

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

The gap between provision and need

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Executive summary

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Background

Sexual abuse affects a significant number of children and young people with UK-wide prevalence research (including Northern Ireland) indicating that 11 per cent of males and 21 per cent of females have experienced some kind of sexual abuse in childhood (Cawson et al, 2000). The same prevalence research also tells us that only a small proportion disclose this abuse, with 72 per cent of sexually abused children reporting that they did not tell anyone about the abuse at the time. Although 27 per cent told someone later, around a third (31 per cent) still had not told anyone by early adulthood.

Childhood sexual abuse has been associated with a wide variety of negative outcomes, including 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), depression, and even suicide (Briere and Runtz, 1987). 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) and that a significant number of children experience more than one type of violence (Finkelhor et al, 2007).

Therapeutic services aim to address the mental health issues arising from such abuse. However, 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 (UK).

A summary of the findings from the UK-wide study (Allnock et al, 2009) is available from www.nspcc.org.uk/Inform/research/Findings/sexual_abuse_therapeutic_services_wda67007.html

Service framework

Therapeutic provision for children and young people who have been sexually abused involves a range of service providers largely from the statutory and voluntary sectors. Statutory systems in Northern Ireland operate within an integrated health and social care system, a

system which has recently undergone significant changes under the review of public administration (RPA). Prior to RPA, 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 care 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), while on 1 April 2009 the four HSSBs were replaced by a single health and social care board. It should be noted that, at the time of this research, the four HSSBs were still operational and are discussed as such.

Statutory child and adolescent mental health services (CAMHS) are a key element in the response of HSCTs to the therapeutic needs of children and young people in Northern Ireland. These operate within a four-tier model of provision (Bamford Review of Mental Health and Learning Disability, 2006). 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. Examples of tier 1 and 2 services include statutory and voluntary family centres; education departments providing pastoral care and school-based counselling services; educational psychology, educational welfare officer, emotional and behavioural support teams; youth justice services; and a range of voluntary and community providers. Tier 3 services comprise specialist CAMHS professionals who work as part of multidisciplinary teams and tier 4 services deliver highly specialised interventions and care for the most complex or uncommon disorders or illnesses (eg mental health inpatient and secure residential care units).

Various voluntary services are also available across Northern Ireland. These can either be commissioned by HSSBs and/or HSCTs and work in partnership with statutory agencies or operate as “stand alone” voluntary services.

Policy context

The Bamford Review of Mental Health and Learning Disability (2006) highlighted a lack of strategic oversight in relation to the development of post-abuse intervention services for children and young people. Since then the Northern Ireland government has published a strategy on preventing sexual violence, which outlines plans to develop a more strategic approach to supporting victims (DHSSPS and NIO, 2008). Plans include:

- establishing a sexual assault referral centre (SARC) for Northern Ireland – a one-stop location where female and male victims of rape and serious sexual assault can receive comprehensive forensic, medical and support services
- developing specialist therapeutic provision
- supporting counselling services in schools
- developing and publishing guidance for professionals on therapeutic support to ensure that children and young people are not denied assistance in advance of a court case
- publishing a directory of services for victims of sexual violence and abuse
- HSCTs specifying how ongoing support services will be delivered in conjunction with partners and included in budget agreements with trusts, service delivery plans and service level agreements with voluntary and independent sector providers
- developing and implementing regional standards for recruitment, management, training and support of staff dealing with victims and survivors of sexual violence and abuse.

Additionally, the recently published *Standards for Child Protection Services* (DHSSPS, 2008), emphasises the importance of developing greater strategic oversight in relation to service provision. The standards seek to establish an overall framework to deliver continuous improvement in, and strengthening of, such services in Northern Ireland. They also indicate that there should be an agreed planned programme of audit for the full range of child protection services across HSSBs, HSCTs and agencies. This should include the regular review and audit of therapeutic interventions, professional practice and their effectiveness in achieving specified outcomes for children.

