

National Review of Sexual Abuse Services for Children and Young People

Final Report

June 2011

Health Service Executive

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Content

Executive Summary

Promoting and protecting the health, safety and wellbeing of children who have alleged sexual abuse has to be the priority consideration for all agencies and services that interact with children. Once an allegation of abuse has been raised, it is the responsibility of agencies and services to deal promptly and sensitively with the issue, ensuring the needs of the child are met.

There have been a number of recent reviews which have highlighted systemic service failures to children; the most notable of which has been the Ryan Report; and made recommendations for improving the service response, the governance and accountability arrangements, and the need for better co-ordination and integration across agencies. This has been followed by the production and publication of guidance, including Children First, which sets out the key responsibilities for agencies, defining the protocols for responding to new referrals of child abuse and for inter-agency working.

In 2009, the working Group of Ferns IV reported on the assessment, therapy and counselling needs of children who have been sexually abused, and their families. This report set out the key principles for services; many of which are seen in established and recognised ‘best practice’ models of care in other international healthcare systems. These include:

- An approach where the needs of the child are the primary consideration;
- A multi-agency coordinated approach to identify abuse, assess risk, and devise and implement the management, protection and aftercare of the child;
- 24/7 access to crisis support, specialist clinical and forensic care;
- Access to a multi-disciplinary team who are appropriately qualified, trained, supported and experienced;
- Access to an environment that is welcoming, supportive and accessible; and
- Clear guidance and protocols.

Given all the work that has been undertaken at a central and national level, it was considered timely to take stock of current service provision across the country and understand the extent to which this guidance for good working practices had been implemented and embedded across services, and if not, what the issues and obstacles were that prevented this. Therefore, a rapid review of sexual abuse services was commissioned jointly between the Integrated Services Directorate and the Child and Families Services Directorate of the Health Service Executive;

supported by a multi-agency Steering Group, which included representatives from key agencies and professional staff groups. The remit of the review was to:

- Undertake a baseline review of current provision and configuration of sexual abuse services across the country;
- Compare this with established best practice models of care; and
- Develop an optimum model of care, which improves services for children and their families, makes best use of existing resources, and satisfies statutory regulations and standards.

Assessment of current services

The key characteristics which exemplify best practice of alternative models developed elsewhere, are of services which:

- Are responsive to the needs of the child;
- Are provided in a child friendly environment;
- Minimise the distress resulting through multiple interviews;
- Meet the holistic needs of the child; and
- Ensures the timely collection of forensic evidence by specialist trained clinicians.

Accepting these characteristics as the tenets for best practice, then, the review has highlighted examples of good practice; albeit, many of which are often localised practices. These areas of good practice include:

- The availability of seven specialist interview suites located across the country in child friendly environments for joint interviewing;
- The pool of professional staff trained to undertake specialist interviews;
- 24 hour access to emergency residential care for those children considered to be at risk in some areas of the country;
- Helpline support provided by CARI to parents during an initial 6 week wait.
- Dedicated specialist multidisciplinary teams at St Clare's Unit and St Louise's Unit in Dublin, providing a wide range of assessment and therapeutic services;
- The Family Centre in Cork and the Community Child Centre at Waterford, both providing assessment and medical services through a dedicated multidisciplinary team;
- Access to a range of therapy services across other parts of the country provided by the HSE and voluntary providers, including CARI;

- Psychological support services provided by the Rape Crisis Centres to those over 14 years of age;
- For those children over 14 years of age, 24/7 SATU services are available; the main provider at Rotunda Maternity Hospital, with five other units located in Cork, Letterkenny, Galway, Mullingar and Waterford;
- For children under 14 years of age living in the Mid West and Galway, the availability of a specialist forensic examiner in and out of hours;
- Trained community and acute paediatricians across the country to provide in hours forensic and medical examinations; including Sligo, Cork, Waterford and Dublin Mid Leinster; and
- Trained community paediatricians to provide in hours medical examinations, including Sligo, Donegal, Mayo.

However, despite the revised policy and guidance, and the areas of good practice, there remain some serious concerns and issues, impacting on achieving good service delivery and care for children, which have been identified. At an operational level, most of these concerns and issues are well known and understood and there is a sense of frustration across professionals and agencies that still the systems, processes and resources and not aligned better to provide a better, quicker and more appropriate response to these children and their families. It is, therefore, imperative, that these issues be addressed urgently.

These issues impacting on service delivery and quality of care include:

- The lack of consistency of a standardised model of care and little interagency planning and collaboration;
- The lack of consistent adherence to the national policy for joint interviewing;
- No common IT and information service supporting services;
- The lack of agreed guidelines for service provision and baseline of good practice in order to benchmark and audit services;
- The lack of standards of practice for forensic examination;
- Limited dedicated services in place to provide medical and forensic services to children under 14 years of age;
- No social worker service available out of hours and at weekends;
- Variations in times taken to undertake initial assessments by the social worker service;
- Variation in the waiting times for a full therapeutic assessment;

- Outside of Dublin, the poor access to well coordinated and holistic therapeutic services;
- Variation in the referral route across services;
- Limited adherence to the policy for joint interviewing;
- The expectation for children to have to tell their stories a number of time to different agencies;
- Difficulties in accessing training by some agencies;
- Differences in contracting and Service Level Agreements with many of the voluntary providers resulting in variability in service provision and access; and
- Difficulties in accessing appropriately trained translation services.

Developing the optimum model of care

In order to address these service delivery deficiencies and variation, an optimum model of care has been recommended, which builds on those areas of good practice across the country and suggests a pragmatic solution, which is both affordable, making best use of available resources, and most easily implemented. This does mean that, in the short term, there will be some local operational service variation although the underlying standards and principles of care will be the same, namely:

- A model which is child and family centred; taking a holistic view of the needs of the child;
- The collaboration across agencies and inter-agency working;
- An equitable and consistent service across the regions and both in and out of hours;
- An accepted and agreed framework of standards, including:
    - A standardised level of communication;
    - Timely and appropriate access to services;
    - Supporting governance infrastructure; and
- Improved working across geographical and service sector boundaries.

Outlined below are the recommendations of this review, each of which addresses a key component of the model to achieve the optimum care within the available resources and taking account of likely levels of demand for sexual abuse services across the regions. These recommendations will need to form part of the wider child protection standards of practice and operational protocols.

Component of model and key issues	Recommendation
Initial response Outside of normal working hours, there is lack of a responsive social worker service	Develop a single point of access to services in the form of a telephone contact number which would trigger the involvement of a local duty social worker, regardless of which service/agency the child presents. This review recommends a contact number for each sub-region (e.g. HSE South, one number for the counties of Waterford, Wexford, Carlow, Kilkenny, South Tipperary, and one number for the counties of Cork and Kerry) be available for extended hours 17:00-22:00 during weekdays and 09:00-22:00 at weekends, supported through an on-call arrangement with appropriately trained duty social workers.
Initial access Variability in the length of time a child and family wait for initial assessment	Where a response is required, the local duty social worker undertakes an immediate pre-screen/assessment on site i.e. where the child and family presents. This review recommends that this practice be undertaken for extended hours, 17:00-22:00 during weekdays and 09:00-22:00 at weekends, through an on-call arrangement covering a sub-regional geographical area. The attending duty social worker would liaise with professionals where the child presented to undertake the immediate actions required e.g. informing An Garda Síochána, making the child safe and arranging a medical examination etc.
Forensic/Medical examination Lack of a consistent and equitable service provision for those under 14 years of age Difficulties in availability of professionals in some parts of the country due to lack of training, equipment and facilities No standardised accredited training in place	The establishment of a telephone advice line, consisting of a rota of professionals trained in paediatrics and experienced in medical examinations of this nature to advise the local duty social workers on the need for a medical examination; available between 09:00-22:00 seven days per week Where it is deemed appropriate that the child has a medical examination (for forensic purposes or not), this review recommends that: • The current SATUs providing medical/forensic medical examinations for children over the age of 14 continue; • The current children's SATU in Galway providing medical/forensic medical examinations for children under the age of 14 in and out of hours continues; • The current services providing medical/forensic medical examinations for children under the age of 14 in appropriate facilities (e.g. Waterford, Cork, Sligo and Dublin Mid Leinster) continue, but also provide additional support over the weekends. We would consider the support required being an additional 4 hours on-call on Saturday and Sunday (e.g. for the Waterford service currently providing medical/ forensic medical examinations in normal working hours, cover would now extend over the weekend with medical examiners available to be called in over two 4 hour periods at the weekend). Where facialities are not currently forensically sound, these should be upgraded; • For other areas, medical/forensic medical examinations should be undertaken by a rota of appropriately trained professionals (community paediatrician, Emergency care paediatrician, GP or a private provider) available to undertake examinations between 09:00-17:00 Monday to Friday and for 4 hours (on-call) on Saturday and Sunday. The cover provided in this manner will result in a child having to wait no more than 20 hours for a medical examination, where it is deemed appropriate to undertake and examination immediately. The professionals undertaking the medical/forensic medical examinations should have the necessary knowledge, skills and experience to undertake the examination. Training should be provided to an increased number of professionals to increase the pool of available resources.

Component of model and key issues	Recommendation
Multiagency Referral Variation in the timing and format of multi-agency communication and discussion	Central to the pathway is the Multiagency Referral Team (MRT), which is established as an opportunity to work collegiately to maximise the benefit and outcome to the child and their family. It is viewed as optimum to use the referral team to both signpost and assess the outcomes for the child, as well as referring the child to the appropriate services and receiving outcomes and updates on their progress. This review recommends that the MRT meeting is established as a fixed weekly meeting in each region, with agreed representative membership. The MRT will be iterative in the pathway and the child's case will be presented to this team at a number of steps in the process, To support instances where the recommended next steps should be therapeutic or child and adolescent mental health intervention, the MRT should have referral rights to these services to ensure timely access to care for the child through the pathway.
Joint interviewing Lack of adherence to policy guidelines. Differences in understanding and interpretation of these guidelines	Joint interviewing is recommended as the benefit to the child is a potential reduction in the number of interviews needed to gather the necessary information. However, this is only achievable when the information can be shared and used for other purposes. Also, the role of the social worker must be clearly defined and this definition be supported at an operational level so that social workers can be assured of their position and contribution to the interview. As such, this review recommends that the outcomes of the interview be re-established. We recognise that there is a single purpose of the interview under the Criminal Evidence Act 1992 but it is considered that the outcomes i.e. the information, should also support the HSE social work team to develop the relevant action plans and make conclusions on the credibility of the allegation. This information should also be available to the MRT for further assessment of the child's individual needs. We would continue to advocate the need for specialist interviewers only to complete the interview.
Child interview and assessment Lack of a consistent approach to information sharing. Variation in waiting times	We would recommend that the current professionals involved in the full assessment of children (social workers and psychologists within and outside specialist units) continue in this role, undertaking assessments in cases where a criminal investigation is not being pursued. Where a criminal investigation is being pursued and in cases where a further assessment is required to determine credibility and therapeutic needs following the joint interview, this should be arranged as soon as possible and in line with the needs of the child. Where this is the case, information gathered from the joint interview for evidential purposes should be available to these professionals prior to the full assessment interviews to allow them to only conduct value added, non duplicating interviews. Recommendations on the credibility of the allegation (where not determined in the joint interview) and the need for therapeutic treatment should be established as an outcome and reported back to the MRT.
Therapy provision Varying and significant wait times for access to therapy services. Inconsistencies in referral routes.	Therapy needs should be assessed holistically with one referral addressing the potential impact needs of other family members and siblings, reducing the need for additional referrals and subsequent time delays with no value added to the child. We recommend current therapy/mental health service provision is mapped and a directory of services developed per region, which all staff involved in CSA cases are made aware of. This should also outline the criteria for referrals. Validation throughout the project, along with best practice review has identified the benefits of specialist, co-ordinated units such as St. Louise's and St. Clare's. This review recommends that where there is available critical mass of referrals, a similar co-ordinated service approach should be developed e.g. Cork and Galway. Specialist units would act as a hub within a hub and spoke model, with the hub providing support, advice

Component of model and key issues	Recommendation
Inconsistency in therapy services available, dependent on outcome of the assessment and geography	and professional development to the local therapy services (spokes). Options should be explored within the hubs and spokes to combine the available resources of both the HSE and CARI in order to provide an eclectic and more evenly distributed range of therapy services across the country. The provision of local services will ensure minimal travel for children and their families. This allows competencies to be maximised as well as ensuring maintenance of professional standards. Where hub and spoke models still do not reach to the child and their family without considerable travel time or inconvenience, there should be ring-fenced funding for private provision. Any private provision should be assured under the competency assessments agreed previously. Clear referral protocols and criteria for CAMHS services need to be established and understood by all professionals. Referrals to CAMHS can be requested by any professional currently providing a service to the child throughout the pathway, with agreement of the MRT. This should ensure greater uniformity and appropriateness in referrals to these services.

To support the operational implementation of the optimum model of care, there needs to be robust infrastructure that ensures that the standards of care are achieved and maintained focussed on:

- Advocacy;
- Governance and information sharing;
- Competencies and training; and
- Reporting and evaluation.

We have endeavoured to recommend an optimum model of care which makes best use of existing resources across all agencies. However, given the extent of some of the issues which need to be addressed in order to provide a nationally consistent, equitable and accessible service, there is inevitable a call for additional investment. Based on our recommendations, the areas which require additional investment are for:

- Extended working hours for social workers – an additional 5 hours per weekday and 26 hours at weekends provided at a sub-regional level;
- Immediate access to advice of a paediatric medical examiner;
- On-call arrangements at weekends for forensic and medical examinations;
- Additional therapy resources;
- Additional training- forensic medical/medical examinations and joint interviewing; and
- Advocacy resources.

Based on the assumptions and calculations to date, we have identified a potential requirement of an additional investment to sexual abuse services of **€993,500.**

None of the recommendations being made are insurmountable or require a long period of planning; they simply call for a more organised, consistent and collaborative approach to service provision and we have suggested next steps throughout the report. Finding the funds for the additional modest investment to improve access and availability of services would go a long way to significantly improving services for children and their families.

Finally, Mott MacDonald wishes to thank the joint chairs of the Steering Group, Siobhan O'Halloran and Aidan Waterstone of the HSE, together with the all the members of the Steering Group, for their time, commitment and support to us throughout the review in order to complete such a comprehensive review within a 7 week timescale. We would also like to thank all those staff across all agencies who participated in both the engagement interview programme and validation workshops in giving their time and providing invaluable help in supporting our understanding of this service and the issues being faced.

1. Introduction

The Health Service Executive (HSE) has commissioned Mott MacDonald to support and facilitate the national review of sexual abuse services for children and young people across Ireland.

1.1 Project scope

The primary purpose of this National review is to improve the delivery of sexual abuse and related services for children and young people across the country.

For the purposes of the review, the age range for consideration is 0-18 year olds. Where children's and adults services overlap, or where the division is not clear, this will be identified and discussed.

The review covers forensic examination, joint interviewing, assessment of need and therapeutic services, as well as specialist services, provided across the four regions of the HSE, considering sexual assault services as a component part of sexual abuse services.

The objectives of this review, as set out in the terms of reference by the HSE, are:

- To determine the current and anticipated level of demand on sexual abuse and related services for children and young people in Ireland.
- To review other work undertaken in this area including the work of the Clinical Expert Group and the Ferns IV Working Group.
- Within the constraints of existing levels of resource:
  - Advise on the appropriate multidisciplinary model of care in the area of sexual abuse services for children and young people;
  - To assess the current provision of sexual abuse services nationally for children and young people against this model;
  - To determine the appropriate linkages between these services and adult sexual abuse services;
  - Bring forward proposals for the configuration of these services nationally including the opportunities that will be provided once the new National Paediatric Hospital is built;
  - To determine the current deployment of resources nationally in this area, (personnel, financial and otherwise) to provide advice on the optimal deployment of these resources;
- To advise on the appropriate governance of these services, including the relationship between the HSE and the Gardai Siochana; and
- To present recommendations to the National Director, Integrated Services Directorate in relation to the above.

1.2 Context of the review

The context for this national review is set within the imperatives to meet statutory regulations and standards, including the new performance indicators detailed in the HSE National Service Plan 2011[1], and to also meet the key objective of promoting and protecting the health and wellbeing of children and families, through improving the quality and consistency of services and establishing clear governance arrangements, as set out by the HSE.

The recommended model and configuration of sexual abuse services from this review will be in line with best practice and the implementation of recommendations arising from the 'Report of the Commission to Inquire into Child Abuse' (Ryan Report), the recent National Guidance on the Protection and Welfare of Children[2] and Recent Rape and Sexual Assault[3] and will build on and support the implementation of recommendations from the recent 'Strategic Review of the Delivery and Management of Children and Family Services' report. This highlighted the need for: less variation in service provision; more visible leadership; clearer organisational structures to support the provision of children's services; and better use of information to allow 'intelligence-led' delivery of services.[4]

1.3 Project Approach

There were three phases of work to complete the review:

- Phase One: baseline review and interview/engagement programme (Appendix A) whose purpose was to develop a detailed baseline of information on the current provision and configuration of sexual abuse and other related services across Ireland and the current and anticipated demand for these services;
- Phase Two: establishing the best practice model of care; and

[1] HSE National Service Plan 2011, Children and Families, page 34 (Indicators related to the percentage of referrals where enquires took place within 24 hours and where an initial assessment took place within 20 days)

[2] Children First: National Guidelines for the Protection and Welfare of Children (2010), Office of the Minister for Health and Children,

[3] National Guidelines on Referral and Forensic Clinical Examination in Ireland, HSE, 2nd edition 2010

[4] Inspiring Confidence in Children and Family Services: Putting children first and meaning it, Strategic review of the delivery and management of children and family services, HSE, October 2009

- Phase Three: determining the optimum model of care. To contrast the best practice models of care for sexual abuse and related services, with the current national configuration and provision. This will inform recommendations on an optimal model of care, an appropriate governance structure, the optimal deployment of supporting resources; accompanied by an implementation plan for the future provision of the optimal service model.

The key deliverables from the review are:

- A final report following discussion and sign off with the Steering group and the National Director of the Integrated Services Directorate; and
- A presentation of the final report to the Steering Group and National Director of the Integrated Services Directorate.

This draft final report presents the findings from all Phases of the approach and sets out our recommendations by the HSE and other agencies.

2. Best practice

2.1 Overview

Prior to setting out how the optimum model of care for Ireland could look, recognising the financial constraints for any major new investments in service developments, it is important that we establish the key characteristics of the model that would be expected to be exhibited by best practice models.

This section of the report provides an overview of models of care for children and young people who have been the victims of sexual abuse established in health systems elsewhere in the world.

Further details are provided in Appendix B.

2.2 Key principles for best practice care

A comparison of established and recognised 'best practice' models of care across different health systems, identifies that there are similarities in the key principles of best practice care. These include:

- An approach where the needs of the child are the primary consideration, ensuring that the number of interviews and examinations are minimised;
- A multi-agency coordinated approach to identify abuse, assess risk and devise and implement management, protection and aftercare plans effectively;
- Twenty-four hour access to crisis support, specialist clinical and forensic care. Rapid access to a medical or forensic examination as required;
- Access to a multi-disciplinary team who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children;
- Access to an environment that is welcoming, supportive and accessible. There should also be access to a dedicated forensic facility to ensure a robust chain of evidence; and
- Clear guidance and protocols.

Indeed, many of these best practice principles have been identified as part of the Ferns IV Working Group proposed model for service delivery[5] (set out in Appendix C).

5 Report of the Ferns 4 (Children) Working Group: Assessment, therapy and counselling needs of children who have been sexually abused, and their families (2009) HSE

2.3 Pathway of care

A recent international review of models of service provision revealed that whilst in some countries a single model of provision predominates, in the majority there are a range of models, as well as less organised forms of provision, operating simultaneously. Therefore for most victims of rape/sexual assault, the responses they encounter depend not only on which country they live in but also where they live within that country.[6]

However, regardless of this variation in service models, the care pathway for these children and young people all include similar service components, including:

- Assessment and interviewing to consider their physical, sexual, mental and social care needs;
- Medical Examination, either:
  - Forensic Medical Examination for acute cases; or
  - Medical Examination for non-acute cases;
- Follow up care, including access to therapeutic services, mental health services and independent sexual violence advisors.

The following sections briefly discuss the best practice evidence associated with each component of this pathway.

2.3.1 Assessment and Examination Services: Models of Care

2.3.1.1 Sexual Assault (Referral) Centres (SARC)

There are a number of models of Sexual Assault Centres, responding to concerns about the lack of dedicated services for victims of sexual assault. Some countries such as Canada have extensive networks, while others such as Germany, Switzerland and the UK have a number of centres, often located in major cities or locations where women's groups or committed medical staff have campaigned to improve local provision.[7]

6 Kelly, L. and Regan, L. (2003) Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations, Rape Crisis Network Europe.

7 O'Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

In terms of coverage, there are currently 30 existing SARCs and a further 16 are under development in police force areas across England and Wales. It is intended that across England, there will be a SARC in each police force area by 2011.

Within the UK, 'SARCs are now widely recognised as a fundamental part of the overall suite of support provided to victims of serious sexual assault and abuse, within the local community setting. The co-ordination of health, counselling and criminal justice forensic services addressed in a 'one stop' location has provided the basis for the development of SARCs across the country'[8].

The National Service Guidelines for developing Sexual Assault Referral Centres[9] define the following minimum elements of service for SARC's:

- Twenty-four hour access to crisis support, first-aid, safeguarding, specialist clinical and forensic care in a secure unit;
- Appropriately trained crisis workers;
- Choice of gender of physician, where possible;
- Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported;
- Dedicated forensically approved premises and a facility with decontamination protocols following each examination;
- The medical consultation includes risk assessment of harm/self-harm, an assessment of vulnerability and sexual health and immediate access to emergency contraception, post-exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed;
- Access to support, advocacy and follow-up;
- Well co-ordinated interagency arrangements in place; and
- Minimum dataset and appropriate data collection procedures.

The SARC model reflects that timely access into appropriate sexual health and mental health services is essential. It is suggested that therapeutic interventions can prevent the onset of chronic Post-Traumatic Stress Disorder (PTSD) if received soon after the traumatic sexual experience.

Comparing SARC services based across England, it is apparent that there is inconsistency in the minimum age of a child or young person eligible for treatment at current SARC services, varying from children aged from 0 years up to 16 years of age; and dependent on availability of resources and the local arrangements in place for children's services.[10]

8 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

9 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

10 Department of Health Children and Mental Health Division and Home Office Violent Crime Unit (2005) Developing Sexual Assault Referral Centres (SARCs) –

2.3.1.2 Child Advocacy Model

CACs provide a neutral, child-friendly facility where all the government agencies can interview and examine the child in a coordinated interviewing process.

The Child Advocacy Model involves Child Advocacy Centers (CACs) which are one-stop systems. The objective of CACs is to reduce trauma to the child abuse victim by coordinating a child's interview to include professionals from multiple agencies, which can reduce the number of interviews and improve the quality of the investigation.[11]

CACs represent a neutral third party where representatives from each partner agency can collaborate in a collegial environment. This is considered to be a more effective and efficient way to deliver services: improving the accuracy of overall assessment, prediction of risk, and development of intervention strategies; reducing confusion between multiple agencies; and avoiding the duplication of services. [12]

The National Children's Alliance have developed CAC standards for accreditation which identify the critical functions of a CAC[13]:

- Joint investigative interviews;
- Multidisciplinary case review team;
- A case tracking system;
- A medical examination;
- Mental health evaluation and treatment;
- Access to community and emergency services; and
- An advocacy and criminal justice system liaison.

Children Houses have been established in Iceland, Sweden and in Norway and are based on the CAC model where the needs of the child are defined as "a primary consideration" rather than the child having to adapt to the needs of the different agencies of societies. [14]

2.3.1.3 Child Abuse and Rape Enquiry Units

Within Northern Ireland, Child Abuse and Rape Enquiry Units (CARE) have been established, where for both adult and child victims of acute

National Service Guidelines

11 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

12 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

13 National Children's Alliance, Member Standards, http://www.nncac.org/network.html.

14 Gudbrandsson B (n.d.) "Under one roof" Towards the best interest of the child in cases of child sexual abuse. Government Agency for Child Protection, Iceland

There are four CARE Units, managed and funded by the Police Service Northern Ireland. All four Units located in a police environment.

and chronic rape/sexual assault are interviewed and examined. This service is provided by a dedicated trained police officer who makes all the arrangements to interview the victim within the CARE unit and arranges the forensic medical examination, as necessary.

Whilst this model provides dedicated, well-trained and experienced Police Officers dealing exclusively with cases of sexual assault and abuse in both adults and children, it is entirely police-managed and has only limited links to health services. [15]

2.3.2 Joint interviewing

The responsibility in dealing with child sexual abuse is often divided between a number of agencies:

- Child protection systems or the social services are to ensure the child's safety and the appropriate support services and therapy;
- The health professions need to be involved for medical examination and intervention;
- Law enforcement is responsible for the criminal investigation and the prosecution for deciding on whether indictment is made or not; and
- The role of the court system is to determine the guilt or innocence of the alleged offender.

'In order to fulfil their roles, all these different agencies need to examine the child victim's account. Consequently, it is commonplace that children are subjected to repeated interviews by different professionals in many locations; a condition that research findings have showed to result in re-victimisation of the child that can even be more painful for the child than the original abuse'.[16]

In line with CAC and Children's House model, a joint interviewing approach sees that the needs of the child are defined as a primary consideration rather than the child having to adapt to the needs of the different agencies of societies..[17]

Whilst it is recognised that more research needs to be done to validate the advantages of involving the justice system in a joint process to

15 O'Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

16 Gudbrandsson B (n.d.) "Under one roof" Towards the best interest of the child in cases of child sexual abuse. Government Agency for Child Protection, Iceland

17 Gudbrandsson B (n.d.) "Under one roof" Towards the best interest of the child in cases of child sexual abuse. Government Agency for Child Protection, Iceland

investigate child abuse, one study of CACs concluded that there appeared to be increased coordination on investigations and child forensic interviewing[18], key benefits identified include a shorter caseworker response times, more substantiated reports, more criminal prosecutions and more guilty pleas. [19]

2.3.3 Medical Examination Services

In addition to the medical examination addressing the child or young person's needs, forensic examinations must also address the justice system's needs for rigorous evidence collection. It is reported that good practice involves understanding this dual function, and recognising that whilst they can often be combined relatively seamlessly, there may be conflicts for the complainant and/or the medical examiner.[20]

Best practice indicates that forensic examinations should be undertaken in dedicated forensically approved premises and a facility with decontamination protocols following each examination to ensure high quality forensic integrity and a robust chain of evidence, including:

- Protocols, procedures and audit in place for decontaminating examination facilities;
- Following professional guidance[21] on sample collection and labelling, and the recommended equipment for obtaining forensic samples from complainants and suspects; and
- Regular multidisciplinary meetings for staff to discuss queries and practical issues with key experts and receive updates on developments in forensic practice from the lead forensic physician. [22]

Other issues (although not child specific) identified to be critical in ensuring that forensic examinations maximise the evidential potential and provide comfort, reassurance and necessary health input, include:

- Speedy response;
- Trained and skilled practitioners;
- Choice of examiner;

18 Theodore P et al (2007) Child forensic interviewing in Children's Advocacy Centers: Empirical data on a practice model

19 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

20 Du Mont, J., & Parnis, D, in press, 'Forensic nursing in the context of sexual assault: Comparing the opinions and practices of nurse examiners and nurses' Applied Nursing Research.

21 For example, guidance from the Faculty of Forensic and Legal Medicine

22 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

- Time to move at the speed the victim/survivor is comfortable with;
- Protocols and evidence kits which are applied flexibly, according to the facts of the case; and
- Provision of, or links to, medical follow up and advocacy/support services.[23]

Some of the service models reflect these key criteria, as, for example, SARCs require that access to a forensic physician is normally available within one hour and that there should be a choice regarding the gender of a physician where possible. [24] SARCs must also provide access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children and state that:

- Paediatricians who undertake assessments of children with an allegation of sexual assault must have higher level competencies (above level 3) in paediatric and forensic medicine; and
- Forensic physicians, whether working with children or adults or both, have practical experience of working as a Sexual Offences Examiner, with ongoing supervision such as peer review, annual appraisal and revalidation underpinned by continuing professional development.[25]

Guidelines also state an ideal service should be available 24/7 or provide a service for some part or all of every day, including weekends. To achieve adequate medical staffing rotas for acute medical child protection work may well need to draw on networks such as managed clinical networks.[26]

Within the CARE Unit in Northern Ireland, it is noted that examinations of children are usually carried out jointly by the senior doctor at the Garnerville Unit and community or consultant paediatricians. Many of the eight doctors who cover the 24-hour rota work elsewhere part-time; either as GPs or at senior registrar level in hospitals, in addition to rota cover at the CARE Unit.[27]

23 Kelly, L. and Regan, L. (2003) Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations, Rape Crisis Network Europe.

