and young people are to be reached and making directories of services available to victims and their families.**

Although almost all managers/practitioners who took part in in-depth interviews reported being satisfied with the ability of their service to provide for the special needs of sexually abused children and young people, such as black and minority ethnic groups and those with a disability, none reported providing specific services to such groups. Similarly, although two in five services reported additional categories of children and young people to whom they were unable to provide a service, specialist provision reported no such difficulties. The provision of therapeutic services was considered to be non-discriminatory in nature, although low numbers of such groups within service caseloads was a concern for some. It should also be noted that few services were able to provide a breakdown of the ethnicity of service users, indicating that **data collection mechanisms need to be developed to assist with the monitoring of access to therapeutic services by different ethnic and religious groups.**

Accessibility of premises and information for specific groups of children and young people with additional needs also varied. For example, although more than 90 per cent reported being wheelchair accessible, only 15 per cent of services had a lift. Service information in Braille was available in 38 per cent of projects and induction loops to assist those with hearing difficulties in only 17 per cent. Access to home-based therapeutic support was provided by less than half of the services (47 per cent) and disability support workers were available in only 40 per cent of services. **This suggests the need to develop a more strategic approach to meeting the needs of different groups of sexually abused children and young people, including the development of emergency cover and, potentially, home-based interventions.**

### **Meeting demands**

Commissioners interviewed were clear that the nature of service provision was aimed at responding to identified needs within the local population, ascertained through the monitoring of the number of referrals and waiting lists. Although waiting times were common, most services reported being able to treat children and young people within three months. Nonetheless, longer waiting times were noted in a number of projects and this was

highlighted in the in-depth interviews as a particular difficulty in working with cases involving younger children, as their recall of events was often time limited. Reduction of waiting times was also clearly linked to increased resources by interviewees. **This highlights the need to agree maximum waiting times between the point of referral, assessment and treatment as part of the strategic plan to develop regional standards for therapeutic support services** (DHSSPS and NIO, 2008). Nonetheless, the concerns of one practitioner in relation to prioritising caseloads based on length of time on the waiting list, as opposed to need, should be borne in mind and a flexible approach adopted. Linking waiting times with initial assessments of need may assist this process.

A vast majority of services reported that they did not have a maximum waiting time after which they stopped accepting referrals and only two services stated they had had to stop accepting referrals in the past twelve months. Nonetheless, over a quarter thought this would be likely or very likely to happen in the next 12 months, pointing to current difficulties in meeting demand for the services. This was confirmed by the fact that a majority of services reported an inability to meet current levels of demand either within their own service or within their wider catchment areas. Extra members of staff were considered key to addressing this capacity deficit with most suggesting the need for one to three additional full-time posts. Three in five also reported having a greater mix of skills and better planning and management as ways of better meeting demands. **Increased resources to develop staff capacity within this field and reduce waiting times are needed to help services meet current levels of demands and develop further capacity.**

### **Models of service provision**

Examination of current staff complements indicates that social workers are the professional group most commonly available to therapeutic support services, followed by nurses, psychiatrists and psychologists. Non-specialist provision such as CAMHS and criminal justice based services tends to involve a broad range of disciplines; specialist provision, on the other hand, is more clearly social work based and less obviously multidisciplinary, although one-third also have psychotherapists available to the service. Certainly the managers interviewed appeared keen to embrace staff with a wider mix of skills, although one specialist service manager stressed the importance of staff having a social work qualification as well as other therapeutic expertise, because so many cases involved child protection issues.

In terms of the type or model of therapies offered, a broad range was evident with cognitive behavioural therapy (CBT), creative therapies and family therapies being the

most common. A majority of services indicated an eclectic use of different therapeutic approaches and providers often talked about tailoring the therapeutic approach to the individual needs, age, understanding and personality of the child or young person.