Statistics for Northern Ireland

Children and young people account for a quarter of the population in Northern Ireland. UK prevalence research (Cawson et al, 2000) indicates that a significant proportion of this group of children and young people will experience some form of sexual violence but that only a small proportion will disclose this. There is a range of official child protection and police statistics in relation to those who disclose abuse; these provide an overview of sexual violence cases involving children and young people known to statutory agencies and service providers.

The figures tell us that approximately 900 new sexual offences against children and young people become known to police every year and that, on average, 225 children and young

people are placed on the child protection register in relation to sexual abuse by social services each year. A huge degree of overlap between these figures would be expected, as cases placed on the register are most likely to have police involvement.

Current guidance stipulates that, where a victim is a child, “joint protocol” investigation procedures involving the Police Service of Northern Ireland (PSNI) and social services should be implemented. Although official 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 considerably lower than the total number of sexual offences recorded against children. While there may be a variety of reasons to explain this discrepancy, there are no published statistics available with which to identify what, if any, therapeutic intervention may have been offered to children and young people who have reported sexual violence to the police but who have not been referred to social services. Equally the extent of therapeutic intervention offered to children and young people who are placed on the child protection register and/or are looked after by HSCTs is not known.

Methods

Aims

Key aims of the mapping project were to:

- map 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
- evaluate the accessibility and approachability of services to children and young people
- consider the provision of services in relation to the identifiable demand and need
- interview 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 using a national

questionnaire to map the provision of services geographically and to identify the range of services available and any gaps in provision.

Initially, potentially relevant services were identified through contact with NSPCC services, as well as directories of services provided on HSCT websites. Each HSCT appointed a link person to assist with further development of the service list; relevant managers/practitioners were contacted to confirm service locations and details within their area. The final contact list totalled 68 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. A broad, self-labelling definition for therapeutic services was adopted, which sought to include all services (mainstream and specialist) that considered they were providing a therapeutic service to children and young people who had experienced sexual abuse. Where the service engaged in some level of direct therapeutic work with the children and young people, they were included in the mapping.

A total of 47 services participated in the mapping and provided information in relation to a number of areas, including staff qualifications, models of therapy and numbers of referrals. 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.

Phase 2

Phase 2 involved follow-up interviews with a small sample of service providers and commissioners to obtain their views on needs and service availability. A total of 10 in-depth interviews were completed involving six service managers (identified from phase 1) and four commissioners across two HSCT areas (one urban and one urban/rural). All interviews were recorded and 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.

Ethics

Ethical approval for the mapping research for all four jurisdictions was given by the National Research Ethics Service (NRES), as well as 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.

Key findings

- The mapping project identified a total of 47 relevant services across Northern Ireland, six of which (13 per cent) were projects/services specialising in therapeutic work with victims of sexual abuse or child maltreatment and two of which (4 per cent) were specialist SHB projects, 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 HSCT and Northern HSCT.
- 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 accept referrals from a broad range of professional groups with social care professionals, healthcare professionals, 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 ages 3–5 and 17–18.
- 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 them.
- 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. CBT, creative therapies and family therapy were the most commonly reported therapy models.
- Almost all services reported routinely working with other services (98 per cent) in the delivery of therapeutic support.

- Each service had, on average, six professionals available to it with social workers being the most commonly available, 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, they were unable to provide a service, including children and young people with severe mental health problems and learning disabilities, young offenders and 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 from Monday to Friday. Weekend coverage and emergency out-of-hours cover were reported in 17 per cent and 22 per cent of services respectively.
- The three most common ways services reported improving the quality of the service offered were regular case assessment/review by responsible worker, feedback from children and young people, and monitoring returns to an internal data collection body. The least common methods of service improvement were service outcome measures and use of internal and external research.

- 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. 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 person'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 staff training provided 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. Services reported some degree of therapeutic work with a total of 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 services 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, with those up to nine years for 25 per cent and with 16–17 year-olds 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.

Key gaps/discussion points

- 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 resources. 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 demand 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 services 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.
- Specialist provision currently uses an eclectic, multi-modal 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 the needs of sexually abused children and young people. To achieve this, DHSSPS should consider the development of a service framework covering this area of provision. 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 services 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 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 about available services
- better provision for children who display sexually harmful behaviour and young offenders.

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