24 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

25 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

26 DH (2008) Draft Guide for Services for Children provided by Sexual Assault referral Centres (SARCs)

27 O'Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

Forensic nurses are also being considered forensic nursing has been introduced in Europe, the US and Canada as a means of addressing problems encountered with the recruitment and retention of female doctors and providing the best possible service for victims. In the US, forensic nurses now conduct the majority of forensic medical examinations on both adults and children and includes provision of services to the police and criminal justice system.[28]

In the UK, by contrast, the scope of the forensic nurse's practice is limited where they are accepted by the courts as an ordinary witness only, as opposed to the doctor who is seen as an expert witness. The evaluation of the UK forensic nursing pilot programme suggested that ''the obvious next step for the long term lies in the development of the forensic nurse's role from documenter to interpreter of her own evidence, as is common practice in North America.[29]

2.3.4 Accessibility

Research has shown that early evidence gathering and victim support are key factors in successful prosecutions and to supporting victims' access to sexual health and NHS services. [30]

It is widely accepted that accessibility to sexual assault services is essential and that regardless of location, it is important to create an environment 'that is welcoming, supportive and accessible. The aim is to encourage more victims to come forward, including under 16 year olds, to ensure they also access services including sexual health/teenage pregnancy'. [31]

A core standard for some services is that they are a neutral facility. As part of the CAC, this is defined as a designated separate facility where professionals and families can meet.[32] Other models differ in their physical location. For example, many of the SARC services established within the UK are co-located within a hospital.[33] CARE units in Northern Ireland are located in a police environment, where the interview rooms are equipped with adjoining observation rooms, video

[28] Regan L., Lovett J., Kelly, L. (2004) 'Forensic Nursing: An Option For Improving Responses To Reported Rape And Sexual Assault', Home Office, London.

[29] Regan L., Lovett J., Kelly, L. (2004) 'Forensic Nursing: An Option For Improving Responses To Reported Rape And Sexual Assault', Home Office, London.

30 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

31 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

32 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

33 Department of Health Children and Mental Health Division and Home Office Violent Crime Unit (2005) Developing Sexual Assault Referral Centres (SARCs) – National Service Guidelines

links and camera recording equipment. These facilities are used particularly in cases of child abuse where the child victims are being interviewed or also in interviewing vulnerable adults, such as those with learning difficulties. The medical examination rooms provide colposcopy, photography and video documentation facilities.[34]

In a 2005 review, it was reported that in some police force areas, police choose to take the statement within the SARC environment, which may involve the victim travelling up to 1.5 hours to the facility. SARC police liaison officers have reported that this is acceptable to victims because of the enhanced and prompt service they will receive on their arrival.[35]

2.3.5 Follow Up Care

The models discussed provide access or referral to follow up care, which may include:

- Hospital and wider health services for treatment of injuries;
- GUM services for ongoing sexual health needs;
- Mental health services for children and adolescents;
- Therapeutic and counselling services;
- Victim support, for information on police and court procedures, advice on claiming compensation and advocacy services; and
- Specialist rape crisis and other sexual violence organisations where clients may have a preference for counselling/advocacy away from the centre or required long-term counselling.

It is generally accepted that early access to services for children and young people is essential to ensure improved outcomes.

2.3.5.1 Therapeutic interventions

It is clear that a variety of therapeutic approaches can be used when working with children and young people ranging from use of specialist therapies such as ‘Cognitive Behavioural Therapy/(CBT)’, ‘Family Therapy’, ‘Psychodynamic approaches’ and approaches such as ‘EMDR’ [Eye Movement Desensitisation and Reprocessing] [36] through to ‘creative therapies’.

34 O’Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

35 Department of Health Children and Mental Health Division and Home Office Violent Crime Unit (2005) Developing Sexual Assault Referral Centres (SARCs) – National Service Guidelines

36 Stafford A, Morgan-Klein N, Kelly S (2009) Mapping Therapeutic Services to Children and Young People who have been Sexually Abused Services in Scotland

Key characteristics of best practice models of therapy have been identified within Ferns IV, these characteristics include:

- Clear referral criteria;
- Provision by a multi-disciplinary skilled team who understand issues of sexual abuse and sexual assault;
- The availability of therapy services ranging from play and activity based creative and arts therapies through to Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR)
- Individual psychotherapy, family therapy, parent support and ready access to child and adolescent psychiatry; and
- Be provided in child friendly, private and confidential environment.

It is also apparent that waiting times for such therapy services also vary considerably; the recent review of therapeutic services in the UK found that 'waiting lists for a service average three months, although this also varies quite significantly and can be as long as a year. Services prioritise children with the most severe symptoms and problematic behaviour, as they lack the resources to quickly see all children who have experienced sexual abuse. Some services are managing excess demand by closing their waiting lists'. [37]

In addressing this, it is recommended that consideration be given to forming an area or even regional clusters to ensure a variety of therapeutic interventions are accessible across a range of providers. [38]

2.3.5.2 Other ongoing support

"For children and young people who have been maltreated by their parents or carers, it is especially important that the professionals trying to help them do not add to the feelings of being powerless and vulnerable". (Munro 2011:18, par.1.33)

The recent Munro review of the child protection system in England 2011 concludes that just as the system must listen to the experiences and views of the professionals working with children and families, so it must listen to the children themselves. Social workers often identify that they lack the necessary skills and confidence in undertaking direct work with children, while another constraint is having the necessary time. It

37 Allnock D et al (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need. NSPCC

38 Allnock D et al (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need. NSPCC

asserts that like many other professionals social workers' priorities are set by the organisations they are working for.

A recent review of Children and Young people's views of the child protection system in England 2011 found many of the children had only a partial understanding of the child protection process. Professionals engaged with the child and young person should not assume that the child is not of sufficient age and understanding to know something about the child protection process. [39]

It is important that they receive information appropriate to their needs. This is likely to be different from case to case and professionals need to take into account the fact that information (sometimes erroneous) may come from other sources, such as older siblings, parents, friends or the media. In the current study parents varied in their views about how much the child should know about the child protection process. Some parents made it clear that they wanted to protect their children from knowledge about the formal child protection system whilst some spoke to their children about what was going on.

As part of the care provided to the child and young person, they could have access to Independent Sexual Violence Advisors (ISVAs), who are specially trained to provide proactive and tailored assistance and advice to victims of sexual violence. Within the UK, ISVAs are located in either SARCs or voluntary projects and their role is to provide effective support and clear information to SARC users at all points of the process from report through to court. This is victim led. [40] Their main responsibilities can be broadly grouped into the following areas:

- Advice and support;
- Where required, supporting victims, giving information and assistance through the criminal justice process; and
- Multi-agency partnership working on behalf of the victim.[41]

2.3.6 Conclusions

Based on this overview of alternative models developed elsewhere, there are a number of key characteristics which exemplify best practice, these include services which:

[39] Office of the Children's Commissioner, "Don't make assumptions", Children and Young People's views of the Child Protection System and Messages for Change, March 2011

40 National Support Team for Response to Sexual Violence (January 2010) Department of Health and Home Office

41 Home Office (2009) Independent Sexual Violence Advisors: A Process Evaluation

- Are responsive to the needs of the child;
- Are provided in a child friendly environment;
- Minimises the distress resulting through multiple interviews;
- Meet the holistic needs of the child; and
- Ensures the timely collection of forensic evidence by specialist trained clinicians.

3. The findings and themes of the baseline assessment

3.1 What we have done

To capture the current profile of service provision, we have undertaken a stakeholder engagement programme and issued data collection templates for capturing service details to ensure consistency in the data and information collected. We have also reviewed publically available information and the Ferns IV working group report.

A selected engagement programme has been undertaken via face to-face and telephone interviews and has included:

- St Louise's Unit, Our Lady's Hospital, Crumlin;
- St Clare's Unit, Children's University Hospital, Temple Street;
- An Garda Síochána;
- Consultant paediatricians;
- Sexual Assault Treatment Units (SATU);
- National Director of Children's Services;
- Operational service managers and clinicians across the four regions;
- CARI Foundation;
- One in Four (although provides service to adults only);
- Rape Crisis Network;
- HSE Child Care Managers; and
- Granada Institute.

Details of those involved in the engagement programme are listed in Appendix A.

This has been augmented by the facilitation of regional based workshops attended by key stakeholders to confirm the baseline position and to better understand the gaps and key constraints and difficulties in current service provision.

Full descriptions of local service profiles within each of the four regions can be found in Appendix F.

3.2 Terminology

For the purpose of clarity in describing the baseline, we have defined our terminology, which is referred to throughout the following section of the report, below:

Terminology	Our understanding/definition
Joint interview/ Specialist section 16 (1) (b) interview	An electronically recorded interview undertaken with children under the age of 14, for evidential purposes in accordance with Section 16(1) (b) of the Criminal Evidence Act, 1992. Interviews should be undertaken by trained HSE Social Workers and Gardai only, in specialised facilities.
Initial assessment	Initial assessments undertaken by HSE social workers or Gardai following notification of alleged Child Sexual Abuse, to either agency, and following completion of initial child protection measures. Initial assessments will inform/form part of multi agency strategy meetings to determine the actions to be taken.
Full assessment	A therapeutic assessment of the child and family undertaken by social workers and/or psychologists comprising of an assessment of credibility, impact and therapeutic need. The assessment service then makes recommendations around the safety, welfare and therapeutic need, to the HSE Social work service who refer children and families on to appropriate therapeutic services where necessary.
Forensic medical examination	A medical examination required within 72 hours of an alleged assault in order for forensically sound evidence to be gathered.
Medical examination	A medical examination to identify and address the medical needs of children and allow medical treatment/screening to be provided.

3.3 Current demand for services

The review has identified a lack of common reporting and data collection, both across the regions, inter agency and across agencies. We were unable to ascertain actual numbers of children referred to the service and the outcomes of those referred in terms of the complete pathway, however we have been able to reflect parts of the pathway through the information provided, which is outlined in Appendix H.

3.4 Areas of good practice

It is important to recognise and acknowledge that currently across the country there are examples where elements of service provision are considered to be good, appropriate resources and facilities are available and/or working relationships between agencies are well developed. Given this, it demonstrates that, within existing resources, it should be possible to improve services for children and young people and provide a better coordinated and comprehensive service.

Service areas demonstrating good practice include:

Joint interviewing

- The availability of seven specialist interview suites located across the country in child friendly environments; and
- The pool of 72 Gardai and 30 HSE social workers trained to undertake specialist interviews (accepting that there is disparity in the distribution of these trained staff across the country).

Initial assessment

- There is a national pilot currently in operation in Donegal to provide out of hours social work provision when children are removed from their parents/carers out of hours (where the Gardai remove children under Section 12), a key requirement considered by a number of agencies. A second pilot is also underway in Cork.
- 24 hour access to emergency residential care for those children considered to be at risk (e.g. services currently available in Wicklow and Kildare); and
- Helpline support provided by CARI to parents during an initial 6 week wait.

Full assessment and therapy

- Dedicated specialist multidisciplinary teams at St Clare's Unit and St Louise's Unit in Dublin, providing a wide range of assessment and therapeutic services;

- Therapy outcomes measured through pre and post assessments within the specialist units and by CARI;
- Formalised professional development, supervision and training for staff within the specialist units;
- The Family Centre in Cork providing assessment and medical services through a dedicated multidisciplinary team;
- The Community Child Centre at Waterford providing dedicated assessment and medical services by a multidisciplinary team;
- Access to a range of therapy services across other parts of the country provided by the HSE and voluntary providers, including CARI;
- Psychological support services provided by the Rape Crisis Centres to those over 14 years of age;
- Data and information collection processes developed by the Rape Crisis Network to understand trends and patterns of behaviour; and
- Links between the Granada Institute and the specialist units in Dublin to reconcile families.

Forensic medical and medical examinations

- For those children over 14 years of age, 24/7 SATU services are available; the main provider at Rotunda Maternity Hospital, with five other units located in Cork, Letterkenny, Galway, Mullingar and Waterford;
- For children under 14 years of age living in the Mid West and Galway, the availability of a specialist forensic examiner in and out of hours;
- Trained community and acute paediatricians across the country to provide in hours forensic and medical examinations; including Sligo, Cork, Waterford and Dublin Mid Leinster; and
- Trained community paediatricians to provide in hours medical examinations, including Sligo, Donegal, Mayo.

3.5 Issues impacting on service delivery and quality of care

However, despite these areas of good practice, throughout the review, there have been a number of issues and consistent messages from the services which directly impact on their ability to provide services along the agreed pathways or impact on the timely outcome and quality of care for the children and young people and their support network. These issues include:

Governance

- There is considered to be lack of consistency in terms of a standardised model of care and the co-ordination of services, and little interagency planning and collaboration. A whole systems

approach needs to be adopted and there needs to be an interagency planning model for services, with greater clarity on decision making;

- There are few formal working relationships established and little interagency collaboration, resulting in essential data not being shared; although it is recognised that there is a lack of legislative support in relation to interagency sharing of information. In this respect, there needs to be a clear legislative basis to allow for interagency sharing of information between all relevant stakeholders.
- It is recognised that some joint working is currently in place with different agencies involved in the provision of sexual abuse services, such as the policy and training in place between the HSE and An Garda Síochána for undertaking joint interviewing for investigative purposes, in line with the Children First guidelines. However, as will be discussed, operationally, this policy is not being adhered to;
- There is no common IT and information service supporting services, therefore information cannot easily be shared;
- There is a lack of agreed guidelines for service provision and baseline of good practice in order to benchmark and audit services; subsequently there is a significant difference in standards of care across the country. This is demonstrated through cases that are being put through the family law courts;
- There is also a lack of standards of practice for forensic examination (in children under 14) meaning the approaches professionals take are varied, difficult to monitor and quality assure; and
- Principles around governance, audit and training need to be put in place.

Lack of acute child sexual abuse services

- Where children require medical services; both forensic medical examination (within 72 hours of event) or medical examination, there are limited dedicated services in place to provide this if the child is under the age of 14. Only the service in Galway provides a dedicated out of hours forensic and medical examinations service:
  - For children over the age of 14, adult SATU centres can be accessed depending on the child's location (Currently 6 SATU units across the Country). For children under the age of 14 or where a SATU is not available, both forensic medical examinations and medical examinations are undertaken by paediatricians, community paediatricians, GPs or A&E physicians;
  - There are variations across the country in terms of the medical professionals willing to carry out forensic medical examinations/ medical examinations as these professionals often lack the

specialist training required, do not have the required experience in this area, and lack the necessary equipment and appropriate facility to undertake the medical assessment; and
  - Where medical services are required out of hours these issues are exacerbated.
- There is no apparent delivery of an explicit service. Instead there are a series of professionals working together where possible to deliver a package of support and treatment for sexually abused children.

Access to Services

- When children present to various settings/agencies the initial response depends on the time of day. There are no HSE social worker services available out of hours aside from the national pilot in HSE West. Out of hours the Gardai are notified and are then given the responsibility to undertake an initial assessment and co-ordinate the initial needs of the child. Children must wait for normal working hours to access HSE social workers;
- Historically, there has been a lack of service for children in need of emergency care placements, with the Gardai experiencing difficulties in finding appropriate accommodation. To lessen this issue, the HSE has commissioned a private provider, Five Rivers, to provide emergency care placements in locations across the County. Furthermore, a pilot scheme is being undertaken in HSE West (Donegal) of on-call social workers able to provide assistance out of hours when children are removed from their parents/carers;
- Following notification, there is a considerable difference in the time for initial assessments being undertaken by HSE social workers. This can be undertaken immediately, but in some cases, may take up to 3 days, depending on the severity of the case determined from information at referral. This introduces considerable inequity into the national provision of services;
- The waiting times for a full therapeutic assessment vary and the longest reported was 6 weeks. There are no formal interim services in place for children and families over this time (although some may use CARI, RCN, National Counselling Service or ISPCC helplines);
- Access to well co-ordinated and holistic therapeutic services is consistently poor across the country with only two services (St Louise's Unit and St Clare's Unit) having their own specialist therapy for sexually abused children. All other services use established HSE services including CAMHS (referrals only made when there is a risk of self-harm), Psychology and Play Therapy services, although the waiting lists for these services are often long. There is little funding available to facilitate access to private provision of therapy services; and

- There is variation in the referral route across services. Some services have an 'open door' referral process whereby anyone can refer in, including family and children themselves, whilst others only accept referrals from social workers. The same pattern is then repeated when accessing treatment and therapeutic interventions; some services can directly refer into therapies, and indeed, in some instances, provide their own services, whilst others have to refer back to the original referrer to then refer on to therapy services. This adds non-value added steps to the child's experience and increases the time to treatment.

Non standardisation of assessment processes

- There is a policy in place for joint interviewing to be undertaken by the Gardai and a HSE representative and for investigative purposes under Section 16 (1)(b) of the Criminal Evidence Act, 1992. In line with guidance from Children First, these interviews should be conducted in specialist facilities, jointly by Gardai and HSE professionals who have undertaken specialist training. However this policy is not currently adhered to, despite the specialist training being undertaken by both the Gardai and social workers, it was reported that in most cases a joint interview is not undertaken, with the Garda only undertaking the interview. Noted reasons for this include:
  - the availability of trained social workers to participate in the interviews;
  - the low number of trained social workers available to participate;
  - the perceived difficultly of the course and high failure rate associated (currently 40%); and
  - the length of the course and problem of releasing staff to participate;
- The length of the full therapeutic assessment of a child is variable and can take place over a number of months, with the longest length mentioned being 12 months;
- Professionals noted that due to little central co-ordination of services, children are expected to 'tell their story' a number of times to different agencies.

Training

Within the An Garda Síochána, a number of Gardai are keen to undertake the specialist training required to interview children in this manner, however before this training can be completed the Gardai are required to complete a short course on the Children's First guidelines. This course, provided by the HSE, however, has not been made available for a number of years resulting in the diminishing number of Garda who can undertake specialist

interviews. It was reported that this issue, needs to be quickly addressed in order to re-build the capacity of Gardai able to undertake specialist interviews;
- Locally, a range of specialist training is accessed by professionals involved in undertaking assessments and delivering therapeutic services in cases of child sexual abuse. However, this is not currently standardised nationally and there are no accredited training programmes for professionals working in these services (post their professional qualifications).

Informal contracting and Service Level Agreement (SLA)

- Throughout the review we have identified areas where holiday and study leave cover was provided by neighbouring support services on an 'ad-hoc' basis with no formal agreement in place. Often this arrangement was the result of informal relationships across the organisations, and as such, there is a high risk to continuity of care should either party in these relationships move or change. This is a particular issue in HSE West were a private provider is providing much of the forensic medical and medical examinations;
- There is no consistent, national SLA in place for many of the voluntary providers, including CARI and RCCs, and as such, local agreements are made, increasing variation across the country. This includes instances where the Rape Crisis Centres will see children under 14 years in some areas but not in others.

Service gaps

- As outlined earlier, there are very limited dedicated services for children under 14 who require acute medical services and there is variation in the medical resources available, their training, equipment and facilities to undertake medical examinations;
- There is a difficulty in accessing translation services in different regions out of hours, in emergency cases the Gardai can provide this but variations exist across the Country. A similar situation is faced for children who require additional support service i.e. those with disabilities and special needs;
- Child protection guidelines are focused on children reporting the incident but do not really consider the prevention aspect of this, these different perspectives need to be reflected. Services should also be focused on the preventative, public health model;
- There is a lack of appropriate data and information across the inter-agency interfaces to build an accurate picture of demand and response to child sexual abuse. Data is not of a high quality, is undefined and is unable to be shared in a format that provides a picture of the service; and

- There seems to be a lack of services or easy access to services across the country for children with sexually dysfunctional behaviour, despite this being recognised as a critical service.

3.6 Conclusion

From the issues highlighted through our engagement and workshop programme, it is evident that there are a number of fundamental concerns which must be addressed in order that there is improved, consistent and standardised provision of sexual abuse and sexual assault services nationally for children and young people.

However, in doing so, we need to ensure that, where possible, we build on the examples of good practice across the country and do not propose actions for service change that would materially damage, undo and/or compromise service quality where current provision is considered to be good and working effectively for children and young people. At the same time though, we must recognise that for some of the services which are reporting that they work well, much of this is driven through personal networks and contacts as opposed to developed and appropriate processes and protocols. This can result in the services fragmenting when these individuals are no longer involved in this service provision.

Therefore, it is imperative, that we learn the lessons from the examples of good practice currently in operation nationally together with international best practice to define clear standards of care, establish operational protocols and formalise networks of communication to ensure appropriate and seamless inter-agency working.

The next section of the report sets out our recommendations for an optimum model of care across Ireland within the constraints of the available staffing and financial resources.

4. Developing the optimum model of care: guiding principles

We are cognisant that the development of a 'one size fits all' pathway across the whole of Ireland is not necessarily the most pragmatic approach to developing a robust model of sexual abuse and sexual assault services for children and young people. Whilst we have developed an optimum model, identified later in the report, which has been discussed and developed in conjunction with a number of regional validation workshops, as stated earlier, we also recognise the valuable work that has already been completed in various regions. It is important that this good work is only enhanced or enabled to improve, and is not superseded without adding value to the region's users.

It is important that the measurement of success of any model developed is based on the outcomes for the child. These should be consistent across the regions, ensuring parity and equity of outcomes from accessing the service.

Therefore it is recognised and accepted that the model may differ slightly from region to region to reflect already established quality processes that achieve the outcomes agreed from the optimum model development.

With this tenet in mind during the regional validation workshops, and incorporating best practice, we established a set of principles, important to be incorporated into any new model developed, as well as any regional variations or localisation to this model.

These principles ensure that best practice is embedded across the delivery of sexual abuse and sexual assault services for children and young people nationally.

4.1 Child and Family Centred

Any optimum model and/or regional variation should add value to the child and/or family at every step. Non-value added or duplicate steps developed to meet professional staff group requirements should not be developed within models. Any outcomes from the model should be measureable around the clinical and experience outcomes for the child and their family.

4.2 Collaboration across agencies and inter agency working

The experience of accessing sexual abuse services for children and young people should be seamless for the child, with them potentially unaware of the provider of the service. This means that the delivery of services should happen collaboratively, sharing access to the child and

information pertaining to the case wherever possible, as well as recognising the need for additional agency resource at the earliest opportunity and sharing information to date. This collaborative approach also requires feedback and updates to all agencies to ensure next steps are intercollegiate.

4.3 Equitable and Consistent

The delivery model should ensure equity and consistency for the child across a number of levels including:

- Where they access the service – The point of access following disclosure or suspicion i.e. Gardai, school, Emergency Department etc. should share the same start point for service delivery i.e. the child should receive the same service;
- The time they access the service – Regardless of the time the child accesses the service, the service provision they receive and the outcomes should not differ. The model should be developed with agreed timeline standards for each process step which should be met, irrelevant of time of access;
- The professionals at each stage of the process - The competencies of staff available at each stage of the process should be the same, irrelevant of the particular time or day and/or geography.

4.4 Consistent Communication and Referral

There should be assurance that at each stage of the process there is a standardised level of communication and feedback and that each outcome is fed into the appropriate stages. All referrals should be pragmatically dealt with and formally communicated when appropriate. This will ensure that an understanding of who is involved and what feedback they have received will be known at each stage.

This consistency will also ensure that data collection and monitoring, as well as collective reporting is possible.

4.5 Timely

Timeliness is essential at all process steps of the service delivery model. There is a need to acknowledge that in some instances along the pathway there is a legitimate need for a time gap between delivery of services for the child and their family when information is being gathered or planning between interagencies is ongoing. However, the model must stipulate the accepted maximum length of time, based on best practice at each step, with a clear mechanism for continuous monitoring to ensure the timescales are being met.

4.6 Agreed Standards and Guidelines

There needs to be agreed standards to support process steps, which clearly define the accepted framework and outcomes. These standards and protocols will support the timeliness and accessibility principles agreed.

4.7 Governance

Any model developed must be supported with a robust infrastructure including a professional governance wrapper around the service that provides monitoring and support in a range of areas including:

- Training - All training needs to be aligned to the business needs of the model and should, where possible, be accredited to support workforce mobility and assurance of competencies;
- Supervision – Sexual Abuse Services are recognised as a stressful care delivery model, and as such, it is vital that professionals are supported through a range of tools including professional supervision, reflective practice, peer review and debriefing. This may require a wider than regional approach due to numbers of staff and availability of professionals to offer supervision pertinent to individual staff groups; and
- Monitoring and Reporting – Any model implemented should be evaluated and reported on at all levels to monitor effectiveness and outcomes. This will require agreement on minimum datasets and common reporting.

4.8 Working across geographical boundaries

There are instances where, due to the low volumes of cases and the need to maintain professional competency, as well as delivering a pragmatic solution, there will be a requirement for some services to deliver to a wider geographical area, potentially covering areas usually seen as ‘out of area’.

4.9 Improved integration across the HSE care sectors

At present, there are good examples in regions where professionals from across different healthcare sectors are providing services across the sexual abuse pathway, including community paediatricians and acute paediatricians providing forensic medical/medical examinations. Improved integration across sectors will support accessibility and competency based delivery as well as supervision, and will address critical mass and economic viability concerns.

4.10 Build on existing services

Where services are already established, working well and meeting all guiding principles, the proposed model and process steps should build on those services to acknowledge good practice already developed and to maximise outcomes and resources.

4.11 Holistic Approach

Sexual abuse services are recognised as a traumatic event for both the child assaulted and, in some instances, the immediate and wider family and support network. It is important that the multi-agency approach manages the event holistically including sibling referrals and assessment and family therapy. The model developed should ensure that this approach is adopted at the beginning of the process to prevent the child and their family being 'bounced' between services and to ensure the services are delivered in synchronisation and not sequentially.

5. Developing the optimum model of care: pathway components

This section of the report sets out for each key component of the sexual abuse and sexual assault pathway, our recommendations for future service configuration and delivery, based on:

- Building on the good practice identified to date;
- Addressing the issues which are seen to be negatively impacting on the achievement of delivering high quality and efficient service provision;
- Incorporating elements of best practice care models; and
- Providing pragmatic solutions, which can be implemented quickly and most easily and require no additional or minimal investment to achieve.

5.1 Initial response

5.1.1 Findings and issues

Allegations of child sexual abuse can present to a variety of different agencies including: An Garda Síochána, HSE social services, Schools, Emergency Departments and GPs. Currently, the initial response to the allegation is dependent on what time of day the allegation is made: within normal working hours (09:00-17:00) the response is co-ordinated by local duty social workers who are notified by the agency where the child presents; and who ensure the initial needs of the child are met and undertake/arrange an initial assessment of the child's welfare. Anecdotal evidence suggests that this initial response in normal working hours is dependent on the personnel involved with little standardisation in the response and with variations of approaches being adopted in similar cases.

Outside normal working hours, services and agencies, such as Emergency Departments and An Garda Síochána, must handle the allegation of child sexual abuse with no input from the HSE social services. The child and family must wait for normal working hours to resume for the local duty social worker to undertake/arrange an initial assessment. An Garda Síochána holds the responsibility for ensuring the safety of the child in these instances and after an immediate assessment of the child's safety may need to remove the child from their current place of residence (An Garda Síochána powers under Section 12). Difficulties in arranging an emergency care placement for the child have been alleviated by the HSE commissioning a private provider of emergency care placements 'Five Rivers' to provide places nationally, however difficulties still persist in locating local places swiftly.

5.1.2 Summary of best practice

Best practice evidence would suggest that the initial response to presentations of child sexual abuse should be timely and standardised regardless of the time of day to ensure the outcomes for the child are uniform.