Almost two-thirds of services (64 per cent) reported an extra specialist qualification being needed to deliver the therapy and in more than two-thirds of cases social workers, psychologists, psychiatrists, psychotherapists, teachers and youth workers required additional experience to work in the service. Most of the managers/practitioners interviewed took the view that therapeutic services should only be provided by appropriately trained and qualified staff. Nonetheless, a substantial minority of services did not need specialist qualifications or additional experience. Thirteen per cent also reported having non-professionally qualified health and social care workers available to the service, although this did not apply to any specialist service providers.

**Future development of service provision and agreed standards for working with sexually abused children and young people in Northern Ireland should involve consideration of the most appropriate model of service delivery to meet the needs of sexually abused children and young people. This should take account of the distribution and skill mix of professionals available to services, the range of therapeutic approaches offered, the level and nature of qualifications and experience required to deliver the service, the degree of supervision needed, and the use of non-qualified staff/volunteers.**

### **Training and supervision**

Half of those who took part in the mapping (51 per cent) thought that demand for their service would be more fully met through more or better directed training and development opportunities for staff. Likewise, half reported the amount of training provided internally by the service/organisation to be good or excellent, with 27 per cent reporting it as average and 16 per cent as poor or very poor. All services reported the quality of the training as average to good, suggesting that quantity was more of an issue than quality in terms of in-house training provision.

However, the in-depth interviews highlighted concern about internal training among specialist service providers, with two managers stressing the specialist nature of their work with child abuse victims and the current lack of in-house specialist training to help develop this training. Even those who reported being satisfied with the amount and quality of in-service training acknowledged that training provided by their agencies/organisations tended to be more

general and there was a lack of more specialist training with which to develop expertise in this field. As a result, managers often looked to external training services to address these gaps. There was also a feeling that current qualifying and post-qualifying training provision needs to focus on sexual abuse or specialist training, which enabled practitioners to develop their skills.

**The provision of specialist training to equip therapeutic practitioners to develop their skills and expertise in the field of child sexual abuse is an area requiring further development.**

The in-depth interviews demonstrated that staff supervision is a key way in which managers monitor the service and satisfy themselves that staff are correctly carrying out the therapies and intervention models offered by the service. While a majority of those interviewed in both phases of the research were generally happy with the amount and quality of the supervision provided by their service, one manager who took part in the in-depth interviews indicated that this could be improved by the provision of clinical supervision. Overall, a majority of services (87 per cent) report facilitating access to clinical supervision for practitioners in their own discipline. However, this was only provided in one in three specialist services and almost all services reporting no access to clinical supervision were within the voluntary sector. **As part of the development of services standards, consideration should be given to the most appropriate form of supervision for practitioners in this field.**

### **Monitoring and review**

Services indicated that their work was monitored by a variety of mechanisms, with regular reviews, feedback from service users and their families, internal audit and collection of data for monitoring purposes being common to a majority of services. Although 60 per cent reported measuring client outcomes, only 43 per cent indicated that they had service outcome measures in place. External evaluations and data collection for external monitoring was also less common, as was the use of both internal and external research.

**As such, objective assessment of service effectiveness through external research, evaluation and data monitoring appeared to be something of a gap in monitoring and review processes at the time of the research. The adoption of a standard service outcome measure would also be a useful addition to this process.** Nonetheless, concerns about monitoring and review processes becoming a “numbers” and “targets” game need to be borne

in mind and care needs to be taken to ensure that such processes do not become an end in themselves but are used to actually improve services.

The views of children and young people and families/carers appeared to be regularly taken into account through review and feedback from both groups. Nonetheless, there is still room for improvement given that roughly one-third of services do not currently make use of feedback forms or exit interviews/questionnaires. The involvement of children and young people in staff recruitment was also shown to be extremely rare, while only two in five services regularly consulted with a children and young people's user group. Equally, several of those interviewed recognised **user involvement as an area that could be developed and improved further.**

### **Gaps and challenges**

Between the phase 1 and 2 interviews, managers and practitioners identified a wealth of gaps and challenges relating to current provision for children and young people in Northern Ireland who had been sexually abused. Much of this reiterated the discussion above, emphasising the overall lack of services, the lack of appropriate resources, staff and training, delays in children and young people receiving a service, the lack of out-of-hours coverage and the lack of provision for specific groups (those with autism and learning disability, Eastern Europeans, female juvenile offenders, young people in rural areas, looked after children, young men, the hearing impaired and young adults aged 18–25).

