



Northern Ireland
Assembly

Committee for the Office of the First Minister
and deputy First Minister

OFFICIAL REPORT (Hansard)

Victims and Survivors Service

6 February 2013

NORTHERN IRELAND ASSEMBLY

Committee for the Office of the First Minister and deputy First Minister

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Members present for all or part of the proceedings:

Mr Chris Lyttle (Deputy Chairperson)
Mr Colum Eastwood
Ms Megan Fearon
Mr Paul Givan
Mrs Brenda Hale
Mr John McCallister
Ms Bronwyn McGahan
Mr Stephen Moutray
Mr George Robinson

Witnesses:

Mrs Anne Dorbie	Victims and Survivors Service
Miss Sara Templer	Victims and Survivors Service

The Deputy Chairperson: We welcome to the Committee Anne Dorbie, who is the chief executive of the Victims and Survivors Service, and Sara Templer, its information officer. Anne and Sara; you are very welcome. Would you like to start by making some opening comments?

Mrs Anne Dorbie (Victims and Survivors Service): Thank you very much for the invitation to come to the Committee. We have provided you with some bits of our presentation that I will talk you through. The first page is a useful reminder to people of the role of the service and where it fits into the new landscape for victims and survivors, because we are conscious that the landscape has been changing over the past few years.

The Victims and Survivors Service (VSS) is the delivery body for funding for victims and survivors, both individuals and groups. It takes its direction from the Office of the First and the deputy First Minister, and we are very much the delivery body for services, a point which I want to emphasise going forward. The presentation refers to the "victims practice meetings", and I will elaborate on that process later.

The Victims and Survivors Service was established last April, and we regard this as very much the transition year. It absorbs the functions of the victims unit of the Community Relations Council and the Northern Ireland Memorial Fund. The function of the victims unit of the Community Relations Council transferred to the service in November, and the four staff of the Northern Ireland Memorial Fund will move to the service in March and April. It is in the process of winding up, and I am sure that you will

be aware that the fund closed on 7 January. It is moving and closing its funding programmes, as we speak.

The Victims and Survivors Service differs in how it targets victims and survivors, inasmuch as we are very focused on the assessment of need. That is something that is probably quite topical, and I am sure that you will be aware of it. Over the next calendar year, the Victims and Survivors Service will carry out a 100% assessment of all victims and survivors who avail themselves of a health and well-being intervention — largely counselling, cognitive behaviour therapy, eye movement desensitization and reprocessing (EMDR), and complementary therapies — and anybody who receives financial assistance.

The purpose of that assessment of all individuals is, first, to ensure that victims and survivors are getting the correct package of care, treatment course or provision of services and that they are aware of all the services that may be available to them. Secondly, it is to ensure that such services are of the highest standard and to make sure that the therapists involved in them have the skills and expertise to deliver on that assessed need. Thirdly, and importantly, the service will be the repository of all that information for the purpose of monitoring and evaluation, so that we can feed back to the Department and make sure that any emerging or recurring themes of need are met and dealt with and so that we can respond to those needs and ensure that resources are directed in the right way.

I will come back to the funding table in a second and continue with the theme of assessment of need, which I know is topical. The Victims and Survivors Service has done just under 300 direct assessments of individuals. They are largely self-referrals — people who have been on the chronic pain and disability support list for the Northern Ireland Memorial Fund. I will come back to why we have targeted those individuals.

The assessment process is an assessment of need and very much a stage 1 process. I will not get into the detail, but if anyone wants one, we have here copies of the client journey. The process is based on the assessment of need, as prescribed by the Commission for Victims and Survivors, along several areas of need, which are listed in the presentation.

Someone who comes to the service first has a chat with one of our assessors. We establish, along these areas of need, how we can best signpost those individuals and best meet their needs, broadly under the headings in the presentation. The process is entirely confidential; we do not share the information with anybody else, and we adhere to the strictest information security rules. If a need is identified, the next thing to happen is that the service refers the client to the 50 to 55 groups that it already funds, if that is where the client wishes to go. That is always the first port of call, no matter what the service — it could be health and well-being, social support, welfare advice, help through the advocacy process, or whatever. However, there are instances of individuals not wanting to go to victims and survivors' groups, so it is then up to the service to identify a suitable organisation to refer them to. I will come back to some of those statistics in a second. Therefore, it is very much around identifying what meets the needs of those individuals and what they feel comfortable going forward with. I mentioned that, to date, we have been dealing largely with self-referrals and that we are working our way through the Northern Ireland Memorial Fund's chronic pain and disabilities support list.