In the UK, it is common practice to have an out of hours duty social worker who can respond to alleged cases of child protection and child sexual abuse. In the UK the task of the Emergency Duty Team (EDT) is to help all vulnerable people providing an out of hour's emergency service. The EDT priority has to be carefully focused on 'emergencies' and their assessment and intervention ensuring the vulnerable person's safety and overall welfare until a more thorough assessment of need can be carried out the next working day.

5.1.3 Recommendations

To facilitate a standardised response to the presentation of child sexual abuse across the country, we would recommend that a single point of access to services is developed in the form of a telephone contact number which would trigger the involvement of a local duty social worker, regardless of which service/agency the child presents.

Within normal working hours, we acknowledge that, in all areas this number exists and is known locally (identified in Appendix 2 of Children First). We would recommend however, that a contact number for each sub-region (e.g. HSE South, one number for the counties of Waterford, Wexford, Carlow, Kilkenny, South Tipperary, and one number for the counties of Cork and Kerry) be available for extended hours 17:00-22:00 during weekdays and 09:00-22:00 at weekends, supported through an on-call arrangement with appropriately trained duty social workers. We envisage this would involve an increased resource of 8 sub-regional on-call duty social workers (2 per region) responding to calls during these extended hours throughout the week and weekend.

These on-call duty social workers would be able to liaise with the referring service/agency where the child presents, to determine immediate actions, including for example, whether the allegation requires a response, whether the duty social worker needs to

make an immediate assessment, and/or whether An Garda Síochána need to be notified etc.

5.2 Initial access

5.2.1 Findings and issues

As outlined, currently there is variability in the responses to the presentation of child sexual abuse, depending on the time of day and the service/agency to which the child presents. There is also limited access to the appropriate professionals following the presentation, which as discussed is more prominent out of hours.

When HSE social services is notified, there is variability in the length of time the child and family then wait for an initial assessment, this can currently take place immediately, or within 3-4 days of notification, depending on the perceived severity of the case determined from referral information.

5.2.2 Summary of best practice

Best practice states that the child and family should receive an immediate timely response, with swift decision making being undertaken based on a needs-led assessment of the child and family (i.e. consideration of the welfare of the child and factors wider than the allegation of sexual abuse).

5.2.3 Recommendations

As per standard practice in some areas, in normal working hours, we would recommend that where a response is required, the local duty social worker undertakes an immediate pre-screen/assessment on site i.e. where the child and family have presented. We would recommend that this practice also be undertaken for extended hours, 17:00-22:00 during weekdays and 09:00-22:00 at weekends, through an on-call arrangement covering a sub-regional geographical area. This would be triggered through the single point of access contact number available on a sub-regional basis, as described earlier.

For presentations after 22:00 the current practice of services/agencies available out of hours, such as Emergency Departments and An Garda Síochána handling the allegation of

child sexual abuse would continue; however the local duty social worker would be available the next day at 09:00 to undertake an initial assessment, where required, and the maximum time children would be required to wait would be 11 hours, compared to the current maximum potential of 88 hours (for example over a bank holiday weekend).

This extended hours provision should ensure that the vast majority of cases are dealt with immediately.

In instances where they are more than one presentation of child sexual abuse requiring a on-site initial assessment, the social worker currently responding to the first presentation would need to liaise with the other on-call social worker within their region to respond to the second presentation. Given the volume of cases likely to be reported during these extended hours, we consider the frequency of this occurring small.

The attending duty social worker would liaise with professionals where the child presents to undertake the immediate actions required e.g. informing An Garda Síochána, making the child safe and/or arranging a medical examination etc.

The opinion of professionals is that the remit of social worker provision recommended for the initial response and access out of hours could be broadened to respond to other types of child abuse and not just child sexual abuse. Whilst this is outside the remit of the review this further recommendation should be seriously considered by the HSE.

5.2.4 Suggested next steps

- *Take the lessons learnt from the current pilots of out of hours social worker provision underway in Donegal and HSE South and incorporate into this service provision;*
- *Determine the telephone number to be used on a sub-regional level for accessing the social worker, utilising current established numbers;*
- *Determine the resources to be involved in the extended hours cover on a sub-regional basis (additional 51 hours per sub-region) and build a sub-regional rota for this cover;*

- *Clearly outline the rules and processes for the social worker provision e.g. the social worker will provide advice until 22:00, where a social worker is responding to one case and another case requires a response, the other social worker within the region will respond etc;*

- *Ensure a clear understanding of the out of hours processes across the sub-regions with professionals across health, education, Gardai and care home systems;*

- *Determine the data and information to be gathered to monitor the effectiveness of the service both by the social worker and the agencies where the child presents e.g. number of presentations by time of day, number of telephone calls by time of day, number of responses made and outcome of response; and*

- *The extended hours recommended is based on a pragmatic balance between covering as many hours as possible and meeting anticipated demands for the service. We suggest that this extended service provision is evaluated after 6 months, reviewing the profile of times in which the service was utilised and the volume of presentations. This will determine the need, if any, for the out of hours service times to be revised.*

Suggested timescale: 6 months

5.3 Forensic/Medical examination

5.3.1 Findings and issues

When a medical examination of a child is required (for forensic purposes or not), currently there is a lack of consistency in the provision of appropriate trained professionals, facilities and equipment to undertake medical examinations and inequality in the services available dependent on the age of the child.

Currently, children over the age of 14 requiring a medical examination, can access adult sexual assault treatment units (SATUs). There are currently six adult SATUs in locations across the country which are available 24/7 and are staffed with forensically trained medical examiners.

Currently, children under the age of 14 requiring medical examination, (or all children where a SATU is not available), in the majority rely on a mixture of professionals willing to undertake examinations, although in some areas services have been developed including: the children's SATU attached to the adult service established in Galway and services operating in Cork, Waterford, Sligo and Dublin Mid Leinster which provide medical examinations within appropriate facilities in normal working hours. The professionals currently undertaking medical examinations include community paediatricians, emergency care paediatricians and GPs, however the availability of these professionals is variable across the country; in many areas there are few professionals willing to undertake examinations due to lack of appropriate training, facilities and equipment.

There is currently no standardised accredited training in place for professionals undertaking paediatric forensic medical/medical examinations.

5.3.2 Summary of best practice

Best practice care refers to access to forensic physicians and other practitioners who are appropriately qualified, trained and experienced in sexual offences examinations being available to undertake examinations. In the UK, paediatricians who undertake assessments of children with an allegation of sexual assault must have higher level competencies (above Level 3) in paediatric and forensic medicine.

Forensic nurses are also being considered, forensic nursing has been introduced in Europe, the US and Canada as a means of addressing problems encountered with the recruitment and retention of female doctors and providing the best possible service for victims. In the US, forensic nurses now conduct the majority of forensic medical examinations on both adults and children and includes provision of services to the police and criminal justice system.

In the UK, by contrast, the scope of the forensic nurse's practice is currently limited where they are accepted by the courts as an ordinary witness only, as opposed to the doctor who is seen as an expert witness. There is however an increase in the number of forensic nurse examiners who, once trained are competent in forensic examination, and viewed as equal members of the forensic team in all aspects other than court attendance.

Whilst there is no apparent research on the contribution of forensic nurse examiners specifically to paediatric examinations, the role is acknowledged within adult sexual assault services as providing improved daytime access and accessibility to female examiners without compromise on quality or patient experience and outcomes.

Research has identified that the environment in which examinations are undertaken is critical and that a private, dedicated space which is clinically appropriate but is also a calming and relaxing location is required. Best practice also indicates that forensic examinations should be undertaken in forensically approved premises and facilities where decontamination protocols can be followed.

The medical examination rooms should provide colposcopy, photography and video documentation facilities.

The medical consultation should involve risk assessment of harm/self-harm, together with an assessment of vulnerability and sexual health with immediate access to emergency contraception, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services.

The provision of such services is thought to reduce the long term costs associated with sexual abuse and deliver benefits to the victim in terms of better health, wellbeing and quality of life.

5.3.3 Recommendations

Not all children will require a medical examination, however, to support the determination of the need for a medical examination, we would propose the establishment of a telephone advice line consisting of a rota of professionals trained in paediatrics and experienced in medical examinations of this nature, to advise the local duty social workers on the need for a medical examination. The advice would be supplementary to discussions with the Gardai regarding the need for forensic examination.

Given that duty social workers will be available between 09:00-22:00 seven days per week to undertake initial assessments on site where required, we would envisage the medical examination advice line be available similarly throughout this time.

Where it is deemed appropriate that the child has a medical examination (for forensic purposes or not), the medical examination should then be arranged locally within the appropriate time determined (e.g. within 72 hours if forensic medical examination, or at an appropriate time for medical examinations, when the child is psychologically able); recognising that it is not always appropriate to examine a child in the middle of the night.

To allow this practice to take place, we recommend that

- **The current SATUs providing medical/forensic medical examinations for children over the age of 14 continue;**
- **The current children's SATU in Galway providing medical/forensic medical examinations for children under the age of 14 in and out of hours continues;**
- **The current services providing medical/forensic medical examinations for children under the age of 14 in appropriate facilities (e.g. Waterford, Cork, Sligo) continue, but also provide additional support over the weekends. We would consider the support required being an additional 4 hours on-call on Saturday and Sunday (e.g. for the Waterford service currently providing medical/ forensic medical examinations in normal working hours, cover would now extend over the weekend with medical examiners available to be called in over two 4 hour periods at the weekend). Where facilities are not currently**

forensically sound, these should be upgraded;

- For areas where appropriate facilities are not available and there is difficulty locating and accessing appropriate professionals (HSE Dublin Mid Leinster, HSE Dublin North East), medical/forensic medical examinations for children under the age of 14 to be undertaken in existing appropriate facilities such as a room within the adult SATU centres, adjusted to be child friendly. The examinations should be undertaken by a rota of appropriately trained professionals (community paediatrician, Emergency care paediatrician, GP or a private provider) available to undertake examinations between 09:00-17:00 Monday to Friday and for 4 hours (on-call) on Saturday and Sunday.

The cover provided in this manner will result in a child having to wait no more than 20 hours for a medical examination, where it is deemed appropriate to undertake an examination immediately.

The professionals undertaking the medical/forensic medical examinations should have the necessary knowledge, skills and experience to undertake the examination alone, with a permanent record of the findings in the form of photo documentation being made available for a second opinion on the nature and interpretation of the findings. Professionals undertaking medical/forensic medical examinations should be trained in forensic medicine and in the first instance have sufficient experience and confidence in undertaking medical/forensic medical examinations in order to demonstrate professional competence.

In time, all clinical professional staff involved in undertaking these examinations should work towards a standardised accredited training programme in paediatric forensic examination (options are currently being explored in the introduction of such a programme).

In addition to the current pool of resources able to undertake medical examinations, further training should be provided to interested, relevant professionals to increase the pool of resources available e.g. specialist registrars, GPs with specialist interest etc.

To reduce isolated working practices, there should be regional clinical networks established to allow clinicians to discuss cases,

and maintain training and professional development through joint working and shadowing.

The facilities where medical/forensic medical examinations are undertaken, as outlined above, must have the appropriate equipment necessary to undertake the examination e.g. colposcope and equipment for photo-documentation, but does not necessarily have to be within a medical environment such as an Emergency Department or within a Paediatric Hospital.

Each location/facility must have a standardised approach to the package of follow-on healthcare available, e.g. sexually transmitted infection screening, pregnancy testing etc, which are available for all age ranges.

In time, we would also recommend that the role of the forensic nurse examiners be considered as a solution to improving the access to forensic examinations as well as contributing to the quality and outcome of the patient's experience.

The role should be seen as integral to the forensic team and be introduced using robust assurance frameworks, developed around competencies and skills as well as accredited training, professionals have noted a preference for forensic nurse examiners, to have paediatric training, similar to their doctor counterparts.

It is recognised that the development of forensic nurse examiners will take a considerable length of time and that the issue of competency based service delivery must be addressed during this transitional time. The introduction of a new role must be cognisant of the legal needs for the role and the legal acceptance of reports submitted by forensic nurse specialists.

Collaborative working between forensic nurse examiners and forensic medical examiners extends the evidential credibility of forensic nurse examiners, but a longer term aim should be develop the role of forensic nurse examiner from documenter to interpreter of their own evidence.

5.3.4 Suggested next steps

- *Identify a pool of qualified clinicians to take part in a rota to provide paediatric medical advice on the need for medical examinations;*
- *Identify a contact number and determine the process and rules in relation to the telephone advice line. Share information about the advice line with social workers, liaising closely with the rota of social workers identified to provide extended cover on a sub-regional basis;*
- *Evaluate the paediatric advice line after 6 months of operation to determine the volume of calls and the outcomes of advice;*
- *A working party should be established to:*
  - *Review the competency needs for forensic examination and agree a set of minimum competencies with qualified clinicians across the four regions;*
  - *Undertake a gap analysis of key personnel (community paediatricians, acute paediatricians, GPs etc) to identify any competency deficits that require resource to address;*
  - *Agree on the courses to be accessed;*
  - *Determine medical leads;*
  - *Initiate the development of regional clinical networks; and*
  - *Consider the introduction of forensic nurse examiners and act as a conduit to the legal system to include them in any the proposed changes.*
- *Identify a panel of interested and qualified clinicians to partake in a rota for undertaking medical examinations in each of the two Dublin regions;*
- *Determine the rota of qualified clinicians to be involved in undertaking examinations in HSE West and HSE South;*
- *Liaise with the Dublin-based SATUs to negotiate access to a room for medical examinations which can be made child friendly;*
- *Make the necessary updates to current examination rooms to ensure they are forensically sound;*
- *Liaise with linked services e.g. GUM, sexual health services to ensure appropriate access to emergency contraception, PEP and*

follow-up screening;

- *Outline the required data and information to be captured by services undertaking forensic medical/medical examinations and the reporting timescales e.g. number of medical examinations undertaken age of child, time of presentation etc, to be reported quarterly.*

5.4 Multiagency Referral

5.4.1 Findings and issues

Throughout the review, there was significant variation in the timing and format of multiagency communication and discussion.

Children First guidelines state that a multiagency strategy meeting should be arranged by the social work team at any point in the process when it is most appropriate. According to the guidelines,

"at any point during a child protection enquiry it may be considered appropriate to convene a strategy meeting or discussion with all relevant professionals. This meeting can involve any, or all, of the professionals involved at either management or case assessment level, depending on the circumstances. It is particularly important to consider this process following preliminary enquiries".

The meeting serves a range of functions and in accordance with the guidelines should be used to:

- Share available information;
- Consider whether immediate action should be taken to protect the child and other children in the same situation;
- Consider available legal options;
- Plan early intervention;
- Identify possible sources of protection and support for the child;
- Identify sources of further information to facilitate the enquiry and assessment;
- Allocate responsibility for further enquiry; and
- Agree with An Garda Síochána how the remainder of the enquiry will be conducted.

However, there are difficulties in arranging the meeting; the reasons for which are multi faceted and vary across regions including:

- Availability of the originating Gardai;
- Availability of other professionals including social workers, psychologists and other HSE staff; and
- Timing of the meeting to maximise its contribution to the process. At present, the difference in timings of the meeting along the pathway are significant, ranging from one week to six weeks. Some of this difference is attributed to the perceived function of the meeting, whilst there are other differences around the format, with some regions accepting a virtual meeting while others delaying the meeting until everyone can be physically present.

There are instances in some regions where the meetings are not taking place and it appears that often there is a breakdown in communication in these areas between the involved agencies.

5.4.2 Best Practice

It was recognised through the engagement process and validated during the workshops that strategy meetings served a purpose at different stages in the pathway and were a valuable contribution to ensuring evaluation and communication.

One of the principle aims of established Child Advocacy Centres is to facilitate collaboration between multiple agencies, promoting collaboration in a collegial environment. This is considered to be a more effective and efficient way to deliver services to suspected abused children: improving the accuracy of overall assessment, prediction of risk, and development of intervention strategies. It also reduces confusion between multiple agencies and avoids the duplication of services, thus reducing trauma to the child.

With the CAC model, a parallel team meeting could be seen as the Multidisciplinary Case Review Team which includes representation from legal teams, mental health, medical, child protective, and social services. The purpose of the meeting is to review individual cases and make recommendations on the case outcome in areas of prosecution, mental health services, referrals to therapeutic services, child protection issues, and family support.

Similarly, the principal aim of Children's Houses, established in the Nordic countries, is to facilitate coordination of the different agencies involved in dealing with child sexual abuse cases to maximise the outcome for the child, including assessment and access to therapies.

5.4.3 Recommendations

Central to the pathway is the Multiagency Referral Team (MRT); viewed as an opportunity to work collegiately to maximise the benefit and outcome to the child and their family.

It is viewed as optimum to use the MRT to both signpost and assess the outcomes for the child, as well as referring the child to the appropriate services and receiving outcomes and updates on their progress.

We recognise that varying formats of these meetings exist across various regions, and we would recommend that the format of these existing groups and meetings be reviewed.

We would recommend that an MRT meeting is established as a fixed weekly meeting in each sub-region, with agreed representative membership. This should include core representatives from An Garda Síochána, HSE social work team, and child psychologists, and may also include representatives from current specialists assessment and therapy units (e.g. St Louise's, St Clare's) across the Dublin region, dedicated child sexual assault psychologists/therapists, and child mental health services.

It is important that this meeting is scheduled weekly and that there is commitment that a representative from each core agency will be present. It was considered that, whilst the same representative would be optimum, that the commitment for a presence was the most important factor. Whilst not ideal, it was recognised that there may be instances where virtual attendance is acceptable.

The MRT will be iterative in the pathway and the child's case will be presented to this team at a number of steps in the process, including:

- **Initially receive the referral from the social worker who has completed the pre-screening. Ideally this referral will be backed up by attendance from the social worker, and where appropriate, the Gardai involved in the case;**
- **Then make a number of decisions impacting on the next stage of the child's pathway, including:**
    - **The need for a medical examination for physical symptoms and/or therapeutic reasons, if not already undertaken;**
    - **Agreement and arrangement of the joint interview process and/or child assessment;**
    - **The outcome of whether the case is conclusive or inconclusive;**
    - **The need for a full needs based therapy**

assessment. Recommendations should not impact on the services available to the child and their family i.e. identical services should be available to both conclusive and inconclusive cases as required; and

- **Referral to CAMHS.**

- **Once the MRT has made a decision following the initial referral, the outcome from that decision should be fed back to all services/agencies involved in the case.**

To support instances where the recommended next steps should be therapeutic intervention, the MRT should have referral rights to therapies and child and adolescent mental health services to ensure timely access to care for the child through the pathway.

5.4.4 Suggested next steps

- *Locally, to agree the core membership of individuals to meet weekly; and*

- *Inform all agencies of the due decision making process and the referral route to the MRT.*

Suggested timescale: 3 months

5.5 Joint interviewing

5.5.1 Findings and issues

The Criminal Evidence Act 1992 identified a need for a joint approach to electronic recording of interviews with complainants under 14 for evidential purposes.

5.5.1.1 Interpretation

The responding protocol developed between An Garda Síochána and HSE has been subjectively interpreted by each region and as such, there is considerable confusion around its purpose, functionality, outcome and professional attendance. As a result, there are very few instances of joint interviewing occurring.

5.5.1.2 Purpose

The acknowledged purpose of the joint interview is to gain evidential information for potential criminal investigation, and as such, the information must be gleaned, stored and used in a regulated manner that reduces the risk of contamination of potential evidence as well as ensuring that information is initially gathered in an appropriate manner. This primary purpose means that social workers are reluctant to participate in the interviews; worried about contaminating evidence through the use of inappropriate, leading questions or suggestions.

5.5.1.3 Sharing Information

There were also recognised concerns that the information gathered during the interview could not then be used or shared to the wider teams involved in child's case. This leaves other professionals in a potential conflict with their professional accountability as they have information about the child they are not able to use to shape their recommendations and/or actions.

5.5.1.4 Availability

An Garda Síochána policy on the investigation of sexual crime against children and child welfare (2010) stipulates that the interviewing of children following an allegation of sexual abuse should take precedence over other duties, yet the review identified that there were many occasions where the delay in joint interviewing was due to the non availability of both social workers and Gardai.

5.5.1.5 Training

Specialist training for social workers and Gardai to develop skills as specialist interviewers has been developed nationally but uptake is variable, with the Gardai requesting more training places, whilst there is a smaller uptake of social workers. There is also a high failure rate nationally, presently at approximately 40%.

There are some issues around accessing the course as it is a residential course and requires staff to be away from the workplace and family. This directly impacts on business delivery, especially in smaller regions where staffing numbers are low and identifying cover for absence is difficult.

5.5.1.6 Access to interpreters for non English speaking children

There was a shared concern by some about access to appropriately aware and trained interpreters. It was felt that the interpreters were not prepared for the information they would be asked to share in sexual abuse cases, as well as a concern that some of the content of the words could be lost in translation.

Concern was also raised that non-official interpreters were sometimes used e.g. staff with the appropriate language and other members of the non-English community. It was felt that this did not provide sufficient translation services and cultural issues prevented full disclosure. There are currently no professional standards in place in relation to interpreters.

5.5.2 Best Practice

The Greater Manchester and Oldham Social Care joint protocol on investigating allegations of child sexual abuse has a number of tenets including:

- The welfare of the child is paramount; and
- The investigation should be child centred, with an onus on the protection of the child rather than the collection of criminal evidence.

This protocol does not stipulate the need for joint interviewing but rather that

" liaison between the police and social worker after the interview should be completed as soon as practicable and the relevant information should be shared, with a view to assessing the situation and establishing what further action may be necessary"

Achieving Best Evidence (2007) recognises that the optimal quality of evidence is obtained by free recall with minimal contamination, requiring open ended questions.

The standards also recognise that early identification of a vulnerable or intimidated witness and effective inter-agency working in support of the witness will improve the quality of an investigation by assisting the witness to give information to the police and assist the legal process by helping the witness to give their best evidence in court. It recognises that this is best achieved where local criminal justice agencies work together with other agencies to develop effective networks and local protocols for sharing information, as well as comprehensive awareness-raising and training.

Achieving Best Evidence takes account of amendments to the Youth Justice and Criminal Evidence Act 1999, and special measures provisions contained in the Coroners and Justice Act which make reference to:

- Specific provision for the presence of a supporter to the witness in the live link room; and
- Relaxation on the restrictions on a witness giving additional evidence in chief after the witness's video-recorded statement has been admitted as evidence in chief.

Best practice also states that the interviews should be:

- Undertaken in an appropriate, child-friendly environment;
- Be carefully planned by the multi-agency team;
- Consented to by an appropriate adult;
- Only be undertaken by an appropriately trained specialist interviewer;
- The interview content to be made available to all relevant agencies to reduce need for duplicate interviews for the child;
- Only be undertaken after a joint decision made by multi-agencies; and
- Be undertaken at a time/stage most appropriate for the child.

5.5.3 Recommendations

Throughout the review, in accordance with the guiding principles, we have been cognisant of the need for value added to each component of the process for child and their family.

Where a criminal investigation is being undertaken, joint interviewing under Section 16 (1) (b) is recommended. The benefit to the child is a potential reduction in the number of interviews

needed to gather the necessary information, however, this is only achievable when the information can be shared and used for other purposes. This agreement needs to be established to allow the information to be used as soon as possible and without the need for individual prior agreement and permission. The information should also be made available in a visual format, where possible i.e. DVD, to be used by all relevant agencies.

The role of the social worker must be clearly defined and this definition be supported at an operational level so that social workers can be assured of their position and contribution to the interview.

As such, we recommend that the outcomes of the interview be re-established. We recognise that there is a single purpose of the interview under the Criminal Evidence Act 1992 but it is considered that the outcomes i.e. the information, should also support the HSE social work team to develop the relevant action plans and make conclusions about the credibility of the allegation. This information should also be available to the multiagency referral team (MRT) for further assessment of the child's individual needs, if necessary.

We would continue to advocate the need for specialist interviewers only to complete the interview.

Workforce should be planned to ensure there is a sufficient distribution and pool of suitably qualified specialist trained interviewers from both the Gardai and social work in each region. Workforce planning should ensure training is available for professionals on an annual basis to support succession planning and recruitment of new staff.

The timing of the interview will be dependent on a number of variants including the presence of forensic evidence, the wishes of the child and their family and the mental and physical state of the child at the point of disclosure. To allow for planning and arrangement of an appropriate environment, potentially completed by the MRT, as a guide, we would recommend that joint interviews be completed within 10 days of the disclosure, other than in circumstances where an assessment by the MRT or the wishes of the child or their family dictates otherwise.

Recognising that joint interviewing under Section 16 (1) (b) is only relevant to children up to the age of 14, we would recommended

that the principles outlined above, in relation to joint interviewing, timely interviewing and information sharing, be similarly put in place for interviewing children aged 15-18.

5.5.4 Suggested next steps

- *At a strategic level, the policy between the HSE and An Garda Síochána on joint interviewing under Section 16 (1) (b) should be re-visited to ensure the dual outcome of the interview is clearly outlined and understood i.e. outcome is gathered evidence and information required to protect the welfare of the child and draw conclusions on the credibility of the allegation. The policy for information sharing following a joint interview should also be clearly outlined, in line with current legislation;*
- *At an operational level, the dual outcome and role of the social worker should be emphasised with the implementation of the policy regularly tracked to ensure joint interviewing is taking place;*
- *As soon as possible, Children's First training for Garda should be made available by the HSE to allow progression onto the Joint Interviewing training and to ensure an adequate pool of trained resources for joint interviewing is in place; and*
- *The current regional allocation of trained social workers should be assessed and the resultant training needs on a regional basis identified. Training should be made available to social workers and encouraged by regional child care leads to ensure a representative allocation of trained resources in each region. In areas where current numbers of trained social workers are low, the time required for joint interviews should be ringfenced in the medium term to allow the interview to be conducted within the 10 day time period suggested. In time with further trained social workers in place this practice will no longer be required.*

Suggested timescales: 6 months

5.6 Child interview and assessment

There is a lack of a consistent approach to information sharing as previously discussed, and as such, interviewing is often duplicated and its value not maximised across all agency groups. It is often difficult to ascertain therapy needs from minimal information available to those

assessing the child, necessitating further interviewing, and often covering similar issues covered in the joint interview.

It is recognised that there is a need for more than one interview in most instances, but there are instances of multiple interviews with different professional groups covering similar ground, and adding no value to the child's experience.

The legal governance framework around information sharing prevents sharing of information at an operational level in a timely manner, and instead, permission has to be sought at superintendent and senior HSE level. Some regions have developed a local workaround for this, using specific wording around release of information.

The variation in waiting times for assessment is significant across the region, with some waits of up to six weeks for a full assessment.

Additionally, when a child is referred for assessment, there is no standard information request, and as such, the referral can be rejected and returned to the originator for more information, again adding non value added steps to the child's experience.

5.6.1 Best Practice

It is recognised that assessment and further therapeutic interviews are multi professional appropriate to the perceived needs. This is best gleaned from information already available, including evidential interview DVDs and transcripts. These should be available and accessible at an operational level, and be provided in accordance with agreed governance standards on their usage and confidentiality.

Assessment outcomes should be shared to maximise the benefits for the child and should be referred back to the originating referrer to ensure completion of referral cycle and subsequent actions and evaluation.

Any assessment completed should be needs based around the child and should not be fragmented to match the service boundaries i.e. a child disclosing sexual abuse will potentially have experienced physical and emotional abuse in addition to the disclosed allegation of sexual abuse and will need access to services to address those issues.

5.6.2 Recommendations

We would recommend that the current professionals involved in the full assessment of children (social workers and psychologists within and outside specialist units) continue in this role, undertaking assessments in cases where a criminal investigation is not being pursued.

Where a criminal investigation is being pursued and the credibility of the allegation was not established through the joint interview; and a further assessment is required to determine credibility and therapeutic needs following the joint interview, this should be arranged as soon as possible and in line with the needs of the child. Where this is the case, information gathered from the joint interview for evidential purposes should be available to these professionals prior to the full assessment interviews to allow them to only conduct value added, non duplicating interviews.

Recommendations on the credibility of the allegation and the need for therapeutic treatment should be established as an outcome and reported back to the MRT who will then make decisions regarding credibility and therapy referrals.

5.7 Therapy and mental health services

5.7.1 Therapeutic provision

Throughout the review there was acknowledgement of varying but significant wait times for therapy following assessment of the child. Wait times varied significantly dependent on the therapy required, its provision by HSE and other providers, and the geographical region. There were typical wait times of 3-4 months and of some instances of waits of up to two years.