Additional gaps and challenges requiring further development and consideration included:

- services for parents/carers
- facilitative work around disclosure
- improved strategic planning and interagency working
- information for children and young about available services
- better provision for children who display sexually harmful behaviour and young offenders.

Several managers/practitioners also talked about the challenges raised by current legal and court processes, emphasising the difficulties this caused for children and young people and how existing arrangements did little to meet the needs of this vulnerable group of children and young people.

## Section 7: Key gaps and recommendations

- Not all children and young people across Northern Ireland are able to access a specialist service and there appear to be gaps within both the Western HSCT and the Northern HSCT. Other access to therapeutic support services is mainly restricted to those targeting specific issues or groups or provided through more generic services. Whether or not therapeutic support to children and young people should be provided only/mainly by specialist or dedicated services in Northern Ireland is a key issue requiring further discussion and debate in order to inform decision making around future service development.
- Any move away from direct provision of support to sexually abused children has implications for the availability and capacity within specialist provision across Northern Ireland, which will need appropriate resourcing. Agencies working with children and young people will also need to have a common understanding of referral pathways.
- Developments in neuropsychiatry and social neuroscience suggest that trauma can impact on very young children. This may suggest the need to develop specialist therapeutic work with infants and children under three.
- Only one-third of services accept referrals from children and young people and 36 per cent from parents/carers. This is potentially an area for further development, particularly in relation to older teenagers.
- Increased resources to develop staff capacity and reduce waiting times are needed to help services meet current levels of demands and develop further capacity.
- The development of service directories and promotion of available services will need to be adequately resourced to meet any increase in demand.
- There is a need to develop a more strategic approach to meeting the needs of different groups of sexually abused children and young people, including the development of emergency cover and, potentially, outreach and home-based interventions.

- Few services were able to provide a breakdown of the ethnicity of service users, indicating that data collection mechanisms need to be developed to assist with the monitoring of access to therapeutic services by different ethnic and religious groups.
- Currently, specialist provision uses an eclectic, multimodal model of therapeutic intervention delivered by social work practitioners with expertise in sexual abuse and treatment. Future development of service provision and agreed standards for working with sexually abused children and young people in Northern Ireland should involve consideration of the most appropriate model of service delivery to meet their needs. This should take into account:
  - the distribution and skill mix of professionals available to services
  - the range of therapeutic approaches offered
  - the level and nature of qualifications and experience required to deliver the service
  - appropriate supervision arrangements
  - the use of non-qualified staff/volunteers.
- Specialist training is needed to equip therapeutic practitioners to develop their skills and expertise in the field of child sexual abuse.
- As part of the development of service standards, consideration should be given to the most appropriate form of supervision for practitioners in this field.
- Objective assessment of service effectiveness through external research, evaluation and data monitoring appears to be a gap in current monitoring and review processes. The adoption of a standard service outcome measure would also be a useful addition to this process.
- User involvement is an area that could be further developed and improved through greater consultation with children and young people and the use of exit interviews and questionnaires.
- Additional specific gaps include:
  - services for parents/carers
  - facilitative work around disclosure

- improved strategic planning and interagency working
- information for children and young people about available services
- better provision for children who display sexually harmful behaviour and young offenders.

## Section 8: References

Adamson, A., McElearney, A., Bunting, B., Shevlin, M. and Tracey, A. (2006) *Independent schools counselling – does it work?* Belfast: NSPCC Northern Ireland.

Allnock, D., Bunting, L., Price, A., Morgan-Klein, N., Ellis, J., Radford, L. and Stafford, A. (2009) *Sexual abuse and therapeutic services for children and young people: the gap between provision and need.* London: NSPCC.