I have some facts and figures in which I think you will be interested. By the time that this presentation was prepared, we had completed 290 assessments. The majority of the clients who come into the service are male. One in four or five of those individuals has never accessed services before — they have never gone to a victims group, the fund or, indeed, the statutory sector. They have not engaged with anybody before, so they are the hidden victims. One of the reasons why the service was set up was to reach out to those individuals who had never been anywhere before.

The average age is around 55. Just over one third of the completed assessments involved people who had never accessed other dedicated services for victims and survivors. One in two of the clients who show or express a need — around 50% of the people who come through our doors — do so for mental health support. If that happens, they are referred for a stage 2 assessment by a professional and for a psychological assessment. That could be within a victims and survivors' group, a direct service provider or, indeed the statutory sector. Around one in three of those individuals evidence traumatic stress symptoms, with around 6% of those showing extremely acute symptoms of post-traumatic stress disorder (PTSD). Those are very significant symptoms that they present with, and we would have to deal with those very quickly. Generally, we can get someone to a stage 2 assessment within 14 days and into therapy within another 14 days of being seen.

Clients frequently make reference to the traumatic event that has affected them. Those largely occurred around 20 to 25 years ago, which is concurrent with research that has been done in the past. The psychologists that we have been talking to have expressed, not so much anxiety around the people who have been presenting, but the view that those are some of the most complex cases that they have seen in their entire career. That is something that the service will be taking cognisance of in terms of practice development and ensuring that any therapist working with victims and survivors, particularly in those areas, has the skills and expertise to deal with that.

I will move back very quickly to future funding. The victims support programme is divided into three areas. Health and well-being will be a one-year funding programme, and you are probably aware that we are going through the selection process for that at the moment. Over the two-year period, there is a budget of £7.5 million. That is for anything including counselling, psychotherapy, complementary therapies or personal and professional development. We estimate that around 6,000 people should avail themselves of that programme. There is £7.5 million pounds for social support. That includes the softer activities, such as befriending, group activities, personal development, transgenerational youth activities and welfare support. Those things are largely done on a group basis. We estimate that there will be around 7,000 beneficiaries. Individual financial needs will be the suite of programmes that will replace the programmes traditionally funded by the Northern Ireland Memorial Fund. The budget for that will be £4.6 million between 2013 and 2015. The details of those schemes are not yet available. We anticipate around 4,000 beneficiaries of that scheme.

I am sorry that I am jumping from one area to the next. I am going to move on to the table on VSS strategic priorities. At the moment we are looking at moving forward with the next three-year corporate plan in draft. Some of the key strategic priorities that we have identified include funding for services; the individual's assessment and support; best practice in service and therapies; and, of course, our corporate governance and value for money for the organisation. The first two of those strategic priorities are delivered through the victims support programme, which, as I said, and as you will be aware, is divided into health and well-being and social support. The aim of the health and well-being programme is really to contribute to the health and social care of victims and survivors through the provision of individualised courses of treatment. That is really about the service ensuring that the pathway of care really does meet the individual's specific need. The objectives of that are to provide packages of treatment and care, specifically tailored for the individual, which we can ensure deliver on their particular type of need. It is also about providing high-quality care for those individuals, through direct support, either from the service directly, for those who do not want to go to groups, or to organisations, but, overall, it is to ensure that there is a professional best standard, no matter where a victim or survivor goes.

Social support is really about supporting and maintaining the resilience of victims and survivors. There is no hierarchy between the health and well-being programme and the social support programme. We feel that they are absolutely essential to meeting all victims' needs. We want to ensure, through the social support programme, that victims and survivors' mental health and personal well-being is maintained. That could be where somebody goes through a health and well-being intervention and requires some social inclusion at the end of it, or, indeed, it could mean acting as a gateway through social support. By bringing people into a group context, you can start to help them deal with their issues as a victim and survivor in a very careful and managed way.

The social support programme is a two-year funding programme that is very much aimed at group activity and informal engagement, and, for the purposes of social support, somebody does not need to go through an assessment of need. Anything that we do will, within the social support context, be to the best practice standards and on an evidence base.

The third strategic priority is on the best practice in services and therapies, and the two aims for the service over the next number of years are to provide victims and their service providers, whoever they may be, with information on the range of therapeutic services that are available and how to access them. That is a barrier to services for individuals and groups at the moment; they do not know where to go to access those services. We will also ensure that provision of all therapies to those who require them is delivered by staff with the skills and competence appropriate to the level of those interventions, and to national and regionally agreed standards and guidelines. The service is working very closely with the Health and Social Care Board and the Department of Health, Social Services and Public Safety to ensure that anything that we do is congruent with the psychological therapies strategy. Anything that we are advising therapists is dovetailing with the psychological therapies strategy to ensure that there is best practice across the sector.