The review identified that some waits were legitimate and viable as they were seen as sequential therapies or that the child was not yet ready for the therapy.

In some regions, disparate funding is available for private provision of therapies, in which case the wait times are minimal. Also, access to therapy services provided by independent and voluntary sector organisations is variable due to lack of standardised service level agreements.

There is inconsistency to accessing therapies; with some regions requiring therapy assessment outcomes to be returned to the referring

social worker team for onward referral to therapies, whilst some regions have access to co-ordinated specialist centres where the decision on therapy packages is made by a multi professional group with immediate referral into the services.

There is also an inconsistency in the therapies available dependent on the outcome of the credibility and probability assessments. There are less services available to those children and families where the case is seen as inconclusive, with this often eliminating rights to specialist services. One considerable exception to this is CARI who work with inconclusive cases, providing a 'one-stop' assessment and provision of a range of therapy services.

5.7.2 Child & Adolescent Mental Health Services

The immediate response to the trauma suffered by children of child sexual abuse is dealt with by frontline CSA services. However, these children tend to have a higher risk factor of developing mental health problems and, therefore, throughout the pathway, there may be a requirement to refer children to mental health services for assessment and treatment.

Whilst Vision for Change has set a national direction and resource requirements for the development of mental health services, currently services are staffed below this level and there is considered to be a lack of uniformity in access to services and the thresholds and criteria being used. It is also considered that there is a need for greater clarity regarding the roles and functions between the specialist units for therapeutic services and the role of CAMHS to ensure that referrals are timely and appropriate.

5.7.3 Best Practice

Child Sexual Abuse is recognised as having an impact across the wider family including parents and siblings, as well as having a wider impact on the child victim, including emotional abuse, physical abuse and attachment issues. Therefore, it is essential that a holistic approach to therapy is taken, reaching beyond therapies traditionally seen as appropriate to sexual abuse.

This holistic approach is further supported by robust communication between services. Where possible, this communication should begin at the assessment stage where agreement can be reached on appropriate therapies and/or mental health requirements, follow on and parallel therapies/interventions and timescales. This co-ordinated approach

ensures a clear message and timeline for the child and their family and for the professional.

Key characteristics of best practice models of therapy have been identified within Ferns IV, these characteristics include:

- Clear referral criteria;
- Provision by a multi-disciplinary skilled team who understand issues of sexual abuse and sexual assault;
- The availability of therapy services ranging from play and activity based creative and arts therapies through to Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR);
- Individual psychotherapy, family therapy, parent support and ready access to child and adolescent psychiatry; and
- Be provided in child friendly, private and confidential environment.

5.7.4 Recommendations

Therapy needs should be assessed holistically with one referral addressing the potential impact needs of other family members and siblings, reducing the need for additional referrals and subsequent time delays with no value added to the child.

We recommend current therapy/mental health service provision is mapped and a directory of services developed per region, which all staff involved in CSA cases are made aware of. This should also outline the criteria for referrals.

Validation throughout the project, along with best practice review has identified the benefits of specialist, co-ordinated units such as St. Louise's and St. Clare's. We would recommend that where there is available critical mass of referrals, a similar co-ordinated service approach should be developed. In the first instance, centres should be developed in Cork and Galway.

Specialist units would act as a hub within a hub and spoke model, with the hub providing support, advice and professional development to the local therapy services (spokes). Options should be explored within the hubs and spokes to combine the available resources of both the HSE and CARI in order to provide an eclectic and more evenly distributed range of therapy services across the country.

The provision of local services will ensure minimal travel for children and their families. This allows competencies to be maximised as well as ensuring maintenance of professional standards.

Where hub and spoke models still do not reach to the child and their family without considerable travel time or inconvenience, there should be ring-fenced funding for private provision. Any private provision should be assured under the competency assessments agreed previously.

We recommend that the current prioritisation of HSE therapy services should also be reviewed to ensure that the most urgent cases of child sexual abuse are seen within appropriate timescales.

Clear referral protocols and criteria for CAMHS services need to be established and understood by all professionals. Referrals to CAMHS can be requested by any professional currently providing a service to the child throughout the pathway, with agreement of the MRT. As is currently the practice, the needs of the child accessing this service should continue to be prioritised; seeing the most urgent cases within the shortest possible waiting times. This should ensure greater uniformity and appropriateness in referrals to these services.

5.7.5 Suggested next steps

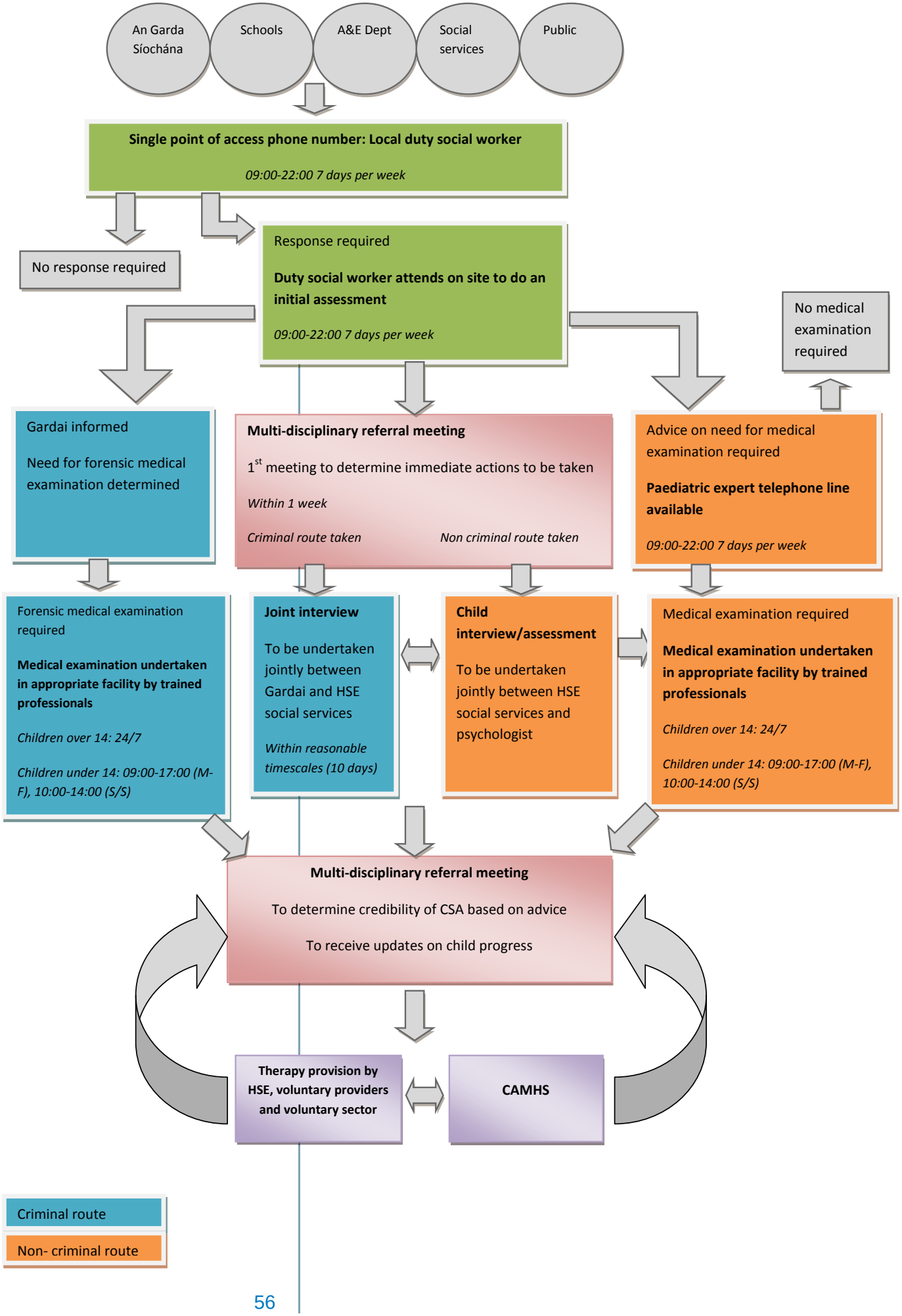
- *Undertake a mapping of current provision of therapy and mental health services and develop a local service directory which can be accessed by all relevant staff;*
- *Agree the criteria and protocols for referrals;*
- *Identify the number of referrals to therapy services per region, to determine the appropriate location of the therapy hubs in addition to the current specialist centres in Dublin;*
- *Following the determination of the hubs, the outreach spokes should then be determined by identifying areas not currently covered by the hubs;*
- *HSE to engage with the voluntary providers to discuss combining*

resources to provide a more holistic and comprehensive service; and

- *Set up a performance monitoring system to monitor waiting times and the proportion of inappropriate referrals.*

5.8 Overall revised pathway of care

Based on the recommendations defined in the component parts of the optimum model of care, the following diagram shows the service pathway for those children and young people referred to the service.


An Garda Síochána
Schools
A&E Dept
Social services
Public
Single point of access phone number: Local duty social worker
09:00-22:00 7 days per week
No response required
Response required
Duty social worker attends on site to do an initial assessment
09:00-22:00 7 days per week
No medical examination required
Gardai informed
Need for forensic medical examination determined
Multi-disciplinary referral meeting
1st meeting to determine immediate actions to be taken
Within 1 week
Criminal route taken
Non criminal route taken
Advice on need for medical examination required
Paediatric expert telephone line available
09:00-22:00 7 days per week
Forensic medical examination required
Medical examination undertaken in appropriate facility by trained professionals
Children over 14: 24/7
Children under 14: 09:00-17:00 (M-F), 10:00-14:00 (S/S)
Joint interview
To be undertaken jointly between Gardai and HSE social services
Within reasonable timescales (10 days)
Child interview/assessment
To be undertaken jointly between HSE social services and psychologist
Medical examination required
Medical examination undertaken in appropriate facility by trained professionals
Children over 14: 24/7
Children under 14: 09:00-17:00 (M-F), 10:00-14:00 (S/S)
Multi-disciplinary referral meeting
To determine credibility of CSA based on advice
To receive updates on child progress
Therapy provision by HSE, voluntary providers and voluntary sector
CAMHS
Criminal route
Non- criminal route

6. Developing the optimum model of care: supporting infrastructure

To support the operational implementation of the optimum model of care, there needs to be robust infrastructure that ensures that the standards of care are achieved and maintained. Detailed below, we have outlined the supporting infrastructure that we recommend should be established focussed on:

- Advocacy;
- Governance and information sharing;
- Competencies and training; and
- Reporting and evaluation.

6.1 Advocacy

Throughout the review it was apparent that the voice of the child and young person is not heard in the child protection system and that there are little quality assurance and review processes underpinning this.

We would recommend that children and families be supported throughout the pathway, through the provision of advice and support services both locally and nationally; this would be appropriate where the child and family are subject to waiting for different services/outcomes of assessments.

In time, a more formal advocacy model could be adopted; providing independent and confidential information and advice, representation and support, and playing an important role in ensuring children have appropriate information and support to communicate their views in formal settings, such as child protection conferences and court proceedings.

6.2 Governance and information sharing

The welfare and protection of children is the responsibility of all citizens and therefore this should be promoted to all those working with children and the public.

There should be increased understanding of the nature of all child abuse through the raising of professional and public awareness as a means to reducing its incidence and effect to develop and promote a learning culture, which seeks to identify areas of vulnerability, and learn lessons in order to pre-empt potential problems. Emphasis should be placed on developing a safe environment to promote evidence-based learning.

The quality of organisational analysis of the information and whether the organisation translates it into service and outcome improvement is

vital. Any inspection framework should examine the child's journey from needing to receiving help, explore how the rights, wishes, feelings and experiences of children and young people inform and shape the provision of services, and look at the effectiveness of the help provided to children, young people and their families

In setting out the governance arrangements for the optimum model of sexual abuse and sexual assault services for children and young people, there are three levels which need to be addressed; wider network, organisational and individual. Much of this will already be in practice, in line with Children First, although it is considered important enough to set out the key requirements.

6.2.1 Wider governance arrangements

Following the pre-screening by the HSE duty social worker, both in hours and out of hours, and where the decision to initiate an assessment has been made, the Standard Notification Form must be completed and sent to the Gardai. Vice versa, the Gardai must notify the HSE social work team of suspected cases of sexual abuse and again complete the Standard Notification Form. This is line with Children First guidelines.

Across the spectrum of services and organisations involved in the care provision, there needs to be regular communication and information sharing, where appropriate. This needs to happen in a timely manner but without compromising or contaminating any of the evidential information that may be obtained to support legal proceedings.

A multidisciplinary referral team should take responsibility for decision making and for coordinating the referrals of child sexual abuse and sexual assault to different services along the pathway and for reviewing waiting times for services. This team should receive progress reports on the child's care at appropriate periods during the child's assessment and therapeutic care.

For professional staff involved in either initially reporting the case to the HSE social work team and/or involved in providing a support service to the child, feedback on the decision making and outcome of the case should be provided.

6.2.2 Governance requirements for organisations

There needs to be clear expectation given to staff of the child sexual abuse service to be delivered, the quality standards to be achieved and expected volume/demand to be met.

Organisations should establish clear roles of accountability and responsibility and ensure that these are communicated to all staff.

Organisations should develop mechanisms to assess and evaluate the outcomes and experience of the service that they are providing to children and young people who have alleged and/or experienced sexual abuse.

Organisations are responsible for managing the performance of units, services and staff members and must ensure that they have the appropriate mechanism in place in which to do this. In child sexual abuse, this means information gathering on referrals and cases, reviewing performance against waiting time standards, and reviewing outcomes.

Organisations should ensure that comprehensive risk management processes have been undertaken and that where risks have been identified, appropriate risk mitigation strategies have been put in place to ensure the safety of children, young people and staff.

Appropriate staffing levels and skill mix to meet the needs of children and young people should be maintained at all times when the service is being provided.

It is the responsibility of the organisation to maintain the health and well being of all staff and that sufficient measures are in place to support those staff undertaking stressful activities, including those which are emotional distressing.

Organisations need to have appropriate mechanisms established to satisfy themselves that staff providing child sexual abuse services are accredited, registered, trained and supervised, and that continuing personal and professional development is being undertaken.

6.2.3 Governance requirements for individual staff members

Each professional staff member will need to ensure that they comply with their appropriate professional body's code of practice and ensure that they maintain their appropriate accreditation and registration.

All members of staff should only undertake those duties and tasks for which they are competent and skilled to do.

Each staff member will be responsible for maintaining their professional competence and in participating in continuing personal and professional development, in line with the service needs and with agreement of their line manager.

All staff will receive formalised training and refresher training courses, as and when appropriate and necessary to undertake their role.

All staff will receive appropriate supervision and debriefing.

6.3 Competencies and training

The review has identified a significant variation in the competencies, accreditations and experience of staff involved in the delivery of sexual abuse services, in particular around forensic and medical examinations. This variation is dependent on:

- The time of day the competency is required;
- The region where the competency is being accessed; and
- The level of immediacy for the service.

6.3.1 Forensic and Medical examinations - Consultant led

At present, there are a range of professionals from various healthcare providers providing forensic and medical examinations including:

- Acute Paediatricians;
- Community Paediatricians;
- Public Health Doctors;
- Accident and Emergency Consultants; and
- Private Paediatric Forensic Examiners.

There is no nationally agreed standard of competency for paediatric forensic or medical examination and as such, it is often a result of the availability and willingness (in terms of competence and confidence) of consultants to undertake these examinations.

The level of accreditation is variable with a small core number of consultant staff accredited in forensic examination. Other staff completing the examinations are experienced in paediatric medicine and emergency medicine. There is also a lack of formalised and accredited training available nationally, with some regions addressing the gap by developing localised training programmes using the expertise of experienced staff. At present, a paediatric consultant is

reviewing the possibility of the development of an e-learning and attendance paediatric forensic medicine course being developed in conjunction with University College, Dublin, based on the existing course available from St Mary's, Manchester.

There is no assurance framework, supported by minimum standards or competencies, around the forensic and medical examination of children, with an acceptance that experience and special interest in the area qualifies staff to participate on the rota.

6.3.2 Joint Interviewing training

There is a comprehensive training course in joint interviewing available to An Garda Síochána and HSE social workers. In total, this course is residential for four weeks and, at present, the pass rate is approximately 60%. The training is viewed as difficult and also causes logistical issues in terms of staff being away from the workplace.

At present, the training can only be started after the Children First guidelines training has been completed. The review has identified that this training is not presently available to the Garda and as such, they are unable to complete the specialist interviewer course.

6.3.3 Recommendations

The review has identified that there is presently a lack of appropriately trained paediatric forensic examiners. We would recommend that the HSE formally approaches St Mary's Manchester or other accredited education providers to review the options for providing a paediatric forensic examination module across Ireland. This course should be open to multi professionals, addressing the present accreditation gaps in both medical and nursing professionals. This will also allow consideration of alternative personnel participating in the on call rota including General Practitioners.

We are cognisant of the need to maintain a service whilst training and accreditation is gained. We would therefore recommend that a working group is bought together to consider and determine an agreed set of competencies for paediatric forensic and medical examinations. Paediatric staff participating in existing on call rotas and staff working in sexual abuse services should then be measured against these agreed competencies to identify gaps which can be addressed prior to the start of a formalised course through localised training and assessment.

6.4 Reporting and evaluation

The review identified a lack of common reporting and data collection, both across regions, inter agency and across agencies. We were unable to ascertain actual numbers of children referred to the service and the outcomes of those referred in, in terms of the complete pathway. Each component part of the pathway collects different data which we were unable to concatenate the child's journey.

This review has also shown that there is a lack of understanding about the numbers of children subjected to sexual abuse, in particular around more 'difficult to measure' areas such as sex trafficking and sexual abuse of homeless children.

There appears to be a lack of co-ordinated data collection, with no one agreed portal for data submission by all agencies. Terminology of measurement also means that different things are perceived to be being measured yet are addressing the same areas of service delivery.

As well as the formal reporting and measuring needed to understand the demand for services and the full picture, some professionals involved in sexual abuse services reported that they were not kept informed of the outcomes of children accessing services. Often, those professionals completing the forensic and medical examinations had no further contact with the case and were unaware of the outcomes for the child.

As children and young people sexual abuse services are further developed following the recommendations within this review, it is essential that robust measurements are wrapped around the changed services, supporting cyclical evaluation across all agencies, identifying the outcomes of the changes.

It is also important that an evaluative cycle is developed that feeds back to all professionals involved in the child's care, identifying areas of good outcome and potential improvement.

6.4.1 Recommendations

We would recommend that a common reporting dataset is established across agencies that measures agreed components of the pathway. It is important that the measurements identify child centred outcomes and measure quality as well as referral numbers. These figures should show the child's journey through the pathway, including transition across various agencies.

These figures should be collected centrally and disseminated to all providers at regular agreed intervals. Where possible, data should be concatenated to produce information. It should also be possible to pull out all data on an individual child basis, allowing instant information of the child to support decision making at an operational level.

Outcomes at each stage of the process should be fed back to the provider of the previous process step, allowing them to understand the outcome of their contribution. This may be most appropriately operationalised through the multiagency referral team (MRT).

7. Developing the optimum model of care: Investment requirements

We have endeavoured to recommend an optimum model of care which makes best use of existing resources across all agencies. However, given the extent of some of the issues which need to be addressed in order to provide a nationally consistent, equitable and accessible service, there is inevitable a call for additional investment.

Our recommendations have identified what we consider to be the most cost-effective solution which improves current provision, will provide an immediate response for the majority of cases being and potentially reduce the long term costs associated with sexual abuse. Evidence from the development of Sexual Assault Referrals Centres in the UK suggests that these models, providing an immediate service to children and adults who have been sexually assaulted, can reduce the number of people later referred for specialist services, such as secondary mental health and sexual health services, as well as reducing multiple assessments and waiting times for patients who use alternative services that are not integrated.[42]

Based on our recommendations, the areas which require additional investment are for:

- Extended working hours for social workers – an additional 5 hours per weekday and 26 hours at weekends provided at a sub-regional level;
- Immediate access to advice of a paediatric medical examiner;
- On-call arrangements at weekends for forensic and medical examinations;
- Additional therapy resources;
- Additional training- forensic medical/medical examinations and joint interviewing; and
- Advocacy resources.

It has been assumed that other recommendations can be implemented within the existing resources, recognising that there needs to be better allocation and prioritisation of resources which are allocated to sexual abuse and sexual assault service for children and young people.

Extended working hours for social workers

Based on the additional 5 hours per weekday and 13 hours a day on Saturday and Sunday i.e. a total of an additional 51 hours per sub-region per week; this equates to 408 hours per week Nationally

[42] DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

assuming 8 sub-regions. This is equivalent to 10.9 WTEs of duty social workers.

Assuming an average annual salary of €50,000 and an on-call allowance of 30% of salary, the total investment required would be **€163,500.**

Immediate access to advice of a paediatric medical examiner

Based on the assumption that in-hours this is provided by hospital and community paediatricians and out of hours by hospital paediatricians, then there is no additional investment required.

On-call arrangements at weekends for forensic and medical examinations

On the assumption that within some regions currently, in-hours there is a sufficient pool of resources through current forensic examiners, hospital and community paediatricians and GPs with specialist training in paediatrics, no new investment is required.

Within the Dublin regions, additional investment is required, in-hours we have assumed a requirement of 0.5 WTE paediatricians qualified in medical examinations for each of the two Dublin regions i.e. an additional in-hours investment of 1.0 WTE.

Out of hours there needs to be weekend on-call provision. Setting aside the current SLA in Galway with a private provider, each of the remaining 7 sub-regions would require the equivalent of 8 hours on-call at weekends.

Assuming an average salary of €190,000, the required additional investment would be **€270,000.**

Additional therapy resources

Outside of the specialist units there are no dedicated therapy services therefore this is uncertainty as to the proportion of time that is assigned to sexual abuse cases. However given the current state of waiting times to services, there is no doubt that some additional investment is required.

On the assumption that there is a National investment of an additional 8 WTEs at an average salary of €70,000 (based on mid-point for clinical psychologist), an additional investment of **€560,000** is required.

Additional training

We have recommended that additional training be provided in relation to joint interviewing under Section 16 (1) (b) interviewing for social workers and Garda (and Children's First training for Garda) however until the current allocation of trained professions is assessed, the volume of training required and the amount of staff 'back-fill' to allow current services to continue, cannot be determined.

Similarly, we have also recommended training in relation to forensic medical and medical examination also be provided, with levels of competency needing to be established and a subsequent gap analysis needed to determine the volume of training and staff 'back-fill' required.

Advocacy

We would recommend that children and families be supported throughout the pathway, through the provision of advice and support services both locally and nationally; this would be appropriate where the child and family are subject to waiting for different services/outcomes of assessments.

Further discussion on the potential provider of this service is required as well as a more detailed understanding of the current service provision both by the HSE, An Garda Síochána and voluntary service providers before required investment can be identified.

Summary of investment

Based on the assumptions and calculations above, we have identified a potential requirement of an additional investment to sexual abuse services of **€993,500.**

Please note that the calculations outlined do not include on-costs such as allowances for pensions/national insurance etc.

Appendices

Appendix A. List of Steering Group members

- **Siobhan O' Halloran:** National Lead, Acute Hospital Services, Joint Chairperson
- **Aidan Waterstone:** Acting Assistant Director, Policy and Strategy, Office of the National Director, Children and Family Services, Joint Chairperson
- **Robert Templeton:** National Specialist, Child Protection, Office of the National Director, Children and Family services
- **John Smyth:** Area lead, Regional Children and Family services, HSE West
- **Oliver Mawe:** Child care manager, HSE South
- **Suzanne Dempsey:** Director of Nursing, Children's University Hospital
- **Dr Niamh Ross:** Principal Clinical Psychologist, St Clare's unit, Children's University Hospital
- **Dr Mary McKay:** Paediatric emergency consultant, Children's University Hospital
- **Dr Imelda Ryan:** Director, St Louise's Unit, Our Lady's Children's hospital
- **Dr Colm Costigan:** Clinical Director, Children's University Hospital
- **Dr Brendan Doody:** Child and Adult Mental Health Service, Consultant Psychiatrist, HSE
- **Detective Superintendent John McCann:** National Bureau of Criminal Investigation
- **Superintendent Fergus Healy:** Crime policy and administration
- **Yvonne Gilligan:** Senior Executive officer, Acute Hospital Services

Appendix B. List of interviewees

To support this review we have conducted face-to-face and telephone interviews with arrange of service professionals and other stakeholders. These interviewees are listed below.

- Robert Templeton, National Specialist Child Protection, Office of the National Director of Children and Family Services
- Gordon Jeyes, National Director of Children and Family Services
- Derek Deasy, Director, St Clare's Unit, Children's University Hospital
- Keith O' Reilly, St Clare's Unit, Children's University Hospital
- Suzanne Dempsey, Director of Nursing, Children's University Hospital
- Breda Mourne, Clinical Nurse Manager, Children's University Hospital
- Anne-Marie Jones, Head of Social Work, Children's University Hospital
- Louise Kyne, Consultant Paediatrician, Children's University Hospital
- Mary McKay, Paediatric Emergency Consultant, Children's University Hospital
- Dr Imelda Ryan, Director, St Louise's Unit, Our Lady's Children's Hospital
- Sean Walsh, Paediatric Emergency Consultant, Our Lady's Children's Hospital
- Ronin O'Sullivan, Paediatric Emergency Consultant, Our Lady's Children's Hospital
- Oliver Mawe, Child Care Manager, HSE South
- Fiachra O'Suilleabhain, Principal Social Worker, The Family Centre, St Finbarr's Hospital, Cork
- Dr Betty Walsh, Unit Manager, Community Child Centre, Waterford
- Trish O'Flynn, Child Care Manager, Galway
- Colin Harrison, Child Care Manager, Sligo/Leitrim
- Dara Gallager, Community Paediatrician, Sligo
- Marie McGuiness, Child Care Manager, Donegal
- Annette McGuire, Child Care Manager, Longford/Westmeath
- Jacqui Deevy, Designated Officer for VAW in the Mid West
- Joanne Nelson, Consultant Paediatrician, Galway
- Paul Murphy, Child Care Manager, Mayo
- Detective Superintendent John McCann, An Garda Síochána
- Superintendent Fergus Healy, An Garda Síochána
- Dr Maeve Eogen, Consultant Obstetrician and Gynaecologist, Rotunda SATU
- Niall Muldoon, Clinical Director, CARI Foundation
- Mary Flaherty, Chief Executive, CARI Foundation
- Joseph Duffy, Clinical Director, Granada Institute
- Fiona Neary, Executive Director, Rape Crisis Network
- Maeve Lewis, Director, One in Four

Appendix C. Best Practice

C.1. Overview

In line with Ireland's National Guidelines on Child Protection, 'Children First', sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal or for that of others use.[43]

This section of the report provides an overview of the best practice models of care for children and young people who have been the victims of sexual assault. Many of these best practice principles have been identified as part of the Ferns IV Working Group proposed model for service delivery[44].

C.2. Pathway of care

A recent international review of models of service provision revealed that whilst in some countries a single model of provision predominates, in the majority there are a range of models, as well as less organised forms of provision, operating simultaneously. Therefore for most victims of rape/sexual assault, the responses they encounter depend not only on which country they live in but also where they live within that country.[45]

However, regardless of this variation in service models, the care pathway for these children and young people all include similar service components, including:

- Assessment and interviewing to consider their physical, sexual, mental and social care needs;
- Medical Examination, either:
  - Forensic Medical Examination for acute; or
  - Medical Examination for non-acute cases;
- Follow up care, including access to therapeutic services, mental health services and independent sexual violence advisors.

The following sections discuss the best practice evidence associated with each component of this pathway.

43 http://www.hse.ie/eng/services/Find_a_Service/Children_and_Family_Services/Child_Welfare_and_Protection/Child%20abuse/

44 Report of the Ferns 4 (Children) Working Group: Assessment, therapy and counselling needs of children who have been sexually abused, and their families (2009) HSE

45 Kelly, L. and Regan, L. (2003) Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations, Rape Crisis Network Europe.