Bamford Review Of Mental Health and Learning Disability (Northern Ireland) (2006) *A vision of a comprehensive child and adolescent mental health service.* Belfast: Mental Health and Learning Disability Review Northern Ireland.  
[www.rmhdni.gov.uk/camh-vision-comprehensive-service.pdf](http://www.rmhdni.gov.uk/camh-vision-comprehensive-service.pdf)

Briere, J. and Runtz, M. (1987). Post sexual abuse trauma: data and implications for clinical practice. *Journal of Interpersonal Violence*, 2(4), pp367–379.

Cawson, P., Wattam, C., Brooker, S. and Kelly, G. (2000) *Child Maltreatment in the UK: A Study of the Prevalence of Child Abuse and Neglect.* London: NSPCC.

Bolton, D. and Rankin, G. (2008) *Mapping of psychological therapies in Northern Ireland. Report no. 1: Health and Social Care Trusts.* Belfast: Northern Ireland Centre for Trauma and Transformation (NICTT).

DHSSPS (2007) *Children Order Statistical Tables 2007.* Belfast: Community Information Branch, Northern Ireland Statistics and Research Agency (NISRA).

Department of Health, Social Services and Public Safety (DHSSPS) and Northern Ireland Office (2008) *Tackling sexual violence and abuse: a regional strategy 2008-2013.* Belfast: Northern Ireland. Department of Health, Social Services and Public Safety (DHSSPS).  
[www.dhsspsni.gov.uk/sexualviolencestrategy08.pdf](http://www.dhsspsni.gov.uk/sexualviolencestrategy08.pdf)

Department of Health, Social Services and Public Safety (DHSSPS) (2003) *Co-operating to Safeguard Children.* Belfast: Department of Health, Social Services and Public Safety (DHSSPS).

DHSSPS (2008) *Standards for Child Protection Services*. Belfast: DHSSPS.

Department of Health, Social Services and Public Safety [Northern Ireland] (2003) *Co-operating to Safeguard Children*. Belfast: DHSSPS.

Eastern Area Child Protection Committee, Northern Area Child Protection Committee, Southern Area Child Protection Committee and Western Area Child Protection Committee (2005) *Area Child Protection Committees' regional policy and procedures*. Belfast: Department of Health, Social Services and Public Safety (DHSSPS).  
[www.dhsspsni.gov.uk/acpregionalstrategy.pdf](http://www.dhsspsni.gov.uk/acpregionalstrategy.pdf)

Finkelhor, D., Ormrod, R. and Turner, H. (2007) Poly-victimization: a neglected component in child victimization. *Child Abuse & Neglect*, 31(1), pp7–26.

Goleman, D. (2007) *Social Intelligence: The New Science of Human Relationships*. New York: Bantam Publishers.

Home Office (2007) *The Corston Report: A Report by Baroness Jean Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System*. London: Home Office.

Messman-Moore, T. L. and Long, P. J. (2003) The role of childhood sexual abuse sequelae in the sexual revictimization of women: an empirical review and theoretical reformulation. *Clinical Psychology Review*, 23, pp537–571.

Northern Ireland Statistics & Research Branch (NISRA) (2007) *Mid-year population estimates 2007*. Belfast :Demography and Methodology Branch, NISRA.

PSNI Central Statistics Unit (2007) [Email] (Personal communication, June 2009).

Roodman, A. and Clum, G. (2001) Revictimization rates and method variance: a meta-analysis. *Clinical Psychology Review*, 21(2), pp183–204.

Walker, L. (1988) *Handbook on sexual abuse of children: Assessment and treatment issues*. New York: Springer Publishing Company.

Yiasouma, K., Gossrau, D. and Leonard, M. (2007) *An Investigation into the Application of Child Protection and Related Procedures with Children and Young People who Display Sexually Harmful Behaviours: A Research Report*. Unpublished research report.



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