One of our objectives this year is to establish a network of multiprofessional and multiagency service providers, and on the first slide in the presentation was something identified as victims practice meetings. That is the replacement for the trauma advisory panels that some members may have been familiar with. That is about ensuring that there is a hub for victims and survivors and a network whereby, if somebody enters the system, whether it is with the service, a group or into the statutory sector, the best possible package of care is tailored to that individual and they do not get lost in the system somewhere.

I talked earlier about the 100% assessment process, and that will identify the need. At the same time, in parallel, the service will, in this calendar year, look at all the qualifications, skills and experience of the therapists who provide those needs. We will ensure that the workforce that we have, through groups and other service providers, is equipped to deal with those needs identified in the 100% assessment process. We are working very closely with the Health and Social Care Board to ensure that that dovetails with the psychological therapies strategy.

We are capturing a lot of the information onto a database to ensure that the service captures all the information and needs of individuals moving forward. Although it is not the role of the service to determine policy, it is very much about giving that information to government so that it can respond to the needs of victims and survivors or anybody who provides those services. We will develop a database and a monitoring and evaluation system in the next year.

I have already mentioned the victims practice meetings. That is the hub to make sure that victims are not lost in the system. We have identified that as an issue in the service, and people have gone to groups or to the statutory sector and got lost somewhere on their way. It is about networking and making sure that the package of care is there. I mentioned chronic pain. The service targeting chronic pain and disability support from the Northern Ireland Memorial Fund is to ensure that, as far as possible, there is no break in assistance to those whom we consider to be the most vulnerable. Members may be aware of work that Wave carried out in responding to the needs of the physically injured, and the service should respond to those needs as best it can. We use that report to inform anything that we can do in the delivery of quality services to those most in need. Without over-egging PTSD, that is an issue in the sector, and we are looking at action-based service improvements so that the service can respond effectively and efficiently to the needs of victims and survivors.

The Deputy Chairperson: Thank you, Anne. It is encouraging to see the work that has been laid out. Although this is, to a certain extent, a background question: why has it taken us so long to get here? That is not your concern, but it is great that people are trying to drive the service forward now, and the key issues that you identify ring true with me as needs that victims and survivors have conveyed and which are remarkably complex.

Mr Eastwood: Who does the assessment? Is it contracted out?

Mrs Dorbie: No. When somebody comes to the Victims and Survivors Service, they are seen by an assessor from the Victims and Survivors Service.

Mr Eastwood: I have been contacted by a number of groups that say that there was a proposal for people to be able to self-assess if they were part of a group. Some of the groups have great expertise in post-traumatic stress and everything else. That recommendation was not taken up by OFMDFM. Is there a reason?

Mrs Dorbie: I am not aware of the reason, but it is the intention that the service will carry out those assessments by its own assessor to ensure that victims and survivors, as I said earlier, are aware of everything that is available to them. It will also ensure that there is quality and best practice in the groups and other service providers; it is not being carried out only in the groups. In addition, it will capture anything that we may feel is necessary in that process, whether it is ensuring that victims and survivors have access to services of the right quality. It will also ensure that, if there are any underlying trends, we can feed those back to the Department, because they could shape future policy.

Mr Eastwood: I understand that a number of people are not involved in any groups at all, but some groups have been doing this work for a long time and have gained significant experience and even accreditation in dealing with some of those things. It worries me a wee bit that victims will have to go through another assessment, having perhaps gone through one or more beforehand. There would be difficulties around that.

I would like to see the groups' experiences of this moving forward. I ask you to bear that in mind. We do not want to put people through a number of different assessments when they have already been through ones that have proven to be quite adequate.

Mrs Dorbie: We call it an assessment. It is actually a needs review. We want people to understand that it really is a very basic chat. It can take 10 minutes, 30 minutes or 40 minutes. It seems quite onerous because it covers a lot of areas, but the client does not have to answer every section. They do not have to talk about something very personal to them, such as their housing or finances. They also do not have to go over the incident. If we know that they have a memorial fund number, we do not need to go over the incident again because we can get that information. We are trying to remove, as best we possibly can, anything that would affect them. We certainly do not want it to be a barrier to any victim or survivor coming forward. We work quite closely with the groups. We have a member of staff who talks to the groups and takes them through the assessment process. I am following that up to see whether there is any way other way in which we could connect with victims and survivors so that they do not in any way feel traumatised or affected by that.