C.3. Assessment and Examination Services

C.3.1. Models of care

C.3.1.1. Sexual Assault (Referral) Centres (SARC)

There are a number of models of Sexual Assault Centres, responding to concerns about the lack of dedicated services for victims of sexual assault. Some countries such as Canada have extensive networks, while others such as Germany, Switzerland and the UK have a number of centres, often located in major cities or locations where women's groups or committed medical staff have campaigned to improve local provision.[46] In Canada, the mandate is 'to attend to the medical, emotional, social and medico-legal needs of the victim in a prompt, professional and compassionate manner and to provide leadership in the prevention of sexual assault'.[47] This emphasises the importance of choice, respect, empowerment and honouring difference, alongside linking crisis intervention, long term support and prevention.[48]

In terms of coverage, there are currently 30 existing SARCs and a further 16 are under development in police force areas across England and Wales. It is intended that across England, there will be a SARC in each police force area by 2011.

Within the UK, 'SARCs are now widely recognised as a fundamental part of the overall suite of support provided to victims of serious sexual assault and abuse, within the local community setting. The co-ordination of health, counselling and criminal justice forensic services addressed in a 'one stop' location has provided the basis for the development of SARCs across the country'[49]. Most SARCs are joint ventures between the police and Primary Care Trusts (PCTs), with close involvement of the voluntary sector.[50]

There are three main referral routes into SARCs:

- Police referral - police officers would normally take anyone reporting rape or sexual assault to the centre for initial assessment and examination;

46 O'Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

47 Du Mont, J. and Parnis,D. (2002). 'Forensic Nursing in the context of Sexual Assault: Comparing the opinions and practices of nurse examiners and nurses' Applied Nursing Research.

48 Kelly, L. and Regan, L. (2003) Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations, Rape Crisis Network Europe.

49 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

50 Department of Health Children and Mental Health Division and Home Office Violent Crime Unit (2005) Developing Sexual Assault Referral Centres (SARCs) – National Service Guidelines

- Self-referral -. Self-referrals may choose whether or not to undergo forensic medical examination; and
- Health and voluntary sector referrals - Staff from services such as A&E, Genito-Urinary Medicine (GUM), family planning, GPs, Social Services and voluntary organisations such as Rape Crisis groups will often be the first people to be told about a rape or sexual assault.

The Health Needs Assessment for the Nottingham SARC examines these core components against five SARC services based across England, a copy of which is contained in Appendix B.

Comparing five SARC services based across England, it is apparent that there is inconsistency in the minimum age of a child or young person eligible for treatment at current SARC services. The five services considered here provide services to children aged from 0 years, 13 years, 14 years or 16 years of age and it is reported that this dependent on availability of resources, and the local arrangements in place for children's services.[51] A recent UK review undertaken by the NSPCC recommended that more needs to be done to ensure that sexually abused, raped or sexually exploited young people should be able to access confidential advice, and to self-refer to specialist services. In particular, it is noted that 'rolling out and evaluating Sexual Assault Referral Centres for Children's services are particularly welcome in this context'.[52]

The National Service Guidelines for developing Sexual Assault Referral Centres[53] define the following minimum elements of service for SARC's:

- Twenty-four hour access to crisis support, first-aid, safeguarding, specialist clinical and forensic care in a secure unit. A forensic physician is normally available within one hour;
- Appropriately trained crisis workers to provide immediate support to the victim and significant others where relevant;
- Choice of gender of physician, where possible;
- Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children;
- Dedicated forensically approved premises and a facility with decontamination protocols following each examination to ensure high quality forensic integrity and a robust chain of evidence;

51 Department of Health Children and Mental Health Division and Home Office Violent Crime Unit (2005) Developing Sexual Assault Referral Centres (SARCs) – National Service Guidelines

52 Allnock D et al (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need. NSPCC

53 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

- The medical consultation includes risk assessment of harm/self-harm, together with an assessment of vulnerability and sexual health; there is immediate access to emergency contraception, post-exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed;
- Access to support, advocacy and follow-up through an independent sexual violence adviser (ISVA) service, including support throughout the criminal justice process, should the victim choose that route;
- Well co-ordinated interagency arrangements in place, involving local third sector service organisations supporting victims and survivors, local safeguarding Children Boards (LSCBs) where children are seen, and are reviewed regularly to support the SARC in delivering to agreed care pathways and standards;
- The SARC has a core team to provide 24/7 cover for a service which meets NHS standards of clinical governance and the European Working Time Directive; and
- Minimum dataset and appropriate data collection procedures in each SARC.

The SARC model reflects that timely access into appropriate sexual health services is essential for children and adults after a sexual assault. Risks to sexual health include unplanned pregnancy, and sexually transmitted infections. It is also recognised that timely access into Mental Health Services for children and adults is imperative. It is suggested that therapeutic interventions can prevent the onset of chronic Post-Traumatic Stress Disorder (PTSD) if received soon after the traumatic sexual experience. Further, Cognitive Behavioural Therapy (CBT) in the treatment of female victims of sexual assault, as compared to a control group, that those receiving CBT reported less severe symptoms of PTSD at 2 months and 5.5 months after treatment.[55]

As an example, the set up costs of the three SARCs that comprise the London Havens SARC were £0.3m and running costs are up to £1 million/1000 cases/per annum. [54]

The set-up and running cost of a SARC will vary according to a variety of factors such as:

- Whether it is located in existing accommodation or new build;
- The staffing arrangements; and
- The level of demand for the SARC service.[56]

54 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

55 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

56 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

Each adult rape is estimated to cost over £76,000 in its emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health services and costs incurred in the criminal justice system. [58]

To assess the net benefit, the set-up and running costs of SARCs must be offset against the likely savings to the wider health economy and the long-term costs to the economy as a whole. For instance, the effective services provided by a SARC may reduce the number of people later referred for specialist services, such as secondary mental health and sexual health services, as well as reducing multiple assessments and waiting times for patients who use alternative services that are not integrated.[57]

Addressing the needs of victims early through the provision of SARCs can reduce the long term costs associated with sexual assault and deliver benefits to victims in terms of better health, wellbeing and quality of life as well as long term productivity savings in services if the immediate aftermath of sexual assault is managed effectively. [59]

SARCs have been highlighted as good practice in several reports,[60] and a study evaluating the inter-agency, integrated approach to service provision, provided by the SARCs in the UK identified that SARC service users rated the environment and conduct of the forensic examiner as the highest in comparison to users of other models with a higher proportion of cases resulted in forensic medical examinations. It was also found that the examiners in SARCs were more likely to conduct the examination with care and sensitivity, including offering as much control as possible to the victim.[61]

C.3.1.2. Child Advocacy Model

CACs provide a neutral, child-friendly facility where all the government agencies can interview and examine the child in a coordinated interviewing process.

The Child Advocacy Model involves Child Advocacy Centers (CACs) which are one-stop systems in which services can be made more accessible and service delivery can be more efficient through co-location and coordination of services that are normally provided by more than one agency. The objective of CACs is to reduce trauma to the child abuse victim by coordinating a child's interview to include professionals from multiple agencies, which can reduce the number of

57 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

58 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

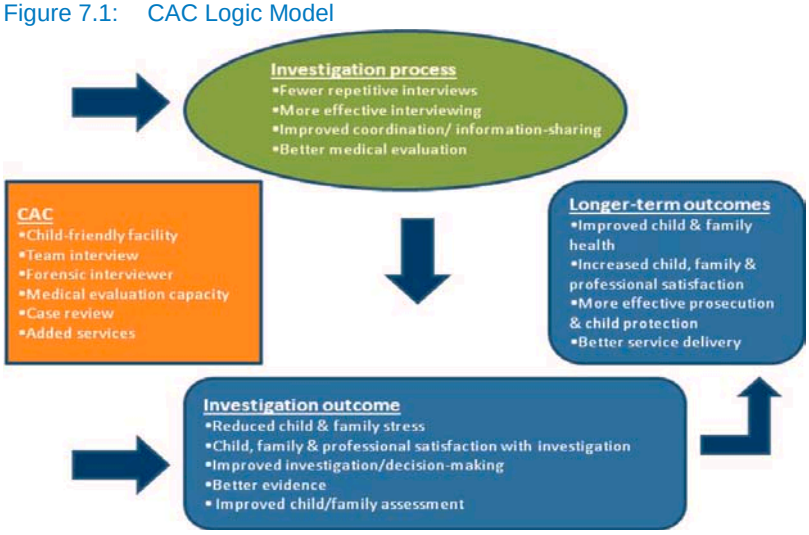
59 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

60 Including the Report on the Joint Inspection into the Investigation and Prosecution of Cases involving Allegations of Rape (HMCPSI/HMIC, 2002); and Home Office Research Study 285, Sexual Assault Referral Centres: developing good practice and maximising potentials (Lovett et al., 2004).

61 Lovett, J. Regan, L. Kelly, L. (2004) Sexual Assault Referral Centres: Developing Good Practice and Maximising Potentials, London, Home Office.

interviews and improve the quality of the investigation.[62] The core principles of the CAC model are shown in Figure 7.1.

Figure 7.1: CAC Logic Model



Source: Crimes against Children Research Center, University of New Hampshire

Collaboration between multiple agencies is essential to the CAC model of care, where CACs represent a neutral third party where representatives from each partner agency can collaborate in a collegial environment. This is considered to be a more effective and efficient way to deliver services to suspected abused children: improving the accuracy of overall assessment, prediction of risk, and development of intervention strategies; reducing confusion between multiple agencies; and avoiding the duplication of services. [63]

Two CAC case study examples are provided in Appendix C and it is important to note that the CACs do vary, as for example:

- Some provide only a child-friendly facility for interviews while others offer comprehensive on-site medical and mental health services;
- Some CACs serve only victims of sexual abuse, while others serve all victims of abuse and neglect; and
- The number of children served by each CAC also varies widely—from 200 to 5,000 children a year.

The 5 Core Disciplines of Child Advocacy Centers:

- Child Protective Services
- Law Enforcement
- Therapy treatment providers
- Medical/health care professionals
- Prosecutors

62 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

63 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

However, regardless of these variations, the National Children's Alliance have developed CAC standards for accreditation which identify the critical functions of a CAC, as shown in Table 7.1 below.

Table 7.1: National Children's Alliance CAC Accreditation Standards

Critical functions for CAC	Description
Joint Investigative Interviews	Conducted by child protective service investigators, social service intake workers, and law enforcement to facilitate both investigations and reduce the need for multiple interviews.
A Multidisciplinary Case Review Team	Representing prosecution, law enforcement, mental health, medical, child protective, and social services that reviews cases and makes recommendations on the case outcome in areas of prosecution, mental health services, child protection issues, and family support.
A Case Tracking System	Monitors each case's progress through the system. Information is used to appraise professionals and families of the case's progress. This also prevents cases from "falling through the cracks."
A Medical Examination	Performed by a paediatrician with specialised training. The examination is sometimes done on-site at the local child advocacy centre or in an affiliated hospital or regional diagnostic centre.
Mental Health Evaluation and Treatment	Provided by clinicians familiar with the specialized area of child abuse/family violence. The clinicians must also be able/willing to work with other professionals involved in the case (police, prosecutors, social services) for optimum case results.
Community and Emergency Services	For the child advocacy centre to be effective, the centre's staff must maintain a resource directory of a wide range of services for families. Referrals are often required for emergency housing, child placement, legal aid, childcare assistance, and immediate needs. These concrete service referrals are essential to maintaining the family's well-being and often the case itself.
An Advocacy and Criminal Justice System Liaison	Between outside agencies and units within the court system and prosecutor's offices. The centre serves as the central point for all professionals working on each case. Ideally, initial meetings with those involved (prosecutors, police, mental health, victim-witness) are always scheduled at the centre to provide continuity and familiarity.

Source: National Children's Alliance[64]

Whilst the outcomes of CACs have not been extensively validated through control group research between CACs and traditional child protection agencies, anecdotal evidence and preliminary research indicates that CACs:

- Reduce the number of child abuse interviews for the victim;
- Improve collaboration between multiple government agencies;
- Lead to better evidence collection;
- Improve due process for parents by moving the investigation out of the juvenile court system;
- Result in fewer foster-care placements for abused children; and

64 National Children's Alliance, Member Standards, http://www.nncac.org/network.html.

- Can increase confessions, prosecution rates, and convictions for perpetrators.[65]

C.3.1.3. Child Abuse and Rape Enquiry Units

Within Northern Ireland, Child Abuse and Rape Enquiry Units (CARE) have been established, where for both adult and child victims of acute and chronic rape/sexual assault are interviewed and examined.

There are four CARE Units, managed and funded by the Police Service Northern Ireland. All four Units located in a police environment.

When a victim reports the rape/sexual assault, a dedicated trained police officer makes all the arrangements to interview the victim within the CARE unit and arranges the forensic medical examination as necessary.

The benefits of this model of care are reported to include having dedicated, well-trained and experienced Police Officers dealing exclusively with cases of sexual assault and abuse in both adults and children. Funding is available from the PSNI to provide adequate facilities, staff training and remunerate the doctors for their time and expertise.[66]

Disadvantages are reported to include being entirely police-managed and having only limited links to health services. To date, there is no facility for a person who declines police involvement to avail of the services. A facility where a person could have a medical examination including taking forensic evidence samples, which could be securely stored, is being considered. Links to counselling services are also limited. [67]

C.3.1.4. Children's Houses

Children Houses have been established in Iceland, Sweden and in Norway and are based on the CAC model where the needs of the child are defined as "a primary consideration" rather than the child having to adapt to the needs of the different agencies of societies. [68]

The needs of the child are the primary consideration

65 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

66 O'Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

67 O'Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

68 Gudbrandsson B (n.d.) "Under one roof" Towards the best interest of the child in cases of child sexual abuse. Government Agency for Child Protection, Iceland

With the overt aim of preventing repetitive interviews, a child friendly setting, “Barnahús”, the “Children’s House”, was created; an environment designed to make the child feel secure and comfortable. The aim was also to facilitate coordination of the different agencies in society in dealing with child sexual abuse cases.

The core of the concept of the Children’s House is the joint investigative interview of the child victim, including medical examination and therapeutic services that are also provided in the Children’s House. Thus, the Children’s House provides a comprehensive service for the child victim and her/his family under one roof and has benefits from the accumulation of experience and knowledge that can be transmitted to the public and professionals alike.[69]

The interdisciplinary and multiagency approach of the Children’s House in Iceland has been identified as best practice[70], acknowledging the importance of a professional approach to child sexual abuse, which combines sound legal, medical and social practices with child friendly work procedures in full compliance with the UN Convention on the Rights of the Child.

C.3.1.5. Centres of Excellence

This ‘Nordic model of rape victim centres’ common to Scandinavia is usually hospital based and often developed through the vision and leadership of a committed female doctor. What distinguishes a Centre of Excellence is that they are reported to be usually well funded, recognised nationally (and often internationally) as holding extensive expertise, and invariably undertake research and publish findings in medical and other journals.[71]

These Centres of Excellence represent a national resource and are usually based in a city

Whilst some attend to children and adults, most are limited to adult sexual assault; some are limited to cases reported to the police, others have an open self-referral policy.

69 Gudbrandsson B (n.d.) “Under one roof” Towards the best interest of the child in cases of child sexual abuse. Government Agency for Child Protection, Iceland

70 By the International Save the Children Alliance in the study Child Abuse and Adult Justice 2002 and the International Society for the Prevention of Child Abuse and Neglect, ISPCAN, presented the Children’s House with the “Multidisciplinary Team Award” at their International Congress in York, UK, 2006.

71 Kelly, L. and Regan, L. (2003) Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations, Rape Crisis Network Europe.

Their core services, therefore, tend to encompass: emergency medical treatment/care; forensic examination, often using the latest equipment and informed by research; and crisis counselling. Several examples also provide longer term support, and some level of advocacy. There tend to be very strong links with other agencies, especially the police and prosecutors. Their role is to be an example of best practice, continually updating knowledge and skills, in the light of their own and the wider international knowledge base.

While those who attend such centres will be seen by skilled and experienced staff, there are a number of disadvantages for those outside of the catchment area who cannot access the services. Resources tend to be drawn to the centre, with limited development and provision elsewhere. [72]

C.3.2. Joint interviewing

The responsibility in dealing with child sexual abuse is often divided between a numbers of agencies:

- Child protection systems or the social services are to ensure the child's safety and the appropriate support services and therapy;
- The health professions need to be involved for medical examination and intervention;
- Law enforcement is responsible for the criminal investigation and the prosecution for deciding on whether indictment is made or not; and
- The role of the court system is to determine the guilt or innocence of the alleged offender.

'In order to fulfil their roles, all these different agencies need to examine the child victim's account. Consequently it is commonplace that children are subjected to repeated interviews by different professionals in many locations; a condition that research findings have showed to result in re-victimisation of the child that can even be more painful for the child than the original abuse'.[73]

In line with CAC and Children's House model, and the growing trend to incorporate law enforcement into child protection,[74] a joint interviewing

72 Kelly, L. and Regan, L. (2003) Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations, Rape Crisis Network Europe.

73 Gudbrandsson B (n.d.) "Under one roof" Towards the best interest of the child in cases of child sexual abuse. Government Agency for Child Protection, Iceland

74 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

approach would see the needs of the child were defined as a primary consideration rather than the child having to adapt to the needs of the different agencies of societies; the principle of the Child Advocacy Model.[75]

A 2009 review on investigation processes undertaken by the United Nations reported that 'some significant progress has been made through the establishment of the so-called "child advocacy model", which adopts a multidisciplinary approach during the investigation. The most important component of this model is the fact that law enforcement officials are accompanied by child specialists and mental health-care providers when they conduct interviews of children. This model offers greater potential for protecting not only the child but also the accused, because it ensures that interviews are conducted in a more thorough and accurate way'.[76]

Taking the example of Children's Houses, the joint investigative interview of the child victim is executed by a trained professional interviewer under the formal authority of a court judge, observed by representatives of the police and prosecution, the defence lawyer, the child's legal advocate and the child's social worker. The actual interview is implemented in a child friendly interviewing room but the representatives of the different agencies observe via the use of a closed circuit television. The interview is videotaped for multiple purposes. Such an approach ensures professional criminal investigation and "due process" for the suspect without compromising the principle of the best interest of the child. [77]

A similar approach is taken within the CAC where the interviewer excuses themself for a moment, steps out of the room, then asks the other viewers (from the police or sheriff's office or CPS or the district attorney's office who are watching in a separate room) if there is anything missed, or any statement that should be reviewed again.[78]

Whilst it is recognised that more cross-comparison research needs to be done to validate the advantages of involving the justice system in a

75 Gudbrandsson B (n.d.) "Under one roof" Towards the best interest of the child in cases of child sexual abuse. Government Agency for Child Protection, Iceland

76 United Nations Office On Drugs And Crime (2009) Justice in Matters involving Child Victims and Witnesses of Crime

77 Gudbrandsson B (n.d.) "Under one roof" Towards the best interest of the child in cases of child sexual abuse. Government Agency for Child Protection, Iceland

78 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

joint process to investigate child abuse, one study of CACs concluded that there appeared to be increased coordination on investigations and child forensic interviewing[79] and the following benefits have been identified from undertaking joint investigations:

- Shorter caseworker response times;
- Lengthier investigations;
- More contacts during the investigations;
- More frequent use of face-to-face interviews with persons involved in the case;
- More custody removals;
- More perpetrator departures from the home;
- More perpetrator confessions;
- More frequent victim corroboration;
- More substantiated reports;
- More dependency filings;
- More criminal prosecutions; and
- More guilty pleas. [80]

C.3.3. Medical Examination Services

The medical consultation will include risk assessment of harm/self-harm, together with an assessment of vulnerability and sexual health; there is immediate access to emergency contraception, post-exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.[81]

In addition to this medical examination addressing the child or young person's needs, forensic examinations must also address the justice system's needs for rigorous evidence collection. It is reported that good practice involves understanding this dual function, and recognising that whilst they can often be combined relatively seamlessly, there may be conflicts for the complainant and/or the medical examiner.[82]

79 Theodore P et al (2007) Child forensic interviewing in Children's Advocacy Centers: Empirical data on a practice model

80 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

81 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

82 Du Mont, J., & Parnis, D, in press, 'Forensic nursing in the context of sexual assault: Comparing the opinions and practices of nurse examiners and nurses' Applied Nursing Research.

Best practice indicates that forensic examinations should be undertaken in dedicated forensically approved premises and a facility with decontamination protocols following each examination to ensure high quality forensic integrity and a robust chain of evidence, including:

- Protocols, procedures and audit in place for decontaminating examination facilities;
- Following professional guidance[83] on sample collection and labelling, and the recommended equipment for obtaining forensic samples from complainants and suspects; and
- Regular multidisciplinary meetings for staff to discuss queries and practical issues with key experts and receive updates on developments in forensic practice from the lead forensic physician. [84]

Research has identified that the environment in which examinations take place is critical. A private, dedicated space, which combines clinical needs for cleanliness in the examination room with a separate calming and relaxing location to undertake interviews and support are minimum requirements. Other issues (although not child specific) identified to be critical in ensuring that forensic examinations maximise the evidential potential and provide comfort, reassurance and necessary health input to complainants, include:

- Speedy response;
- Avoiding the triage system in hospital A&E departments;
- A private, dedicated space;
- A well equipped examination room;
- Trained and skilled practitioners;
- Female examiners;
- A streamlined victim-centred information gathering process;
- Time to move at the speed the victim/survivor is comfortable with;
- Protocols and evidence kits which are applied flexibly, according to the facts of the case;
- Space to discuss the process, debrief and undertake crisis intervention; and
- Provision of, or links to, medical follow up and advocacy/support services.[85]

Some of the service models reflect these key criteria, as for example, SARCs require that access to a forensic physician is normally available

83 For example, guidance from the Faculty of Forensic and Legal Medicine

84 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

85 Kelly, L. and Regan, L. (2003) Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations, Rape Crisis Network Europe.

within one hour and that there should be a choice regarding the gender of a physician where possible [86]

SARCs must also provide access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children and state that:

- Paediatricians who undertake assessments of children with an allegation of sexual assault must have higher level competencies (above level 3) in paediatric and forensic medicine;
- Forensic physicians, whether working with children or adults or both, have practical experience of working as a Sexual Offences Examiner, with ongoing supervision such as peer review, annual appraisal and revalidation underpinned by continuing professional development; and
- For examination of children and young people, forensic physicians follow the FFLM47 and Royal College of Paediatrics and Child Health (RCPCH) guidelines and other local protocols.[87]

Within the CARE Unit in Northern Ireland, it is noted that examinations of children are usually carried out jointly by the senior doctor at the Garnerville Unit and community or consultant paediatricians. Many of the eight doctors who cover the 24-hour rota work elsewhere part-time; either as GPs or at senior registrar level in hospitals, in addition to rota cover at the CARE Unit.[88]

Guidelines also state an ideal service should be available 24/7, providing a service for some part or all of every day, including weekends. To achieve adequate medical staffing rotas for acute medical child protection work may well need to draw on networks such as managed clinical networks.[89]

Forensic nurses are also being considered forensic nursing has been introduced in Europe, the US and Canada as a means of addressing problems encountered with the recruitment and retention of female doctors and providing the best possible service for victims. In the US,

86 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

87 DH (2009) A Resource for Developing Sexual Assault Referral Centres (SARCs)

88 O'Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

89 DH (2008) Draft Guide for Services for Children provided by Sexual Assault referral Centres (SARCs)

forensic nurses now conduct the majority of forensic medical examinations on both adults and children and includes provision of services to the police and criminal justice system.[90]

In the UK, by contrast, the scope of the forensic nurse's practice is limited where they are accepted by the courts as an ordinary witness only, as opposed to the doctor who is seen as an expert witness. The evaluation of the UK forensic nursing pilot programme suggested that ''the obvious next step for the long term lies in the development of the forensic nurse's role from documenter to interpreter of her own evidence, as is common practice in North America.[91]

The Lancashire SAFE (Sexual Assault Forensic Examination) Centre, a joint venture between Lancashire Teaching Hospitals NHS Foundation Trust and Lancashire Constabulary, incorporates nursing forensic examiners in its forensic team, improving the 24 hour access to the service. All the nursing staff have backgrounds in gynaecology, sexual health and contraceptive services.

The forensic examiners course managed by St Mary's Manchester acknowledges the role of forensic examiners according to competency, and as such, both medical and nursing staff are entitled to enrol on the course. The entry requirements are mainly dependent on holding a clinical qualification and having previous relevant experience. The two modular courses cover a range of competencies and issues including:

- Classifying and documenting injuries;
- The wider criminal justice context of police and legal processes;
- Exploration of forensic science, ethics, child protection, statement writing, and social and psychological issues;
- Medico-legal aspects of work with rape and sexual assault;
- Paediatric examination;
- Advanced legal issues including court role play and the role of the professional witness; and
- Criminology.

An evaluative study of the outcomes on forensic nursing examiner interventions at St Marys Sexual Assault Referral Centre conducted

90 Regan L., Lovett J., Kelly, L. (2004) 'Forensic Nursing: An Option For Improving Responses To Reported Rape And Sexual Assault', Home Office, London.

91 Regan L., Lovett J., Kelly, L. (2004) 'Forensic Nursing: An Option For Improving Responses To Reported Rape And Sexual Assault', Home Office, London.

over a two year period, showed there were benefits to incorporating forensic nurse examiners into the forensic team, including [92]:

- Improved access times for daytime examinations - 25% seen within 3 hours of the police reporting and 50% seen within 6 hours
- Patient preference for female examiners met
- No statistically different conviction rates
- Cost effective way to extend the availability of the service

C.3.4. Team composition

Collaboration and an inter-agency approach are integral to models such as CACs and SARCs. Reflecting that children or young people who may have been sexually abused quite often experience more than one type of abuse and so sexual abuse cannot be dealt with in isolation, these children require a multi-access, disciplinary and multi-agency coordinated approach to identify abuse, assess risk and devise and implement management, protection and aftercare plans effectively.[93]

Access to one stop services such as CACs and SARCs will allow access to a multidisciplinary team, which may include:

- Crisis workers;
- Forensic physicians or Paediatricians;
- Forensic nurse examiners;
- Independent Sexual Violence Advisors (ISVA);
- A counselling coordinator and access to counsellors (often provided by third sector organisations);
- Clinical psychologists;
- Health advisors;
- Children and young persons therapist;
- Culturally specific access – such as an Asian development worker;
- Law enforcement representatives; and
- Representatives of victim advocacy groups.

These should teams meet regularly to discuss and make decisions regarding the investigation, treatment of the victim, and prosecution of the perpetrator.[94] Centres will also be supported by a Centre Manager and Administrative staff.

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[92] Forensic Nursing: an option for improving responses to reported rape and sexual assault; Regan, Lovett, Kelly; Home Office online report 28/04

93 HM Government (2006). Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.

94 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

C.3.5. Accessibility

Research has shown that early evidence gathering and victim support are key factors in successful prosecutions and to supporting victims' access to sexual health and NHS services. [95]

It is widely accepted that accessibility to sexual assault services is essential and that regardless of location, it is important to create an environment 'that is welcoming, supportive and accessible. The aim is to encourage more victims to come forward, including under 16 year olds, to ensure they also access services including sexual health/teenage pregnancy'. [96]

A core standard of such services are that they are a neutral facility. As part of the CAC, this is defined as a designated separate facility where professionals and families can meet. This facility, ideally, is close to other services geographically for the convenience of professionals and families.[97]

Other models differ in their physical location. For example, CARE units in Northern Ireland are located in a police environment, where the interview rooms are equipped with adjoining observation rooms, video links and camera recording equipment. These facilities are used particularly in cases of child abuse where the child victims are being interviewed or also in interviewing vulnerable adults, such as those with learning difficulties. The medical examination rooms provide colposcopy, photography and video documentation facilities.[98]

In contrast, many of the SARC services established within the UK are co-located within a hospital, a health building (e.g. sexual health centre), although some may be on a police site. It is noted that SARCs are normally managed by health professionals or the voluntary sector and located in health premises or residential buildings with no visible links to the police, so as not to deter self-referrals.[99]

In a 2005 review, it was reported that in some police force areas, police choose to take the statement within the SARC environment, which may

95 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

96 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

97 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

98 O'Shea A (2006) Sexual Assault Treatment Services: A National Review. Written on behalf of the Sexual Assault Review Committee

99 Department of Health Children and Mental Health Division and Home Office Violent Crime Unit (2005) Developing Sexual Assault Referral Centres (SARCs) – National Service Guidelines

involve the victim travelling up to 1.5 hours to the facility. SARC police liaison officers have reported that this is acceptable to victims because of the enhanced and prompt service they will receive on their arrival.[100]

7.1.1.1 Initial access to services

In the UK The task of the Emergency Duty Team (also known as “EDT”) is to help all vulnerable people in an emergency providing an out of hours emergency service .The EDT priority has to be carefully focused on ‘emergencies’ and their assessment and intervention ensuring the vulnerable person’s safety and overall welfare until a more thorough assessment of need can be carried out the next working day.