Mr Eastwood: Is it the case that there was a proposal that groups would be able to self-assess?

Mrs Dorbie: No. There was an aspiration by groups to have that facility, but it has not come to pass.

Mr Eastwood: There is no particular reason for that?

Mrs Dorbie: No.

Mr McCallister: You do some of the assessment with some of your own people. Presumably, you buy in expertise as and when you need to. How do you link in with accessing the health service? How do you refer them to, or get them into, the health service system, if that is required?

Mrs Dorbie: When they come into us, we do not contract out the stage 1 process; they are seen by an assessor from the service. That is a very broad assessment; it is like a needs review. We just capture everything. People can skip sections. They are not made to do anything that they do not want to do. I reiterate that they do not have to come to Great Victoria Street — I know that that is another concern. Our assessment team travels throughout Northern Ireland. It does assessments in people's homes. It has also done them in GPs' surgeries. It will do an assessment wherever the person feels comfortable carrying it out.

Mr McCallister: Who mainly refers people to you? Is it a mix of existing victims' groups, a number of which are in my constituency, or is it GPs? Is there a range?

Mrs Dorbie: Largely, to date, it has been self-referrals. People have come to the service. We also approach those who are on the chronic pain list of the Northern Ireland Memorial Fund. It is pretty much the case that people come to us directly. We will work with groups around their members over the course of this calendar year. That is who we will target for assessment.

If a mental health need is identified, the person is referred to a stage 2 or psychological assessment with a suitably qualified clinician. That clinician will work with the individual's GP or the group, if they are already a member of a group. Sometimes, we refer people to groups, and they pick up the psychological assessment because they have people who are equally as well, if not better, qualified to deal with that. If that is the case, then the person remains in the group, and the group deals with it in the same way that it would if the person had come directly to them.

The psychologists or psychotherapists work very closely with the health system to ensure that there is that joined-up approach. However, I will be honest and say that it is fragmented, but we are working very hard on that. The purpose of the victims practice meetings is exactly that; it is where the service will have a dedicated person in each of the trusts in order to have a smooth referral process so that the individual does not get lost. There is no doubt that some of the victims that come to us are lost in the health service.

Mr McCallister: Have some of them been trying desperately to get through the health service but have not been able to navigate their way?

Mrs Dorbie: Yes. Response times are slow and waiting times are long. It is very difficult. We are dealing with people, as you will be aware, who are extremely traumatised. They do find it difficult. Of the people who come forward, one in two have mental health needs, and we find that they get lost in the system because they got tired of waiting for some therapies or something like that, or, indeed, because the trauma is only now presenting itself. The age profile is mostly men who are in their 50s, and they, perhaps, do not want to talk to their GP. For whatever reason, they find that the service is a good space for them.

Mr McCallister: My colleague, Michael Copeland, raised a concern about the welfare reform programme and about how access to some benefits will be affected. Will you go down the route of working with and supporting victims and survivors in that regard?

Mrs Dorbie: We will indeed. It is an area of need that groups have identified in the most recent round of funding for the victims support programme. Groups have applied for welfare support officers. Some people come directly to the service for that support. That is captured in the review of need, and we can support people through that process or we can refer them to groups. There are particular victims and survivors' groups that, no doubt, have excellent expertise in that area.

Again, however, some people do not want to go to those groups for whatever reason. They want the service to provide that. Quite often, people know that a group has a certain expertise, and they approach us to ask whether they can go to that group. It is just about connecting people to the right service.

It has not been applied for in the most recent round of funding, and it does not concern me as much as I thought it might have, but it is a growing concern, particularly for people who come to us with chronic pain. Again, it is about being reassessed. We will work with people as best we can to connect them to groups that can provide advocacy support. We can provide that service directly ourselves.

Mr Givan: Thank you very much for the presentation. You have presented to us with authority on the issue, which will reassure members and give them confidence in how the service is being driven forward, so thank you for that.

When victims first contact the agencies, the complaint that I often hear about the way in which the criminal justice system runs or does not run is that they are passed from pillar to post. They are put in contact with people, to whom they tell their story, but, the next time they get in contact, they are passed to someone else. They constantly have to go over the same ground.

In this service, do you assign people to an individual or a group with whom they will deal repeatedly, so that information, if it changes, is shared so that people do not have to go over the same ground?

Mrs Dorbie: Yes, very much so. We have victims support officers in support of our assessors. We are constructing a database so that people can be assigned a confidential and unique identifier that we can track for exactly that reason. I will ask Sara to tell you a little bit about that.

One of the reasons why we ask for the memorial fund number when someone approaches us is so that they do not have to tell their story again. We do not need people to go over it again and again. Once we know that they have a memorial fund number, 11,000 of which have been assigned in the 10 years that the fund has been in existence, we can track that, go onto the database and get the information. We do not need them to tell their story again.

Sara will tell you a little bit about how we track individuals so that they do not have to do that all again.

Miss Sara Templer (Victims and Survivors Service): We have convened a working group on the monitoring and evaluation processes for which the VSS will be responsible as we roll out the funding over 2013-15. That will also incorporate the data that will be captured for the individual needs review that we will conduct with individuals.

This will be quite a large and complex dataset or streams of datasets. Although we will not be able to assign every individual user a unique identifier immediately at the start of the funding period, it will be a process of assigning users a unique identifier as they come into contact with the different services during that first year. The beauty of that is that, for the first time, we will be able to track where an individual accesses different services; whether with us or with group a, b or c; or whether they access

a range of services, from social support to health and well-being; or whether they have a particular area of need on which they will focus.

This will be the first time that we will have that depth of information. Uniquely, across the world, we will be able to say that we can track those needs, match people to the appropriate services, look at how their needs change and evolve over time, and respond to them appropriately in real time, monitoring and evaluating as we engage with them.

Mr Givan: That is very reassuring. Finally, as funding needs are identified, at what point do people in the organisation ask whether sufficient resources are available and whether they need to make additional bids for resources? How do you assess the funding that has been made available, and is there a need for more?

Mrs Dorbie: We worked very closely with the Office of the First Minister and deputy First Minister in the construction of the business case. I know that you are aware, in the light of the spending review, that the budgets have been set. At the moment, we anticipate the level of demand to be around the same as it has been for the past two years, but to be absolutely honest, we will not know until we do the assessment of need.

One of the nice things about the service is that, because the funding is all in one place, we should be able to move, with OFMDFM's permission, to target areas where we see emerging needs. One of the criticisms in the past has been that there have been underspends in one area that could not be used in others. Hopefully, within the victims package, we will be able to direct those resources as and when they are needed.

At the moment, I do not anticipate any shortfall in funding, but we will not know about that until we do the assessment of need.

Ms McGahan: Thank you for your presentation. We are very supportive of your work. I wanted to make the point that it is critical that your organisation engages with all the groups out there as well as the commissioner. When a person presents themselves to your organisation as a victim, what is the process of assessment? Obviously, mental health is a big issue. I know that you have covered that in a practical way.

Mrs Dorbie: I have a member of staff who engages, one to one, with all the groups to take them through the assessment process. We are very open and transparent about the assessment process. I am trying to drop the word "assessment" because it is a very quick needs review, which is about capturing the individual's information. If the individual is happy with his or her service provision, that is as much as the service needs to do. We just need to know that the person is happy and comfortable with the services that he or she is getting, and then we can come away. If there is anything else that we can help individuals with, we are more than happy to do that.

It is a simple chat. It is a needs review. It is very broad; people do not have to answer the sections that they do not want to answer. I take your point; 50% of the people who come on board do not have mental health needs and do not ask for any help at all in that regard. It is largely about things such as welfare support or help with the Historic Enquiries Team (HET) or the Police Ombudsman — we make connections for them on advocacy. There is also some transgenerational work. We work with people very closely. It could be social support. The number of people who still come forward with problems of social isolation is amazing, and we can refer them to groups for that process.

I accept your point; we have someone engaging on a one-to-one basis, and Sara and our engagement officer and I follow up those visits with phone calls to ask groups whether there is anything else that we can do to allay the fears of their members about the process. We are very happy to go out and have group discussions about the assessment process so that people can have a feel of it before the assessor comes to them.

It is a relaxed process; it is not intended to be in any way intrusive. People do not have to answer sections that they do not wish to answer. It is really about helping them to identify their needs and making sure that those needs are being met, as well as making sure that the groups and therapists who deal with those individuals have the skills and expertise. We are very conscious that, to date, it is a sector that, perhaps, has not had the investment in training that it ought to have had over the past number of years. We have been very focused on getting money out.

It is about making sure that, where needs are being identified, those who deliver the relevant services have access to high quality support for their provision.

The Deputy Chairperson: Anne and Sara, we appreciate your presentation today. I hope that we can maintain contact with you as you develop the service and link it with some of the other bodies, such as the forum and the commission. We wish you well in rolling out the service. It is obviously an extremely important service for victims and survivors in our community, and we wish you well with that.

Mrs Dorbie: Thank you very much.