EDT social work staff endeavour to provide essential information to promote people's health, wellbeing and safety and genuine choice for users and carers having regard for the limited resources out of hours and time available for each emergency.

The EDT staff are able to confer out of hours with the EDT manager who provides supervision, support and advice and can make arrangements for the deployment of additional staff if there are unexpectedly too many referrals to deal with safely. EDT necessarily has clear links and protocols involving other professional teams operating out of hours and those teams within normal office hours.

There is agreement that EDT is an economical and well tested structure good at safeguarding vulnerable persons by being “Family Focussed” and with qualified social workers who are experienced in children and adult safeguarding.

C.3.6. Governance and performance

In responding to local issues such as need and available resources, centres such as CACs are designed and governed at the local level, and may be managed by a multi-agency Governing Boards.[101]

Whilst CACs are locally governed, they operate under the umbrella of the National Children’s Alliance which provides training, technical

100 Department of Health Children and Mental Health Division and Home Office Violent Crime Unit (2005) Developing Sexual Assault Referral Centres (SARCs) – National Service Guidelines

101 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

assistance, and networking opportunities to all CACs. The National Children's Alliance also holds members accountable through a series of reporting forms including a statistical report that includes caseload information on client demographics and type of abuse, data on services delivered such as counselling or medical examinations, reports on perpetrators and demographic characteristics, the disposition of cases including whether the case is substantiated or unfounded, and status of prosecution. Specific performance measures focus on:

- Conviction Rates;
- Number of Clients Served;
- Number of Interviews Conducted;
- Time of Investigative Process;
- Child Safety;
- Client Satisfaction; and
- Interagency Coordination/Team Satisfaction. [102]

Other key outcomes used to evaluate and measure CAC model include:

- Child and Family Investigative Outcomes;
  - More effective investigations;
  - More thorough investigations;
  - Increased emotional support for child;
  - Prompt delivery of service;
  - Increased availability of service;
- Child and Family Post-investigation Outcomes;
  - Child less likely to experience repeat abuse;
  - Decreased stress by child;
- Agency Investigative Outcomes;
  - Accurate decisions;
  - Increase in shared case information;
  - Increased inter-agency coordination;
  - More expertise available;
  - Better evidence;
- Agency Post-investigation Outcomes;
  - Increased percent of at-risk children protected;
  - Increased percent of substantiated cases filed for prosecution;
  - Increased percent of convictions at trial;
  - Increased percent of confessions;
- Community Investigative Outcomes;
  - More resources for investigation;
  - Greater adherence to best practice standard;
  - Better coordination of investigations;

102 National Support Team for Response to Sexual Violence (January 2010) Department of Health and Home Office

  - Better inter-agency relationships;
- Community Post investigative Outcomes;
  - Growth in community resources for child abuse; and
  - Growth in public awareness of child abuse. [103]

A further example of governance is the SARC model of care which is managed by a Strategic Management Board which comprises multi-agency involvement from the NHS, police and voluntary sector. Other key governance features are that:

- The SARC has developed a core team to provide 24/7 cover for the service including arrangements for self-referrals, crisis support, first aid and forensic and clinical care in a secure environment; and
- Regular multi-disciplinary operational meetings are held where practical issues can be discussed and progressed, if necessary, to the Strategic Management Board. [104]

C.4. Follow Up Care

The models discussed will provide access or referral to follow up care, which may include:

- Hospital and wider Health services for treatment of injuries;
- GUM services for ongoing sexual health needs;
- Mental health services for children and adolescents;
- Therapeutic and counselling services;
- Victim support, for information on police and court procedures, advice on claiming compensation and advocacy services; and
- Specialist rape crisis and other sexual violence organisations where clients may have a preference for counselling/advocacy away from the centre or required long-term counselling.

In some models of care, a Child or Young Person' coordinator may conduct a risk or needs assessment if the client wishes to access support/ counselling services.

It is widely accepted that early access to services for children and young people is essential to ensure improved outcomes. A recent review of therapeutic services for children and young people in the UK notes that 'currently, waiting lists are too long leaving children without any service. CAMHS [Child and Adolescent Mental Health Services]

103 National Support Team for Response to Sexual Violence (January 2010) Department of Health and Home Office

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should be require to ask service users about experiences of abuse, so that young people who have experience abuse can have their needs for service assessed'.[105]

C.4.1. Therapeutic interventions

It is clear that a variety of therapeutic approaches can be used when working with children and young people. For example, a recent survey undertaken in Scotland, identified that 'service managers and practitioners named a wide and eclectic range of models of therapy and therapeutic approaches to work...In all, more than 40 different therapies and approaches were reported. This varied by sector. Practitioners in the voluntary sector tended to use 'counselling' and 'person centred' approaches; and to describe themselves as providing 'emotional support', 'empowerment' models. There was a high use of 'creative therapies.' Health reported more use of specialist therapies such as 'Cognitive Behavioural Therapy'(CBT), 'Family Therapy', 'Psychodynamic approaches' and approaches such as 'EMDR' [Eye Movement Desensitisation and Reprocessing].[106]

A recent NSPCC review notes that some therapies, such as CBT and counselling are chosen because research evidence points to their effectiveness in improving outcomes, but the study showed that there is insufficient long-term research on a range of interventions, presenting a possible barrier to both efficiency and service development.[107] However, other research does support the use of therapies such as CBT; in the treatment of female victims of sexual assault, as compared to a control group, that those receiving CBT reported less severe symptoms of PTSD at 2 months and 5.5 months after treatment.[108]

NICE guidance on Post Traumatic Stress Disorder considered evidence from a systematic review of randomised control trials of five therapy groups, including trauma focussed cognitive behavioural therapy, EMDR (Eye Movement Desensitization and Reprocessing) – a form of psychotherapy, stress management, group CBT and other therapies (supportive therapy and non directive counselling, hypnotherapy and

105 Allnock D et al (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need. NSPCC

106 Stafford A, Morgan-Klein N, Kelly S (2009) Mapping Therapeutic Services to Children and Young People who have been Sexually Abused Services in Scotland

107 Allnock D et al (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need. NSPCC

108 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

psychodynamic therapies). The review found trauma focussed CBT showed "clinically important benefits" on all measures of PTSD. The studies include participants who had suffered a range of different traumas including accidents, assaults (including sexual assaults in childhood), military combat and domestic violence. Treatment duration ranged from 4 to 18 sessions of between 50 and 120 minutes. There was evidence of benefit of EMDR but this was less persuasive than CBT evidence. There was no evidence to support therapies classed as other. There was limited evidence of effectiveness for stress management therapies and group CBT therapies. NICE guidance recommends PTSD sufferers be offered a course of outpatient trauma focussed psychological treatment of 8 to 12 sessions weekly by the same therapist where the trauma results from a single event. [109]

The effectiveness of family therapy and systemic interventions where child sexual abuse has occurred has been researched and recently reviewed.[110] It is recommended that programmes be developed that begin with a comprehensive network assessment and include alongside regular family therapy sessions, the option of parent focused and child focused interventions, spanning at least a period of six months, the intensity of which to be matched to the families needs.

Psychoanalytic approaches have also recently been researched. Trowel et al (2002) conducted a multi-centre psychotherapy randomised controlled trail, where 71 sexually abused girls aged 6-14 years old were randomly assigned to focused individual psychotherapy or psycho-educational group therapy. Both therapy groups showed a substantial reduction in psychopathological symptoms and improvement in functioning. Individual therapy was found to lead to greater improvement in manifestations of PTSD.[111]

It is also apparent that waiting times for such therapy services also vary considerably; the recent review of therapeutic services in the UK found that 'waiting lists for a service average three months, although this also varies quite significantly and can be as long as a year. Services prioritise children with the most severe symptoms and problematic behaviour, as they lack the resources to quickly see all children who

109 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

110 Carr Alan (2009) The effectiveness of family therapy and systematic interventions for Child Focused problems. Journal of Family Therapy (2009) 31:3-45

111 Trowell et al (2002) Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. British Journal of Psychiatry 2002 Mar; 180: 234-47

have experienced sexual abuse. Some services are managing excess demand by closing their waiting lists'. [112]

In addressing this, it is recommended that consideration be given to forming an area or even regional clusters to ensure a variety of therapeutic interventions are accessible across a range of providers. [113]

C.4.2. Advocacy

"For children and young people who have been maltreated by their parents or carers, it is especially important that the professionals trying to help them do not add to the feelings of being powerless and vulnerable". (Munro 2011:18, par.1.33)

The recent Munro review of the child protection system in England 2011 concludes that just as the system must listen to the experiences and views of the professionals working with children and families, so it must listen to the children themselves. Social workers often identify that they lack the necessary skills and confidence in undertaking direct work with children, while another constraint is having the necessary time. It asserts that like many other professionals social workers' priorities are set by the organisations they are working for.

The role of the independent reviewing officer was introduced on a statutory basis in 2004 in England for looked after children.

The IRO has a number of specific responsibilities which include:

- promoting the voice of the child
- ensuring that plans for looked after children are based on a detailed and informed assessment, are up-to-date, effective and provide a real and genuine response to each child's needs
- identifying any gaps in the assessment process or provision of service
- making sure that the child understands how an advocate could help and his/her entitlement to one
- offering a safeguard to prevent any 'drift' in care planning for looked after children and the delivery of services to them

112 Allnock D et al (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need. NSPCC

113 Allnock D et al (2009) Sexual abuse and therapeutic services for children and young people: The gap between provision and need. NSPCC

The IRO fulfils a crucial quality assurance function for the Local Authority's service for looked after children, as part of the monitoring function, the IRO also has a duty to monitor the performance of the local authority's function as a corporate parent and to identify any areas of poor practice. This should include identifying patterns of concern emerging not just around individual children but also more generally in relation to the collective experience of it's looked after children of the services they receive. Equally important, the IRO should recognise and report on good practice.

The Regulations do not prescribe the position of IROs within the local authority, but they do prescribe minimum levels of independence. These are that the IRO must be independent of the management of the child's case and independent of the resources allocated to that case.

A recent review of Children and Young people's views of the child protection system in England 2011 found many of the children had only a partial understanding of the child protection process. Professionals engaged with the child and young person should not assume that the child is not of sufficient age and understanding to know something about the child protection process. [114]

It is important that they receive information appropriate to their needs. This is likely to be different from case to case and professionals need to take into account the fact that information (sometimes erroneous) may come from other sources, such as older siblings, parents, friends or the media. In the current study parents varied in their views about how much the child should know about the child protection process. Some parents made it clear that they wanted to protect their children from knowledge about the formal child protection system whilst some spoke to their children about what was going on.

As part of the care provided to the child and young person, they could have access to Independent Sexual Violence Advisors (ISVAs), who are specially trained to provide proactive and tailored assistance and advice to victims of sexual violence. Within the UK, ISVAs are located in either SARCs or voluntary projects and their role is to provide effective support and clear information to SARC users at all points of the process from report through to court. This is victim led. [115] Their main responsibilities can be broadly grouped into the following areas:

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[114] Office of the Children's Commissioner, "Don't make assumptions", Children and Young People's views of the Child Protection System and Messages for Change, March 2011

115 National Support Team for Response to Sexual Violence (January 2010) Department

- Advice and support: providing non-therapeutic support to victims at the point of crisis and beyond, along with other types of practical help and advice;
- Where required, supporting victims, giving information and assistance through the criminal justice process; and
- Multi-agency partnership working on behalf of the victim: liaising with partner agencies in a multi-agency context, providing 'institutional advocacy'.[116]

A recent evaluation of ISVAs concluded that 'in general the introduction of ISVAs was perceived to add value to the existing victim services provided by SARCs and voluntary sector organisations. It was widely acknowledged that ISVAs provided a much needed proactive and tailored service which met the practical, non-therapeutic support and information needs of victims of rape and sexual violence. ISVAs also played a key role in liaising and co-ordinating with other agencies to provide services and information on the police investigation and other CJS and court processes. The location of ISVAs will have an impact on the types of referral received and thus it is likely to affect the services required by victims and subsequently the working practices of ISVAs. There is a need to ensure ISVA work is linked in with partner agencies and, where possible, their strategic plans to help sustain funding and avoid duplications of services'.[117]

C.5. Summary

It is apparent that there are similarities across the best practice models described within this report, which highlight principles for best practice care. These principles include:

- An approach where the needs of the child are the primary consideration, ensuring that the number of interviews and examinations are minimised;
- A multi-agency coordinated approach to identify abuse, assess risk and devise and implement management, protection and aftercare plans effectively;
- Twenty-four hour access to crisis support, specialist clinical and forensic care. Rapid access to a medical or forensic examination as required;

of Health and Home Office

116 Home Office (2009) Independent Sexual Violence Advisors: A Process Evaluation

117 Home Office (2009) Independent Sexual Violence Advisors: A Process Evaluation

- Access to a multi-disciplinary team who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children;
- Access to an environment that is welcoming, supportive and accessible. There should also be access to a dedicated forensic facility to ensure a robust chain of evidence; and
- Clear guidance and protocols.

Appendix D. The Ferns IV Working Group

The Ferns IV Working Group proposed model for service delivery[118] is based on the following best practice principles:

D.1. Assessment Services

- Child sexual abuse assessments have the dual purpose of assessing the credibility of a child's account of sexual abuse and assessing any therapeutic need as it arises for both the child and his/her family
- Assessment services must be sensitive to the needs of children and their families and must meet those needs by respecting the uniqueness of each child and family.
- It is essential that a child has the opportunity to access a service in a timely manner (for example, within a reasonable timeframe after disclosure of the alleged abuse) and a service that is accessible geographically, so as to avoid any further distress. It is essential that the child can have access to a prompt medical examination if appropriate.
- Families should have access to a comprehensive, multidisciplinary team who has specific training, skills and expertise in investigative interviewing.
- Children and families should have access to a facility that is safe, comfortable, child and family friendly. These facilities should have standardized facilities and equipment, e.g. appropriate interviewing facilities, materials, aids and recording equipment to facilitate the investigative interviews.
- The assessment process at all times needs to take cognizance of the need to avoid causing harm or distress to a child by avoiding multiple interviewing and repetitive contacts with different community professionals.
- The importance of ongoing communication and interagency co-operation within the assessment process is integral to the work of an assessment.
- An assessment service should promote and implement policies, practices and procedures that are culturally competent. Cultural competency is defined as the capacity to function in more than one culture, requiring the ability to appreciate, understand and interact with members of diverse populations within the local community.
- Adequate supervision for staff is essential for the purposes of supporting staff in this challenging work and ensuring quality control

118 Report of the Ferns 4 (Children) Working Group: Assessment, therapy and counselling needs of children who have been sexually abused, and their families (2009) HSE

around making decisions where child sexual abuse is concerned and the often complex issues attached to children and families affected by sexual abuse.

- The continued professional development of staff engaged in this work is integral to developing skills and practice that is of a high standard.
- Professionals undertaking CSA assessments must have the ability and skills to assess any other area of risk and /or need that may present itself alongside the concern of sexual abuse.

D.2. Therapy Services

- When a child is referred for therapy it is important to ensure that an assessment of child sexual abuse concerns/credibility has already taken place and the initial concern about sexual abuse has been fully explored/ investigated so that a clear distinction can be made between the assessment and therapy process;
- It is preferable that the assessment of credibility and therapeutic work be undertaken by separate clinicians in order to reduce the likelihood of complications associated with civil and or legal proceedings. Where this is not possible efforts should be made to clearly differentiate between the assessment and therapeutic role, for the benefit of the child and family;
- It is also vital that all outstanding child protection issues are addressed before a child can reasonably be expected to engage in a therapeutic process. In the absence of a stable and safe environment it may not be possible, and may even be harmful for a child to explore their experience of abuse (e.g. insecure care placement; insufficient protection from perpetrator)
- Not all children will require immediate access to therapeutic services. However, usually children who require it will need to be linked to a therapeutic service as soon as possible after assessment;
- Children/families to be seen by professionals with the necessary skills, training and experience to deal with the complex therapeutic issues arising from child sexual abuse;
- Once a child has been referred for therapy an assessment of therapeutic need should take place arising from which a therapeutic plan should be made outlining what interventions will take place and the timing of these;
- Where it is very clear that the sexual abuse concerns are not the central issue consideration may be given to whether this child's needs may be better met in a more generic service. However the therapeutic plan should be holistic, tailored to the individual needs of

a child and other significant members in their system and may need to include a wider focus than the sexual abuse;
- Ideally the child/family should be able to avail of a range of interventions such as individual therapy, family therapy, parent support work or group therapy;
- Parents/carers should be included in regular reviews around the child's therapy and the therapeutic plan (in consultation with the child and respecting their confidentiality);
- Interventions offered should be evidence based while also bearing in mind that therapeutic approaches and the timing of these need to be tailored to the needs of the child and his/her family and should also be guided by ethical decision making processes;
- Given the complexity of child sexual abuse the importance of clear communication and regular interagency collaboration between therapeutic agencies and representatives from the HSE so that each agency is clear about their role and responsibilities and also what pieces of work other agencies are doing is of paramount importance;
- Within the area of sexual abuse there has been a considerable emphasis within the literature on the importance of regular support and supervision for professionals working in this area.

D.3. Medical Examination Services

- Children should have access to a comprehensive medical examination by a medical practitioner who has specific training, skills and expertise in this area.
- The location of the medical services must be considered taking into account the need/right of a child to access a service in an easy and timely manner after disclosure of alleged abuse and the availability of suitably trained and experienced medical personnel.
- Children and families should have access to a facility that is safe, comfortable, child and family friendly. These services should meet required standards and have the necessary equipment, e.g. appropriate recording equipment.
- The medical examiner at all times needs to take cognizance of the need to avoid causing harm or distress to a child and that the welfare of the child is paramount.
- The continued professional development of staff, engaged in this work is integral to developing and maintaining skills and practice that are of a high standard.
- A national database to record the number and nature of medical examinations carried out should be established.

Appendix E. SARC Comparison[119]

	Nottinghamshire SARC	Manchester – St Mary's Centre	Bristol – The Bridge	Derbyshire – Millfield House	The Havens – Whitechapel / Camberwell
1. SARC management	Strategic Management Board (now Funders group) and Centre Management Group	Jointly run by NHS, Police and Police Authority	Multi agency Strategic Board – police, NHS, voluntary organisation, CPS. Have clinical director from Jan 2010	Strategic group (which reports to the Local Criminal Justice Board) and an operational group	The Havens are accountable to the Acute Trust, Metropolitan Police and the Strategic Board (subgroup of the London Sexual Health Commissioning Board. The Strategic Board is multi agency - police, PCTs, CPS, service user, clinical director, paediatrician, voluntary sector.
2. SARC funding	Funded by NHS, Police, local Authority	Funded by NHS, Police and Police Authority	Joint funded by NHS and Police (50%)	Funded by Police and Rape Crisis (via grants accessed)	Police and 31 PCTs provide 50% of funding (with PCT funding top sliced per capita). Lambeth, Southwark & Lewisham PCT is the lead commissioner.
3. Site	Police building	On hospital site	Co – located with Sexual health centre – health building	Police building – house on a housing estate	Camberwell and Paddington on hospital site. Whitechapel in hospital building – privately leased building round the corner from The Royal London Hospital, Whitechapel.
4. Accessibility of SARC	For male and female. 13 years plus – paediatric support inconsistent, but working to make consistent. Acute and non acute Self referrals from 18 years only.	For male and female. From age 0. (Dedicated children's suite, adult suite). 24hr acute provision. Non acute / historic support available. Self referrals from 16 years. Will accept self referral of an older child if accompanied by parents, will follow child protection procedures.	For male and female. From 14 years +, self referrals from 16 years +. 14-16 years are reviewed on case by case basis, involving a strategy discussion, including acute victims.	For males and females. Police referrals from 16 years plus; self referrals from 18 years plus. Acute and non acute cases seen.	For males and females From age 0. Under 13s with paediatrician present. For acute cases for FME, FME and follow up, and follow up for sexual health screening / counselling (up to 1 year). 1 year limit: anyone presenting to service will assault over this time limit is referred onward into other services. Self referral option for all victims.

119 Sexual Assault Referral Centre (SARC): Draft Health Needs Assessment (October 2010), NHS Bassetlaw, NHS Nottingham City and NHS Nottinghamshire County

	Nottinghamshire SARC	Manchester – St Mary's Centre	Bristol – The Bridge	Derbyshire – Millfield House	The Havens – Whitechapel / Camberwell
5. Provision at SARC	Crisis worker; FME, ISVA, counselling co-ordinator, young people's co-ordinator No STI testing or PEP provision EHC provision Police interview facilities	Crisis worker; FME, ISVA, child advocate, counselling. No STI testing for adults, refer to GUM. Can provide STI for children. PEP for HIV (1st 5 days) and Hep B (1st vaccine of accelerated course) can be started, will liaison with GUM / GP for rest of course.	counsellors, crisis workers OOH, Full time day time crisis worker, 1 young person's ISVA, 2 adult ISVAs No STI testing or PEP at present – referral to GUM or A&E. No police interview facility at SARC FME	FME, crisis worker, ISVA. Utilise Rape Crisis for support. No NHS mental health services used. Fast track to GUM services. No STI testing or PEP.	FME by Haven employed doctors (female) with crisis worker support. EHC (Levonelle). HIV PEP and Hep B provision for full course at Haven. Antibiotic prophylaxis for gonorrhoea and Chlamydia. STI screening appointment offered 2 weeks after assault, (incubation period) for Chlamydia, gonorrhoea, trichomoniasis, and 3 months for HIV, HCV and syphilis. Workers include clinical psychologist, young person's worker (a young person's ISVA role), Health advisor, Asian development worker, counsellor. Follow up care will include risk assessment for urgent mental health needs. Follow up appointment, can offer up to 6 sessions offered at Havens. Victims can be referred onward.
6. Service data: a. Acute / non acute	49% acute, 51% non acute	not available	not available	69% acute / 31% non acute	78% acute, 22% non acute (under 1 year from assault)
b. Age	12 – 15 18%, 16-19 19%, 20+ 63%	Not available	Under 16 9% , 16-20 32%, 20+ 59%	27% 14-18, 73% 20+	<5% under 13, ,9% 13 to 15, approx 85% 16 years plus
c. Type of offence	Rape 72% Assault by Penetration 20% Other sex acts 8%	Not available	Rape 79% Assault by penetration 6% Other sexual assault 9% Unknown 6%	Partner rape 16% Stranger rape 9% Acquaintance rape 33% Group rape 2% Sexual assault 6% Assault by penetration 11% Childhood sexual assault 4% Familial childhood sexual assault 8% Other 11%	Approximately 70% rape, 5% serious sexual assault. the remaining 25% comprises multiple assailant cases, suspected drug facilitated sexual assault, assault by penetration.

	Nottinghamshire SARC	Manchester – St Mary's Centre	Bristol – The Bridge	Derbyshire – Millfield House	The Havens – Whitechapel / Camberwell
d. GUM uptake	Offered 60% Known take up 20%	Not available	not available	No data available	40-50% of acute cases
e. Uptake counselling	Offered 91% Known take up 35%	Not available	not available	36% (note added – this has dropped since introduction of ISVAs)	370 couselling sessions provided with 1 month waiting list. % not available
f. Prosecution		Not available	not available	8%	No data available
g. Conviction		Not available	not available	3%	No data available
7. Outcomes data available	No health outcome data extracted. Police data extracted on request.	No health outcome data is routinely extracted. No police data can be accessed; but can be requested from police liaison officer.	No health outcome data is routinely extracted. Police data is not received, but can be available on request. Limited SARC database.	No health outcome data, this is a challenge. There is a procedure in place with police to track cases, and there is a joint database.	Can access health outcome data. Police data for prosecutions and verdicts not often communicated.
8. Referral onward	Referral onward into NHS sexual health, CAMHS, voluntary organisations. Working to establish links into adult mental health services.	Referral onward into NHS sexual health, mental health services, voluntary sector services.	Referral onward into NHS sexual health, mental health services (via A&E for urgent), currently establishing CAMHS links. Voluntary sector services used, including for redirection of historical cases.	GUM fast track referral. Rape crisis for counselling. Referrals into voluntary domestic violence agencies.	Good links into health services. Links to voluntary services.
9. Recommendations	n/a	Establish mechanism for measuring patient outcomes / experience. Do not recommend STI testing on site for adults, as anonymity cannot be guaranteed.	Ensure robust referral pathways. Clinical director employed by the Trust is positive. Consider conducting doctor peer review (Bristol about to start this)	Ensure multi agency partnerships are in place with key agencies.	Do not provide STI screening at point of FME, as incubation period of 2 weeks required. Haven works well with being allied to NHS Trust, but from the client perspective it also works well not being on a hospital site.

Appendix F. Child Advocacy Centre Case Studies[120]

F.1. The Children's Safety Centre—Springdale, Arkansas

In Springdale, Arkansas, the state police child-abuse unit is housed in the Children's Safety Centre, a non-profit organisation that brings together caseworkers, investigators, volunteer advocates, and medical and mental health professionals in a state-of-the-art centre for abused children. Nationwide, it's the first time a state police child-abuse unit has been placed in a children's advocacy centre.

The Children's Safety Centre is designed to be child-friendly. The examination room is equipped with cameras that allow doctors to videotape exams and take still photos from the videos to use as evidence. The room's walls are covered with a mural depicting a summer day in the country with hot-air balloons floating over children playing on grassy hills.

F.2. The Children's Assessment Centre—Harris County, Texas

In Harris County, Texas, The Children's Assessment Center is a one-stop shop for child sexual abuse victims. A public/private venture, it is funded through Harris County Commissioners Court and the Children's Assessment Center Foundation. Eleven partner agencies share the space offering a range of legal, law enforcement, medical and counselling services.

A child suspected of being sexually abused will be brought here for a doctor's examination in the first floor clinic, interviewed and videotaped by specially trained personnel, assigned a child advocate to see him or her through the court system, and given regular counselling sessions.

The centre's goal is to put an end to the practice of having a child go through an emergency room examination, perhaps by a resident who has never handled a rape case before, and then a series of exhausting interviews by assorted law enforcement departments and social service agencies. Sixty seven videotape machines stand in rows and columns in one businesslike room of the centre. Each one leads to rooms where cameras are hidden in closets. In another room someone from the police or sheriff's office or CPS or the district attorney's office watches. The interviewer excuses herself for a moment, steps out of the room, then asks the other viewers if there is anything missed, any statement that should be reviewed again.

120 Snell L (2003) Child Advocacy Centers: One stop on the road to performance-based child protection

When an interview is over, that is it, at least until (and if) the case goes to trial. There is no longer a gauntlet of interviews with different law enforcement and social service agencies for a child to negotiate.

The facility has paintings and photographs lining the walls. There are playrooms and a dance room, lots of space and toys, similar to a well-equipped preschool or daycare centre. Although the centre operates during daytime hours, its personnel are on call around the clock to handle sexual abuse cases involving anyone up to 18 years old.

The Children's Assessment Centre also has much better training for its investigators during sexual-abuse interviews. Leading questions in interviews are out. No confessions are forced.

Appendix G. The baseline assessment

For the purpose of clarity in describing the baseline, we have defined our terminology, which is referred to throughout the following section of the report, below:

Terminology	Our understanding/definition
Joint interview/ Specialist section 16 (1) (b) interview	An electronically recorded interview undertaken with children under the age of 14, for evidential purposes in accordance with Section 16(1) (b) of the Criminal Evidence Act, 1992. Interviews should be undertaken by trained HSE Social Workers and Gardai only, in specialised facilities.
Initial assessment	Initial assessments undertaken by HSE social workers or Gardai following notification of alleged Child Sexual Abuse, to either agency, and following completion of initial child protection measures. Initial assessments will inform/form part of multi agency strategy meetings to determine the actions to be taken.
Full assessment	A therapeutic assessment of the child and family undertaken by social workers and/or psychologists who draw conclusions on the alleged CSA and provide advice to a multidisciplinary team assessment on whether CSA is conclusive or not. A parallel assessment of therapeutic needs is also undertaken in order to develop a therapeutic plan and refer children and families on to appropriate therapeutic services.
Forensic medical examination	A medical examination required within 72 hours of an alleged assault in order for forensically sound evidence to be gathered.
Medical examination	A medical examination to identify and address the medical needs of children and allow medical treatment/screening to be provided.

7.1.2 Baseline profile of acute child sexual abuse services

The presentation of child sexual abuse can be in a variety of ways to a variety of agencies including to: A&E departments, schools, social services, An Garda Síochána, and GPs. A National review of Sexual Assault Treatment Services, undertaken in 2006 by the National Steering Committee on Violence against Women, stated that '*many cases of child sexual abuse come out of hours and often present to staff with little or limited experience in their management' (McKay 2005).*[121]

[121] Sexual Assault Treatment Services, A National Review, National Steering Committee

Through our discussions with consultant paediatricians and other professionals, it appears that this statement still holds true and there is a lack of multidisciplinary approach to the initial management of these children.

When a medical examination of a child is required (for forensic purposes or not), currently there is a lack of consistency in the provision of appropriate trained professionals, facilities and equipment to undertake medical examinations and inequality in the services available dependent on the age of the child.

Children over the age of 14

Currently, children over the age of 14 requiring a medical examination, can access adult sexual assault treatment units (SATUs). There are currently six adult SATUs in locations across the country which are available 24/7 and are staffed with forensically trained medical examiners. These include services provided in Dublin, Cork, Letterkenny, Galway, Mullingar, and Waterford. In Galway, the service is a co-located adults and children service, available 24 hours a day using the services of a private forensic examiner, which is considered to work well, provides efficiencies and overcomes the problem of children in transition.

The SATU services do on occasion support 12-13 year olds but it was recognising that this is not ideal. The SATU services operate 24/7 and forensic examination is undertaken as soon as possible after the event. Examinations are undertaken by forensic examiners (nurse and doctor) and there is also an assisting nurse. Psychological support is provided by the Rape Crisis Centre.

Regular training is provided for all those involved in providing services and there is a national higher diploma which forensic nurses are encouraged to obtain and the medical staff are encouraged to undertake a formal 2 year qualification. In addition, there is an annual study day where the 6 units come together to share best practice. Training on child protection is undertaken.

In relation to governance, there is an active guidelines group for this area of service provision and audits are undertaken and all assessment/processes etc are in line with National guidelines.

on Violence Against Women (2006)

Children under the age of 14

Currently, children under the age of 14 requiring medical examination, (or all children where a SATU is not available), in the majority rely on a mixture of professionals willing to undertake examinations, although in some areas services have been developed including: the children's SATU attached to the adult service established in Galway and services operating in Cork, Waterford, Sligo and Dublin Mid Leinster which provide medical examinations within appropriate facilities in normal working hours.

The professionals currently undertaking medical examinations include community paediatricians, emergency care paediatricians and GPs, however the availability of these professionals is variable across the country (see table below), in many areas there are few professionals willing to undertake examinations due to lack of appropriate training, facilities and equipment and therefore feel unable to provide a robust examination which would form vital evidence in a case being taken to the Courts. In some areas, private providers are able to provide a service, but the service is limited by geographical area and capacity.

Current provision of community paediatricians

Region	WTE	Areas covered
Donegal	2.0	County Donegal; all Donegal except South Donegal (covered by Sligo)
Sligo	2.0	1.0 wte covers South Donegal; West Cavan ; North Leitrim 1.0 wte covers Sligo and South Leitrim Overlap slightly into Mayo
Kilkenny	1.0	
Mayo	1.0	Mayo and Roscommon
Galway County		No formal involvement in CSA - not officially community paediatricians - one covers physical disability and one covers learning disabilities
Galway City		
Limerick / Clare	1.0	
Kerry	1.0	
Cork	1.5	
Cavan	1.0	
County Louth	1.0	
West Meath	1.0 (2 posts – job share)	
Dublin (Temple Street and Crumlin)	0.0	
Dublin – Tallaght	2.0	

There is currently no standardised accredited training in place for professionals undertaking paediatric forensic medical/medical examinations.

The difficulty of sourcing a professional can result in the child having to be transported to inconvenient locations, sometimes necessitating a 2-3 hour drive, which is an unacceptable practice for children in these circumstances. When children are examined, the environment in which they are seen is deemed to be inappropriate, with facilities not meeting the standards required for forensic examination and not providing sufficient privacy.

Furthermore, for children of all ages, there is a lack of structure or sign-posting for linking into the follow-on medical services often required, such as Sexual Health Screening and GP services.

A recent report into these acute medical services, developed by an expert group of Paediatrician, Community Paediatricians, Paediatric Emergency Consultants, Gynaecologists, Medical Social workers and Nurses; suggests the need for a systematic multidisciplinary approach and calls for three specialised centres to be established across the Country[122]. The centres would provide a 24/7 on call service, run through a rota of dedicated Paediatric Forensic examiners, supported by trained nurses. Professionals would be able to contact a central number for advice and be directed to one of the centres where appropriate, or to other services. Discussions around this proposed solution are currently underway.

7.1.3 An Garda Síochána

Emergency response

When presented with an allegation of child sexual abuse, the Gardai follow the process outlined in the Children First guidelines which have been adapted as Gardai policy for the management of Child Sexual Abuse cases. Following the initial allegation, the Gardai remove the child from immediate danger and are able to exercise emergency powers to remove a child from their parent/carer, without a court order, when required.

[122] Investigation and initial medical management of children and adolescents suspected of having been victims of child sexual abuse (2011)

The Gardai then notify the HSE Children and Family services, who have statutory obligations for the protection and welfare of children, through a standard notification form submitted to the HSE Child Care Manager in the locality.

Statistics from the Gardai show that between 2009, there were 1,606 notifications from or to the HSE of concerns about a child's welfare. Of these 1,331 (83%) were referrals made by the Gardai to the HSE and 275 (17%) were those made by the HSE to the Gardai. It should be noted that these figures relate to notifications of child abuse and a breakdown on those related to Child Sexual Abuse is not available.

In acute cases of alleged Child Sexual Abuse, where a medical examination is appropriate (i.e. Forensic examination required within 72 hours or required to address any medical needs/ongoing care), the Gardai, contact a local hospital within their area and arrange for a medical professional to complete a medical examination. As discussed above, this process is difficult due to the lack of dedicated medical services, across the country, to meet these children's needs.

Once immediate medical needs have been met and in cases where the child is removed from their parents/career and current home, the Gardai must then find an appropriate care placement for the child. This is undertaken in collaboration with the HSE Children and Family Social Services. During normal working hours, duty social workers across different localities can be accessed, who then make arrangements for the child. Out of hours however, there is no HSE social work service, and very limited availability of care accommodation places.

Currently, the Gardai work closely with a private organisation, Five Rivers, which has been commissioned by HSE to provide 24 hour emergency residential care. This organisation has a number of locations across the country and works to place children in these settings out of hours. Duty social workers from the HSE, then arrange to meet and take over the care of the child as soon as possible when normal working hours resume. This arrangement is not ideal and does not provide equality of access to care across the country.

It was noted that pilot schemes for the out of hours provision of HSE social worker support in these circumstances, are currently being undertaken in HSE West, as a National pilot. However this is still within the pilot stage and is not common practice across the country. The Gardai feel it is imperative that the lack of 24 hour social work access is addressed as the responsibility for the child in these circumstances should not be residing with the Gardai, as per current practice.

Joint interviewing under section 16 (1) (b)

In line with the Criminal Evidence Act, 1992, Section 16 (1) (b) an agreement for a joint approach between the An Garda Síochána and the HSE was put in place in 2009, for the interviewing of under 14 year olds for evidential purposes.

Interviews of this nature are undertaken in gathering evidence for the criminal investigation of the alleged child sexual abuse under the authority of Section 16 (1)(b) of the Criminal Evidence Act, 1992. In line with guidance from Children First, these interviews should be conducted in specialist facilities, jointly by Gardai and HSE professionals who have undertaken specialist training.

There are currently seven specialist interview suites for the electronic recording of interviews for evidential purposes in accordance with section 16(1) (b), two of which are located in Dublin, with further suites in Sligo, Letterkenny, Cork, Waterford and Limerick. There are currently 72 specialist interviewers within the Garda who have undertaken specialist training in this regard. In comparison there are currently 22 HSE personnel (social workers) who have undertaken this training.

Despite the specialist training being undertaken by both the Gardai and social workers, it was reported that in most cases a *joint* interview is not undertaken, with the Gardai only undertaking the interview.

A number of reasons for this have been discussed through the engagement programme, including: the availability of trained social workers to participate in the interviews; the low number of trained social workers available to participate; the perceived difficulty of the course and high failure rate associated (currently 40%); the length of the course and the problem of releasing staff to participate.

With the An Garda Síochána, a number of Gardai are keen to undertake the specialist training required to interview children in this manner, however before this training can be completed the Garda are required to complete a one week course on the Children's First guidelines. This course is provided by the HSE, however has not been made available for a number of years, resulting in the diminishing number of Garda who can undertake specialist interviews. It was reported that this issue needs to be quickly addressed in order to re-build the capacity of Garda able to undertake specialist interviews.

7.2 Baseline profile of hospital based and community health services

Using the description of service provision documented within the Ferns IV report (September 2009), as the starting point, we have requested service managers across the regions to provide updates as to whether this still provides an accurate reflection of current services and, where possible provide additional service information and details.

7.2.1 HSE Dublin & Mid Leinster

The largest service within Dublin & Mid Leinster is that provided by the St Louise's Unit, Our Lady's Hospital, Crumlin. Other smaller regional services are provided in Laois/Offaly and Longford/Westmeath.

A summary of this service is provided below:

7.2.1.1 St Louise's Unit, Our Lady's Hospital, Crumlin

St Louise's unit	
Services provided	Assessment services and specialist therapy services (for conclusive cases of CSA). Supportive work with parents and careers is also provided. Additional regional assessment services are provided in Wicklow and therapy services at Wicklow, Naas and Athy.
Service access times	9:30-17:00, Monday- Friday
Staffing complement	This service is a dedicated service with full time staff. The staffing complement of the Unit comprises 14 FTE outlined below: ▪ **Psychologist** 1 FTE Principal, 1 FTE Senior, 1 FTE Basic Grade ▪ **Psychiatrist** 1 FTE ▪ **Psychotherapist** 1 FTE Principal, 1 FTE Senior, 1 FTE Basic Grade ▪ **Social Workers** 1 FTE Principal, 2 FTE Senior, 1 FTE Basic Grade ▪ **Community Paediatrician** Available by appointment monthly ▪ **Art Therapist** 0.5 FTE Basic Grade ▪ **Family Therapist** 1 FTE Basic Grade ▪ **Play Therapist** 0.5 FTE Senior, 1 FTE Basic Grade.
Links with other agencies	The Unit has links and interfaces with the HSE, the Gardai, Adult Mental Health Services, Child and Adolescent Mental Health Services, CARI and the Rape Crisis Centres.

Assessment service

The assessment undertaken at St Louise's unit is comprehensive and considers the claim of sexual abuse but also looks at other forms of abuse and family circumstances. It would mirror a comprehensive social care assessment undertaken in the UK. The assessments can take up to 5-6 weeks.

The current waiting time for assessments at St Louise's is between 5-6 weeks (this fluctuates throughout the year depending on demand, and the availability of staff members).

The number of assessments undertaken in 2010 is outlined below:

Assessments (2010)	
New	115
Return	521
Children	*217*
Parents	*190*
DNA	*67*
Cancelled	47
Total	**636**

Therapeutic service

All referrals for therapeutic services come through the HSE. Therapy provided by the Unit is only to those children with confirmed cases of sexual abuse. For those children where the assessment deemed inconclusive, other agencies provide support. The current waiting time for therapy services is 5-6 weeks.

Therapy can be provided over an extended period (1-4 years) and throughout the therapy process the outcomes are measured through pre and post assessments and measurement. The range of therapy provided includes: individual therapy, group therapy, art therapy, play therapy and family therapy. Supportive work with parents, carers, siblings and other family members is also provided as appropriate. The type of therapy provided is needs driven and therefore depends on the individual case.

Medical examinations can be undertaken on children as part in this therapeutic stage, as required; this can sometimes be for reassurance of the child's physical state. In these cases, medical examinations are undertaken by a consultant community paediatrician by appointment.

The number of therapy sessions made available in 2010 is outlined below:

Therapy	
Children attended	1,535
Parents attended	572
DNA	324
Cancelled	604
Psychiatry assessment	33
Total	**3,068**
Family Therapy	
Attended	279
DNA	43
Cancelled	102
Total	**424**
Group Therapy	
Children	338
Parents attended	248
DNA	19
Cancelled	12
Total	**617**
Grand total	**4,109**

Professional development

Each team member at St Louise's is assigned a supervisor and has ongoing training depending on their profession.

Links are in place with St Clare's unit (at a management level) to share good practice; with both units also taking part in conferences and providing training in assessment and therapy for professionals working with children who have been sexually abused.

Highlighted issues

- There is a lack of supportive services available to children and families while they are awaiting their initial appointments with the Unit. As this is potentially a very stressful time for children and families, it is essential that they received adequate support at this time.
- Required medical examinations are undertaken currently by a community paediatrician in the area, but issues of training and achieving a critical mass need to be addressed in order to maintain skills. Also, currently, a number of GPs and paediatricians do not want to carry out medical examinations, often due to lack of equipment including colposcopes.

- To ensure referrals to St Louise's unit are appropriate, there needs to be clarity in place as to its role and that of HSE services providing perceived similar services e.g. CAMHS.

7.2.1.2 Laois/Offaly

Assessment service

For the populations in Laois/Offaly, assessment services can be accessed from a dedicated assessment team comprising a social worker, psychologist, public health nurse and area medical officer.

Therapeutic service

Therapy services can either be accessed through local HSE follow-up therapy services comprising of social workers, psychologist, public health nurse and area medical officer.

7.2.1.3 Longford/Westmeath

Assessment service

Within these Local Health Offices, some assessment service provision is provided by a social worker (1 FTE), public health nurse (0.5 FTE) and community child care lead (1 FTE (2 posts working part time)). The service is provided during normal weekday working hours and staff have basic child sexual abuse assessment training. Currently, waiting times are approximately 8 weeks.

In 2010, there were 53 referral assessments of children undertaken.

Therapeutic service

Team members provide very limited follow-up and psychologists provide therapy service.

7.2.1.4 Child & Adolescent Mental Health Services

Across the region, there are 10.35 wtes of clinical staff per 100,000 population with shortages in senior registrar, occupational therapist, child care worker and other therapists posts. The maximum waiting time

is approximately 12 months although approximately 75% of children are seen for their first appointment within 3 months. There was a 10.5% non-attendance rate in 2009. [123]

[123] Second Annual Child & Adolescent Mental Health Service Report, 2009-2010, Health Service Executive

7.2.2 HSE Dublin North East

7.2.2.1 St Clare's unit, Children's University Hospital, Temple Street

The largest service within Dublin North Central, Dublin North West and Dublin North is St Clare's unit at the Children's University Hospital, Temple Street. A summary of this service is outlined below.

St Clare's unit, Children's University Hospital, Temple Street	
Services provided	Child sexual abuse assessment services and specialist therapy services
Service access times	09:00-17:00 Monday to Friday
Staffing complement	This service is a dedicated service with full time staff. The staffing complement of the team includes: **Director** 1 FTE **Psychologists** 3.6 FTEs (1.0 FTE is currently vacant); **Psychotherapists** 0.8 FTEs **Social Workers** 6.0 FTEs (-0.2 FTEs on parental leave) **Art Therapist** 0.6 FTEs. Line management is mostly organised according to discipline of origin enabling members to retain a stronger identity with their profession. Assessments are undertaken by psychologists and social workers. Therapy is undertaken by psychologists and social workers, art therapist and psychotherapists.
Links with other agencies	The Unit has interface with CARI, NIAP, HSE, Court Services, Gardai and child & family centres.
Volume of referrals	The team offer more than 2,500 appointments per annum. In 2010 there were 231 referrals. The service

St Clare's unit, Children's University Hospital, Temple Street	
	receives a large number of re-referrals and some inappropriate referrals[124]. In 2010, 74 new cases attended for assessment. There were 8 new cases referred directly to therapy and 47 new cases referred to the Therapy team from the Assessment service.

Referral process

Referrals to the Unit are made by the HSE social work service in Dublin North, Dublin North Central and Dublin North West once an initial investigation is undertaken by that service. The Unit operates a duty system whereby parents and other professionals can ring to enquire about the referral process and the service in general. Referral agents complete a referral form and referrals are reviewed on a weekly basis by the unit referral team. At this stage, referred cases may be wait-listed, may require further information from the HSE or Gardai or may be deemed inappropriate referrals if they do not meet referral criteria.

Many referrals also involve attendance at strategy or Professionals meetings or other discussions/meetings prior to deciding on acceptance of a referral. The criteria for referral are as follows:

- an opinion on credibility is required;
- a child has made a disclosure of child sexual abuse; and
- CSA has been witnessed by a third party or the perpetrator has admitted to sexual abuse of a child.

Under certain circumstances, the referral team will consider direct referral to St Clare's therapy service.

Broadly speaking, relationships with Social Work teams are good and the unit endeavours to keep lines of communication open both on a case by case basis and at management level.

The unit also offers training nationally in assessment and therapy and can offer consultations to professionals in a range of services, families and residential units. As part of a teaching hospital, St Clare's offers student placements to Universities nationwide.

[124] Organisational review, St Clare's Unit, Children's University Hospital, Dublin, Tavistock Consultancy Service, 2009

Assessment

Waiting times are currently up to three weeks between accepted referral and first appointment for assessment. In the two years prior to 2009, the number of referrals for assessment had reduced while the complexity of cases has increased.

Some referrals are given priority. Cases where children are under 5, interfamilial abuse cases, or where children have mental health issues, are seen urgently. Before children and families access St Clare's Unit, support may be available from HSE social workers or CARI services.

The assessment team comprises of social workers and clinical and counselling psychologists, who work in pairs by means of a reflective process. If required the unit can refer to St. Frances Clinic for psychiatric assessment and follow-up of clients who are not already attending psychiatric services in the community and who have a need for psychiatric input.

Interviews with children are DVD recorded, comprehensive parent interviews are undertaken and an assessment report is produced and forwarded to the relevant child care manager and allocated social worker or duty team leader. Most of the team members, but not all, work on both the assessment and therapy teams.

Depending on the case, a full assessment may be offered or alternatively, consultation or parent only interviews may be undertaken; these processes are quicker than the full assessment and more appropriate in some cases. Once in the service, the child can attend between 1 and 4 assessment interviews, though the average number of interviews is 2.

In principle, St Clare's would wish to offer an assessment and therapy service to children and families who have experienced all forms of abuse and neglect. Such a development however would have far reaching implications for the current work and would require further training and professional development of staff as well as consultation with relevant stakeholders.

Therapy

The therapy team is jointly managed by a principal clinical psychologist and a principal psychotherapist. The team is multi-disciplinary in nature with clinical psychology, social work, counselling psychology, psychotherapy and art therapy represented. From within their

disciplines clinicians draw from a number of different theoretical models including; systemic psychotherapy, psychoanalytic psychotherapy, art therapy, play therapy/filial play therapy; humanistic and integrative and cognitive behavioural therapy approaches.

The therapy team is open to accepting referrals where the CSA account has been established and deemed credible. There are two main referral routes; most referrals coming from St Clare's assessment service following a CSA assessment; and with other referrals being made directly to the therapy team by an appropriate professional/service e.g. HSE where the CSA account has been assessed, deemed credible and independently documented.

Once a referral for therapy has been accepted, it is allocated and an initial appraisal of therapeutic need is undertaken. Arising from this a therapy plan is devised and agreed with the child/family. This includes what approach/ intervention will be offered, who will attend, and the pacing of the work. A range of interventions can be offered including: individual therapy for the child, parent support work, family therapy and group therapy. In addition to this, the therapy service also offers training and consultation to other services.

The approach adopted is holistic in nature, emphasising the need to be flexible and responsive to the individual needs and unique experiences of children and families. Knowledge and skills in a range of therapeutic interventions are required to support this approach. While clinical practice is informed by relevant research and 'evidence base' for particular models, emphasis is placed on the importance of collaboration and tailoring interventions to the specific circumstances and needs of the clients through 'practice based evidence'.

Professional development and Supervision

The unit provides induction training to new staff and in-service training for all staff annually on relevant topics (e.g. assessment of pre-school children, treating relational trauma). Staff members are given time and funding to pursue short and longer term training courses relevant to the work (e.g. family therapy).

There are comprehensive supervision arrangements in place for both assessment and therapy work. Supervision is provided at a group and an individual level and is seen as an integral part of ensuring a high quality of work is maintained.

Issues

- The unit had initial involvement in the design and delivery of the training to equip professionals (Gardai and HSE Social Workers) to undertake forensic interviews (under Section 16 (1) (b)) in Templemore. This involvement discontinued for a range of reasons. Primarily there were concerns about the lack of governance for joint interviewing, an absence of supervision structures and no clear plan for the implementation of joint interviewing nationally.
- Increasing requests from solicitors seeking access to therapy records for use in legal proceedings is compromising the confidentiality offered to, and seen as necessary for, children who have engaged or are engaging in the therapy process.
- Strategy meetings are rare and yet good practice would dictate that such interagency meetings should always take place to decide the correct course of action for the child.
- Concerns that there are 2 DVD recordings of a child providing accounts of abuse if the child is interviewed by the Gardai and in a Specialist Unit.
- Dangers implicit in multiple interviews by different interviewers in terms of the integrity of the child's account and distress to child and family as a result of giving an account on a number of occasions.
- There is variable response from the Gardai when statements or DVD recorded interviews are sought by the Unit to inform the assessment or indeed to allow for direct referral to therapy. There is lack of legislative support in relation to interagency sharing of information. In this respect, there needs to be a clear legislative basis to allow for interagency sharing of information between all relevant stakeholders.
- It is felt that at the start of the process, there are few support structures in place for parents to make decisions about how the alleged abuse should be handled; there is no advocacy service for parents (which could possibly be handled by CARI). It is a complex system involving multiple agencies and families struggle to understand how things work and to understand what choices they have, as they go through the process
- Language and cultural issues add another layer of complexity to the process. Additional supports in the form of well briefed interpreters

and cultural mediators are required to enable all families to fully engage when concerns about sexual abuse arise.

- A common IT system is needed, across all agencies, relating to child protection issues. There needs to be a common monitoring system to aid prevention and allow abuse to be identified promptly.

7.2.2.2 Meath

Child sexual abuse assessments are undertaken by social workers and community child care leaders during normal office hours, with no out of hours provision. There are no dedicated staff and two social care leaders and three social workers undertake this work. This service is provided at Navan and Dunshaughlin. The service interfaces with the Gardai and the Court Services.

One social worker has completed the specialist training for Section 16 (1) (b) interviewing but is now not available to undertake this work as this staff member was promoted to team leader and no longer has the capacity. A community paediatrician undertakes medical examinations.

There are approximately 25 referrals per annum to the service.

Psychologists provide therapeutic follow up. Current waiting times are up to 6 months.

7.2.2.3 Louth

There is no dedicated services and assessments are undertaken by social workers within the Children & Family Services. The service interfaces with the Gardai and the Court Services.

A hospital based paediatrician undertakes medical examination.

Psychology services and voluntary services such as CARI provide therapeutic follow up.

7.2.2.4 Cavan/Monaghan

The community based service provided in Cavan and Monaghan is summarised below:

Mid West	
Services provided	Assessment services
Service access times	Monday 09:30-17:30 and Tuesday to Friday 09:30-17:00.
Staffing complement	1 FTE senior clinical psychologist and 0.91 FTE senior social work practitioner
Waiting times	6 weeks
Volume of referrals	In 2008, there were 55 referrals for assessment In 2009, there were 52 referrals for assessment In 2010, there were 65 referrals for assessment
Services provided	Therapy services
Service provided by	HSE Clinical psychologists (attached to assessment service)

Assessment services

Across Cavan and Monaghan, assessments are provided by dedicated senior social work practitioners and clinical psychologists. There is 1 FTE senior clinical psychologist and 0.91 FTE senior social work practitioner. Services are provided at St Davnet's Complex, Rooskey, Monaghan and also from the Community Child & Family Services building Drumalee Cross, Cavan (2 days per week).

There is access to a paediatrician for medical examination services.

Access times are Monday 09:30-17:30 and Tuesday to Friday 09:30-17:00. There are no out of hours assessment services provided. The average waiting time is 6 weeks. The service interfaces with the Gardai and the Court Service.

In 2008, there were 55 referrals for assessment, in 2009 52 referrals, and in 2010 65 referrals.

Therapy services

Clinical psychologists attached to the assessment service, provide therapeutic follow up.

7.2.2.5 Child & Adolescent Mental Health Services

Across the region, there are 9.68 wtes of clinical staff per 100,000 population with shortages in senior registrar, occupational therapist, nursing, child care worker and other therapists posts. The maximum waiting time is approximately 12 months with only 5% of children waiting more than 12 months. Approximately 81% of children are seen

for their first appointment within 6 months. There was a 23.7% non-attendance rate in 2009. [125]

[125] Second Annual Child & Adolescent Mental Health Service Report, 2009-2010, Health Service Executive

7.2.3 HSE West

7.2.3.1 Limerick

Ferns IV reports a dedicated assessment service and partial medical and therapy services:

- Two social workers provide assessment;
- Multidisciplinary teams comprising social works and psychologist provides therapeutic follow up; and
- Medical examinations available for children under 14 years.

7.2.3.2 Clare

Ferns IV reports partial services:

- Social workers undertake assessments;
- A psychologist provides follow up. There is also a limited amount of social work follow up; and
- Medical examinations are accessed in Galway.

7.2.3.3 North Tipperary/East Limerick

Ferns IV reports partial services:

- Assessments are undertaken by psychologists and social workers;
- No therapy services available; and
- A hospital based paediatrician undertakes medical assessments.

7.2.3.4 Community based services across Clare, Limerick and North Tipperary

A summary of the community based services provided in the Mid-West is outlined below:

Mid West	
Services provided	Initial assessment/medical examination
Staffing complement	Urgent out of hours medical examinations are provided by a private provider (Paediatrician) located in Galway through liaison with the Garda. Planned medical examinations are also undertaken by a private provider, with the paediatrician devoting 5-6 sessions per week to clinic appointments.
Volume of medical examinations undertaken	2010: HSE West: 44 (year) 2011: HSE West: 18 (first quarter of year)
Services provided	Assessment services
Service access times	9.00-5.00 Monday to Friday
Waiting times	2 weeks
Services provided	Therapy services
Service provided by	HSE services including counselling support, social services, clinical psychology, CAMHS, Also link to voluntary services such as CARI
Waiting times	Long waiting times and when demand becomes too high, sometimes have to bring in private providers to provide services.

Initial referrals of child sexual abuse

As in other regions, for the Mid West services provided across Counties Clare, Limerick and North Tipperary, referrals of child sexual abuse are made to HSE duty social workers or the Garda, depending on the time of day. HSE Social workers operate in normal working hours (09:00-17:00) however there are no out of hours services therefore the Gardai handle referrals out of hours. Liaison between the Gardai and the HSE social work department operates well in working hours but is obviously limited out of hours. For cases which present out of hours, the Gardai notify the HSE of the alleged abuse, as per Gardai policy, and all efforts are made to bring social workers up to date once normal working hours resumed.

In Clare, the timescale for an initial assessment by HSE professionals is the same day for acute and within two days for non-acute cases. In Limerick, the timescales are same day response for acute cases and within three days for non-acute cases.

At present the standards for joint interviewing in line with Section 16 (1) (b), are not being undertaken consistently and more joined up working is needed in this area. There are some areas with social workers who have undertaken the required training for joint interviewing and other areas where social workers trained in this have moved on.

Urgent out of hours medical examinations are provided by a private provider (Paediatrician) located in Galway through liaison with the Gardai. Planned medical examinations are also undertaken by a private provider, with the paediatrician devoting 5-6 sessions per week to clinic appointments. In the first quarter of 2010, 18 medical examinations were undertaken across the whole of HSE West.

Assessment services

For a full assessment, in non-acute cases, the waiting list can be up to 2 weeks. The assessment tool used is based on collaboration with other agencies (schools, Gardai, CAMHS etc). Case conferences are undertaken as part of the assessment process, but these are often limited as the Garda is often not permitted to release certain information about the case. The social workers remain close to the family and child during the case conference period, offering support.

Assessments led by the HSE are undertaken by those with specialist training (from a number of sources in Ireland and the UK) and by established social workers and psychologists, often other social workers shadow to build competence.

Whilst children are waiting for a full assessment, there are some services in place for this interim period; children are allocated a social worker through the duty system who will work with families and parents throughout this time. CARI is also linked into in Limerick.

All assessment interviews are formally recorded and are usually undertaken in HSE offices. For children with special needs colleagues trained to work with these children are used e.g. speech and language therapists.

Therapy services

Where cases of child sexual abuse are confirmed, a multidisciplinary team review the case and assess the needs of the child and family and then refer on to HSE and voluntary services including counselling support, social services, clinical psychology, CAMHS, CARI. The services referred on to in this locality are generic clinical psychology services and not specifically sexual assault/abuse dedicated. There are waiting lists for these HSE based services and sometimes, when demand for services becomes too high private providers are funded by the HSE for a limited time period.

7.2.3.5 Galway

A summary of the community based services provided in Galway is outlined below:

Galway	
Services provided	Initial assessment/medical examination
Staffing complement	Medical examinations undertaken by a paediatrician and consultant obstetrician/gynaecologist. 7 hours per week and on-call cover
Volume of medical examinations undertaken	2010: HSE West: 44 (year) 2011: HSE West: 18 (first quarter of year)
Services provided	Assessment services
Service access times	9.00-5.00 Monday to Friday
Staffing complement	1 FTE social worker 3-4 FTE of other social workers (doing assessments as part of their generic case loads) 0.5 FTE psychologist.
Waiting times	4-5 weeks
Services provided	Therapy services
Service provided by	HSE psychology service
Estimated volume of referrals	10 referrals per annum
Waiting times	3 months for priority referrals 12 months for low priority referrals

Initial referrals of child sexual abuse

As in other regions, for the Galway services, referrals of child sexual abuse are made to HSE duty social workers or the Gardai, depending on the time of day. HSE social workers are not available out of hours.

The main social worker within the team has received specialist Gardai training in Section 16 (1)(b) specialist interviewing.

In relation to medical examinations being undertaken within the region, a private provider undertakes these at a satellite site off hospital grounds at Briarhill, Galway. This satellite site is co-located with the adult SATU service and provides in hours and out of hours. 7 hours per week are dedicated by a consultant paediatrician for in hours examinations and there is also provision of 24/7 on-call/ call-out, provided by two consultants (one paediatrician and one obstetrics/gynaecology). The paediatrician is a highly qualified forensic examiner.

This service has close links with the adult SATU, Rape Crisis Centre and Gardai. In relation to referrals for medical examination, there were a total of 44 in 2010, (however the majority were from across HSE West not just Galway), typically, there are between 6-8 referrals per annum for children residing in Galway. In 2011, for the HSE West region there were 18 referrals in quarter one.

Assessment services

In Galway, assessment services are provided at 43 Shantalla Road, in community facilities. This service is provided by a dedicated social worker, together with other social workers undertaking assessments as part of their generic case loads, and a psychologist.

Current waiting times for assessments are 4-5 weeks. Typically, there are 25-30 referrals per annum for assessments

In terms of training and qualifications, the main social worker has received specialist Gardai training in Section 16 (1)(b) specialist interviewing, whilst other social workers have attended conferences and day training.

Therapy services

Follow up therapy is provided by the HSE psychology service who undertake this work in health centres and local community sites as part

of their case load. Usually, there are around 10 referrals per annum. Current waiting times are up to 3 months for priority referrals and up to 12 months for lower priority referrals.

7.2.3.6 Sligo/Leitrim

Ferns IV reports partial services:

- Community paediatricians provides assessments in conjunction with the local social work team. In Leitrim there is no dedicated service. Social workers undertake initial assessments;
- In Leitrim there is no dedicated therapy service; and
- In Sligo, medical examinations are provided in the General Hospital. In Leitrim, the paediatrician in Sligo provides medical examinations.

7.2.3.7 Mayo

There is no dedicated service in Mayo for child sexual abuse; services are provided by the community paediatrician, social work team (3 members) and 5 psychologists whose remit is child protection. The service is heavily supported by the Gardai and SATU in Galway. A summary of the community based services provided in Mayo is outlined below:

Mayo	
Services provided	Initial assessment/medical examination
Staffing complement	Community paediatrician/ senior area medical officer at Mayo General Hospital for forensic medical examination Community paediatrician for medical examination
Volume of medical examinations undertaken	Approximately 10 referrals for medical examinations per annum
Services provided	Assessment services
Service access times	9.00-5.00 Monday to Friday
Staffing complement	Dedicated services for CSA are not provided 3 FTE social worker Input of 5 FTE Psychologists
Waiting times	No waiting times currently
Estimated volumes of assessments undertaken	20 per annum
Services provided	Therapy services
Service provided by	HSE therapy services
Estimated volume of referrals	15 referrals per annum
Waiting times	No waiting times currently

Initial referrals of child sexual abuse

Referrals of child sexual abuse are received from multi agencies including: Gardai; Schools; Self and family referrals; GPs; Voluntary agencies; and Hospitals. The lack of 24/7 service provision for referrals to social workers within the area, often means there is a need for the Gardai to co-ordinate the support for the child and family. In some instances this has caused problems in terms of information sharing.

A policy for Section 16 (1)(b) joint interviewing by the Gardai and HSE is in place, however it is felt that these interviews are very much led by the Gardai and that additional training is required for social workers. However, currently, there is limited access to the training and the available course means 3-4 weeks away from the workplace, which has a direct business impact.

At present, referrals for forensic examination are seen by a community paediatrician and the senior area medical officer in a joint assessment at Mayo General Hospital. Out of hours, young people over the age of 16 are seen in the adult SATU.

Medical examinations are undertaken by a community paediatrician. Holiday cover for the community paediatrician is presently provided by the Emergency Department for medical examinations whilst forensic examinations are covered by a private provider.

Assessment services

Assessments are completed by combinations of social workers and psychologists, who are brought in for specific cases. All social workers across the three teams within the area are locally trained by St Clare's Unit staff and the duty social worker for each team is responsible for co-ordinating the services when the need arises.

The service is provided 09:00-17:00 weekdays; there are no out of hours services provided. Assessments are provided at social work offices in Ballina, Castlebar and Swinford. The Unit has links with Mayo Rape Crisis Centre and interfaces with private providers for holiday cover etc.

An estimation suggests there are approximately 20 referrals for assessment per annum.

At present there is no wait time for this service and often a child can be seen on the same day. Minimal delays of a few hours can occur due to the availability of all relevant staff at the appropriate time, but the service is still seen as flexible to the needs of the child.

Therapy services

Following the assessment interview, a therapeutic plan is developed and where required, the HSE providers provide relevant therapy services. There is no present waiting list for therapy services and it is estimated that there are 15 referrals to therapy services per annum.

7.2.3.8 Roscommon

In Roscommon, there is no dedicated service for child sexual abuse. Assessments are conducted by social workers and community child care leaders and limited services by psychology. There is limited follow

up therapy undertaken by social workers, child care leaders, psychologists and a child guidance team.

Medical examinations are undertaken in Galway.

7.2.3.9 Donegal

A summary of the community based services provided in Donegal is outlined below:

Donegal	
Services provided	Initial assessment/medical examination
Staffing complement	Medical examinations are provided by a community paediatrician with additional access to a specialist Paediatric consultant in Galway for acute forensic medical examinations.
Volumes of children seen	In 2009, there were in total 72 reports of child sexual abuse.
Services provided	Assessment services
Service access times	9.00-5.00 Monday to Friday
Staffing complement	There are no personnel in the HSE dedicated to child sexual abuse. 28 FTE social work staff who can respond to all child protection and welfare referrals. Working within 4 teams.
Waiting times	Within 24 hours- 20 days depending on the type of referral
Services provided	Therapy services
Service provided by	HSE therapy services (CAMHS, Psychology)
Links to other agencies	National Counselling Services

Initial referrals of child sexual abuse

In Donegal, the local social work team in conjunction with the Gardai receive referrals/notifications of child sexual abuse. Referrals are received from multi agencies including Gardai, schools, self referral, hospitals, etc. This area is currently involved in a pilot, using a new business process in terms of responding to referrals within set timescales. Evaluation of this pilot will populate the referral and treatment models developed in the new national child protection programme.

Referrals in the areas are received by the four social work teams (based geographically). In each of these teams is an intake worker whose main responsibility is to respond to referrals; however all social workers are trained in this if required. There are currently 28 FTE social work staff who can respond to all child protection and welfare referrals. There are no personnel in the HSE dedicated to child sexual abuse.

The four social work teams are not available out of hours- any referrals after 5pm and at weekends need to be referred to the Gardai.

In cases where the Gardai have had to remove a child from their current place of care (Section 12), the Gardai work with a private provider of emergency placements. There is a SLA in place with a care home; Five Rivers, for emergency placements with the HSE social workers then picking the children up on the next working day, when normal working hours resume.

In relation to this, there is a pilot scheme, recently put in place locally for social workers to response when emergency care placements are required (Section 12 requests) out of hours from the Gardai. This is in the form of some informal social worker support out of hours, which includes five social workers. In Donegal, the GP out of hours service can contact them and the social workers will attend if available; this is not a fully staffed or funded service (staff get paid if they attend but not for being on call).

A policy between the HSE and An Garda Síochána on joint interviewing under Section 16 (1) (b) has been put in place locally, with formal training available and undertaken by Gardai and HSE social workers. The Gardai now have good skills following the formal specialist training and undertake interviews well, however, locally a number of social workers have failed the course and therefore there are a low number of

social workers trained in this area, with reports of only one social worker being trained in this area.

Medical examinations are provided by a community paediatrician with additional access to a specialist Paediatric consultant in Galway for acute forensic medical examinations.

Assessment services

All services are provided 09:00-17:00.

In acute cases, initial assessments can be turned around within 24 hours (in office hours) for initial 'emergency' assessment to access welfare. In less acute cases, the initial assessment is completed within 20 days; these times varying depending on the scale of allegation. Decisions on how quickly to respond are very often dependent on the quality of the referral. Strategic meetings are then held with the Gardai to decide on actions. All child protection cases are considered high priority for response and cases such as these do not usually remain on a waiting list.

Locally, a training programme has recently been established for specialist assessment for social workers and St Clare's Unit staff are supporting this. Currently staff have no particular specialist qualifications, although many have over the years been trained in investigative assessment interviewing.

Therapy services

Therapeutic support is provided by the local child psychology service and staff can also refer children to the National Counselling Service. There are also SLA's in place with two local agencies for generic counselling. In criminal cases, the role of victim support is carried out by the social worker who acts as advocacy to the child, attending court hearings etc. Where the outcome of an assessment is non-conclusive, services available to children and families include HSE psychology and CAMHS services. Psychology services are based throughout the county.

The service interfaces with some voluntary sector agencies who provide generic counselling support, including counselling for survivors of sexual abuse.

Highlighted Issues

- From the prospect of the social work teams, the welfare of the child is always paramount however techniques in assessments need to be updated, some out of date methods are being used in gaining disclosures from children.
- Further skills and training is needed for the professionals involved in undertaking medical examinations to ensure the maintenance of criminal evidence which is able to stand up in court. In addition, there is a lack of equipments, for example, colposcopes to undertake medical examinations.
- There is minimal provision for non English speaking clients. Usual translation services are sometimes available but these translations have no specialised training in this area.

7.2.3.10 Child & Adolescent Mental Health Services

Across the region, there are 8.56 wtes of clinical staff per 100,000 population with shortages in senior registrar, occupational therapist, child care worker and other therapists posts. 28% of children wait for more than 12 months for an appointment. Whilst almost 60% of children have their first outpatient appointment within 1 month, over 15% of children waiting more than 12 months. There was a 15.7% non-attendance rate in 2009. [126]

[126] Second Annual Child & Adolescent Mental Health Service Report, 2009-2010, Health Service Executive

7.2.4 HSE South

7.2.4.1 Family Centre, St Finbarr's Hospital, Cork

St Finbarr's provides assessment and medical services undertaken by a dedicated team of social workers, nurses and psychologists. The service operates from the community hospital Douglas Road, Cork, with an outreach service once a week in Tralee, County Kerry. A summary of the service is outlined below:

Cork	
Services provided	Initial assessment/medical examination
Staffing complement	Forensic medical examinations are undertaken by community and acute paediatricians on a rotational basis who are contacted once the referral is received. Over 14 year olds can attend the Adult SATU. Medical examinations are undertaken within St Finbarrs and seen with 5 days.
Services provided	Assessment services and non acute medical services
Service access times	9.00-5.00 Monday to Friday
Staffing complement	The staffing complement of the Unit comprises: **Psychologist** 1 FTE Senior; 1 FTE Basic Grade (unfilled at present); **Social Workers** 1 FTE Principal; 1 FTE Senior Practitioner, 3 FTE Basic Grade; **Community Care Public Health Doctor** 1 FTE (unfilled post) **Clinical Nurse manager** 1 FTE (only 0.5 FTE filled).
Waiting times	3.25 weeks for assessment Non acute medical examinations are usually seen within 1-5 working days from referral.
Estimated volumes of referrals	87 per annum (not split between assessment/medical)

Initial referrals of child sexual abuse

Referrals are received from multi agencies including: Gardai, Schools, Self and family referrals, GPs, Voluntary agencies and Hospitals.

Referrals are received for allegations of sexual abuse only; they do not see sexualised behaviours, and siblings are seen as separate referrals.

The social worker service is not available out of hours and so as in other regions the Gardai deal with alleged cases of Child Sexual Abuse out of hours.

A joint interview policy has been put in place for Section 16 (1) (b) interviewing however it is felt that the Gardai lead this process.

Forensic examinations are completed by community and acute paediatricians on a rotational basis who are contacted once the referral is received. Immediate examinations where forensic evidence may be present is completed within 24 hours, whilst all other cases are referred to the St Finbarrs unit and usually seen within 5 days. Out of hours, young people over the age of 14 are seen in the adult SATU.

Assessment and medical services

St Finbarr's provides assessment and medical services undertaken by a dedicated team of social workers, nurses and psychologists. The service operates from the community hospital Douglas Road, Cork, with an outreach service once a week in Tralee, County Kerry.

The staffing complement of the Unit comprises:

- Psychologist:1 FTE Senior; 1 FTE Basic Grade (unfilled at present);
- Social Workers: 1 FTE Principal; 1 FTE Senior Practitioner, 3 FTE Basic Grade;
- Community Care Public Health Doctor: 1 FTE (unfilled post); and
- Clinical Nurse manager: 1 FTE (only 0.5 FTE filled).

The services are provided 09:00-17:00 weekdays; there are no out of hours services provided by the family centre. There are an average of 87 referrals to the service per annum and there is a current wait time of 3.25 weeks for assessment, although they try to start assessments immediately, where possible. Non acute medical examinations are usually within 1-5 working days from referral.

Most children will be involved in assessment interviews more than once and all interviews are video recorded after gaining consent. The centre is presently working to develop a regular meeting between key agencies including Gardi, Child Protection Teams and psychologists but it is often difficult to get them all together due to other commitments.

The Family Centre also provides support to parents and carers throughout assessments, as well as the local social work departments.

The unit has developed a training and supervising programme for new employees in response to the lack of suitable training for their teams as the unit feels there are very few opportunities to access HSE training in the area of child sexual abuse, particularly for nurses. Clinicians attached to the unit however, have been funded to attend the St Louise's and St Clare's conferences.

Therapy services

A range of therapeutic services are used post assessment and investigation, including HSE and private providers, however, there is still a problem with wait times for accessing therapies.

The Unit has links and interfaces with private psychologists, CAMHS services, Guardians ad litem, and Kerry Adolescent Counselling Services, once the need is assessed as appropriate and parental consent is gained.

7.2.4.2 Community Child Centre, Waterford Regional Hospital

The Community Child Centre provides dedicated assessment services and medical services, undertaken by a dedicated multidisciplinary team of medical, nursing, social work and psychology staff. The service operates from the grounds of Waterford Regional Hospital, and provides services to the South East including Waterford, Wexford, Carlow, Kilkenny and Tipperary. A summary of the service is outlined below:

Waterford	
Services provided	Initial assessment/ Medical examination
Staffing complement	Out of hours medical examination services are provided by the adult SATU for children over 14 and in accordance with each local hospital guidelines (aligned to Guidelines for the Protection and Welfare of Children) for under 14's. Acute forensic examinations requests that can be undertaken in hours are immediately responded to (within 72 hours) and completed by the paediatrician attached to the centre in normal working hours. When annual leave occurs, this is covered by the acute hospital.
Services provided	Assessment services The service sees referrals for sexual abuse as well as referrals for assessment for males up to the age of 18 with sexually harmful behaviours.
Service access times	9.00-5.00 Monday to Friday
Staffing complement	The staffing complement of the Unit comprises: **Senior Medical Officer** 1 FTE **Psychologist** 1.8 FTE **Social Workers** 2 FTE **Nursing** 1 FTE (presently vacant; supported by Public Health nurses for medical examination, no daily presence); and **Administration and clerical support**: 1 FTE
Waiting times	4-6 week wait for assessments
Estimated volumes of referrals	175 in 2010

Initial referrals of child sexual abuse

Out of hours medical examination services are provided by the adult SATU for children over 14 and in accordance with each local hospital guidelines (aligned to Guidelines for the Protection and Welfare of Children) for under 14's.

Acute forensic examinations requests that can be dealt with in-hours, are immediately responded to (within 72 hours) and completed by the senior medical officer attached to the Waterford Community Child centre, in normal working hours. Holiday and study leave cover is provided by SATU for children over 14 and by the acute hospital for under 14's, in line with each hospitals guidelines.

Assessment services

The Community Child Centre provides dedicated assessment services and medical services, undertaken by a dedicated multidisciplinary team of medical, nursing, social work and psychology staff. It also provides assessments for AIM2 (Assessment Intervention and Moving On) for 13-18 year old males with sexually harmful behaviours.

The staffing complement of the Unit comprises:

- Senior Medical Officer: 1 FTE;
- Psychologist:1.8 FTE;
- Social Workers: 2 FTE;
- Nursing: 1 FTE (presently vacant; supported by Public Health nurses for medical examination, no daily presence); and
- Administration and clerical support: 1 FTE.

The services are provided 09:00-17:00 weekdays.

There are an average of 169 referrals to the service per annum (based on actual numbers from 1989 – 2009) with175 referrals in 2010. Referrals are received from the community service area social workers after they have completed an initial assessment on referrals from all agencies. All referrals are discussed in a weekly MDT meeting using an agreed referral criteria. The service sees referrals for sexual abuse as well as referrals for assessment for males up to the age of 18 with sexually harmful behaviours.

Currently, there is a wait time of 4-6 weeks for planned assessments, with priority given to young children, children with disabilities and cases where there are child protection issues. Children will often be interviewed more than once and all interviews are video recorded.

Informal feedback on the assessment is given to the family and key worker within one week, with a formal write up within 4-5 weeks.

Therapy services

A range of therapeutic services are used, however, these can only be referred into by the original referring social worker. The centre cannot directly access therapies.

The Unit has links and interfaces with the local Gardai; adult SATU services, Comhar, Rape Crisis Centres, CARI and Barnardos.

7.2.4.3 Child & Adolescent Mental Health Services

Across the region, there are 7.21 wtes of clinical staff per 100,000 population with shortages in senior registrar, registrar, occupational therapist, child care worker and other therapists posts. 28% of children wait for more than 12 months for an appointment. Whilst almost 65% of children have their first outpatient appointment within 3 months, over 15% of children waiting more than 12 months. There was a 20.3% non-attendance rate in 2009. [127]

[127] Second Annual Child & Adolescent Mental Health Service Report, 2009-2010, Health Service Executive

7.3 Profile of voluntary, charitable and other interface services

In addition to those services being provided from either HSE or voluntary health service facilities, there is a range of other service providers: each provide important elements in the child's welfare and care; which interface with these health based services, and, therefore, are an important consideration for this review.

7.3.1 CARI

CARI is a charitable organisation that is partially funded by the HSE to provide post assessment services for children affected by abuse. In particular, they work with cases where the outcome has been deemed inconclusive. They also work with children who have previously accessed other child sexual abuse services who require treatment in later years and do not want to return to the original unit where their case was dealt with. They also provide helpline support and therapy services for parents and children in the midst of the assessment process.

The child is assessed at the beginning of the process and after the initial 6-8 weeks of therapy they are re-evaluated. This evaluative cycle is repeated every 6-8 weeks throughout the life of the therapy. Support for other family members is also continuously assessed and provided as needed. An average length of service provision is between 18 months to two years

In 2010, CARI provided services to approximately 100 families, within which there were approximately 70 children from 4-21 years (including learning disability clients).

CARI have a strong relationship with the HSE, in particular within Dublin, and this is the only area that has a formal Service Level Agreement. All other service provision is on an area by area basis.

7.3.2 Rape Crisis Network and Centres

There are currently 15 Rape Crisis Centres (RCC) distributed across Ireland, with the exception of the north east. Each is funded by the HSE through agreed Service Level Agreements although much of this basis for funding is historical and centres on the former health boards. As a consequence, there is not an even distribution of service provision with distinct differences in resources and waiting times.

In terms of pathways for children, many of the referrals into the RCC service come via the Sexual Assault Treatment Units (SATU); mainly for children over 14 years; or via staff working in secondary schools talking about sexual violence. Referrals can come from a range of health professionals, including GPs and social workers. Parents are also in contact with the service. Due to the promotion and provision of services to children and the work within schools, the number of referrals are increasing; largely through children's own networks.

RCCs provide psychological support and these services are seen as accessible with, in many cases, shorter waiting times than for HSE services. The service employs professional therapists who are all qualified and supervised.

In total, the service has around 600 clients; many of whom are long term. The service has been surprised by the increasing number of children under 18 years accessing the service and consider that the HSE have not recognised the numbers of children accessing this service. In 2009, there were 69 children aged between 12-17 years; a third of which were referred to RCC by health professionals and a further third by family/friends.

Given the increasing level of demand and need for these services across all age ranges, the RCCs do not actively promote their services. This does, therefore, mean that possibly those most in need do not get access; particularly those in marginalised communities and those with disabilities. Those that do get access are those that have successfully negotiated the system.

The main issue for this service in relation to children and younger adults is, whilst the skills and competencies of staff are well equipped to support those over 14 years, the staff are not trained to provide services to those under 14 years but feel under pressure to do so given the limited availability of alternative services. Also, the service would question whether a RCC is the best location to provide services to children.

Also, the service considers that sexual violence is a 'blind spot' with child protection services focussed mainly on the family and with not enough attention on those victimised outside of the home. Voluntary intoxication by children and young teenagers is also an issue which warrants closer attention.

Finally, the Rape Crisis Network considers that it has a developed a successful information gathering process which provides a useful

insight into trends and differing patterns of behaviours and referral sources. The decision has been made by the HSE to no longer fund for the provision of this service.

7.3.3 Granada Institute

The Granada Institute provided by St John of Gods provides therapy services to men who have abused children and adults and also runs a women's group for women whose partners have been accused. This service has links with St Louise's Unit, St Clare's Unit and CARI and also with NIAP and SIAP adolescent treatment services. Examples of these links include joint projects on training for probation services, housing officers to promote multi-agency working around men who abuse.

Most referrals to this service are made from social workers or the organisations mentioned above. An risk issue flagged by this service is that whilst information is provided back to the social worker of concerns raised after disclosures made during therapy, the Granada Institute have no way of understanding if this information was acted upon since there is no common exchange of information and IT structures.

We understand however that the funding for the service currently provided by the Granada Institute will not continue next year.

Appendix H. Demand for services

H.1. Number of sexual abuse reports

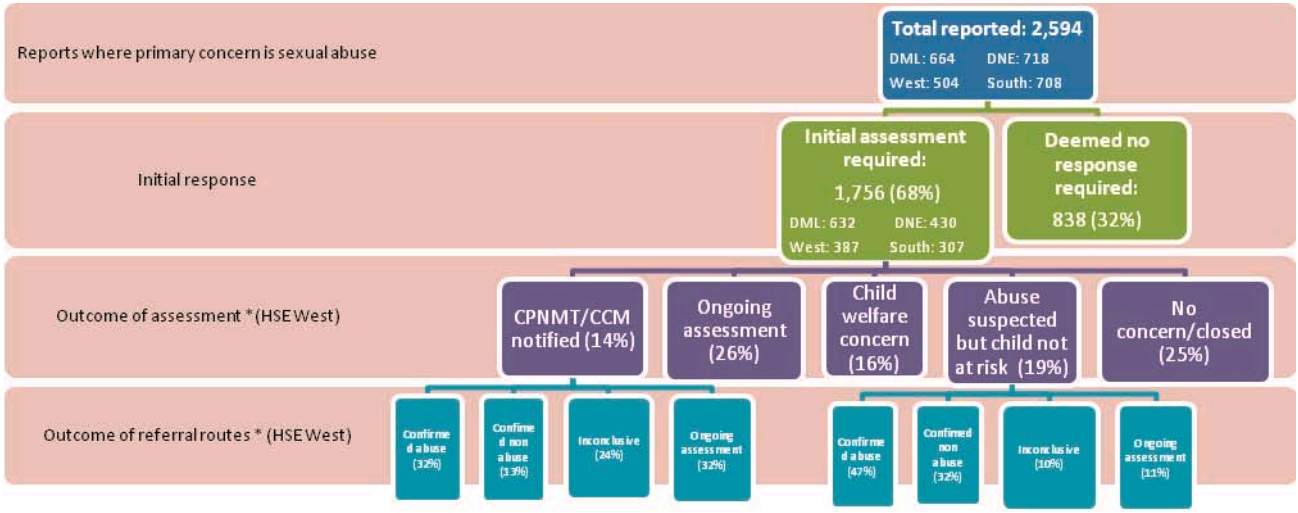
The following diagram includes data from the 2009 Childcare dataset, although it must be noted that the Child Care dataset was introduced as a temporary measure a number of years ago while the National Child Care Information System Project was set up to address the management information needs on a more permanent basis. Therefore some of the data in the dataset is unreliable, because it was established by combining non standardised local information into a single dataset. In many LHOs the data collected is reliable in a local context and but the definitions need tightening to enable national comparisons.

The Childcare database indicates that in 2009, there were 2,500 reports of sexual abuse to social work departments across HSE West, HSE South, HSE Dublin Mid Leinster and HSE Dublin North East.

Of these reports, 70% were responded to, with the remaining 30% deemed not requiring a response. The outcome of the assessment (based on HSE West figures only)[128] can then be mapped, which indicates that a further 25% of cases were closed due to no current concerns.

Of the remaining cases, 16% of children were deemed at risk and 14% referred to CCM/CPNMT, both routes leading to a probability/conclusiveness assessment of child sexual abuse having occurred. The remaining 25% required on-going assessment and child welfare concerns were raised for 16% of the children.

[128] Only for HSE West figures could the number of assessments undertaken be tracked through to the outcome of the assessment.



H.2. Number of forensic medical/ medical examinations

Taking the figures from Galway children's SATU which offers forensic medical and medical examinations to children and which undertook 44 examinations in 2010 and 18 examinations in the first quarter of 2011, (for children across Galway and the Mid-West), we can extrapolate the approximate range of demand for examinations across the country by reflecting the child population. This shows that the potential range of required forensic medical/medical examination is nationally between 288 and 471.

Area	Population (0-14 year olds based on 2006 Census)	Examinations undertaken in 2010	Extrapolation	Examinations undertaken in 2011	Extrapolation
Galway/ Mid-West	132,041	44	44	72*	72
HSE West (excluding Galway and Mid-West)	76,655	-	26	-	42
HSE South	222,881	-	74	-	122
HSE Dublin North East	190,143	-	63	-	104
HSE Dublin Mid-Leinster	242,729	-	81	-	132
Total	**864,449**	**44**	**288**	**72**	**471**

*18 undertaken in first quarter of 2011