Northern Ireland
Assembly

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

OFFICIAL REPORT
(Hansard)

Victims and Survivors: Victims and Survivors Service Briefing

23 October 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Mike Nesbitt (Chairperson)
Mr Chris Lyttle (Deputy Chairperson)
Mr Alex Attwood
Mr Leslie Cree
Ms Megan Fearon
Mr Alex Maskey
Mr Stephen Moutray
Mr Jimmy Spratt

Witnesses:

Mrs Anne Dorbie	Victims and Survivors Service
Ms Katrina Hinfey	Victims and Survivors Service
Miss Sara Templer	Victims and Survivors Service

The Chairperson: We are joined by the chief executive, Anne Dorbie; the head of client services, Katrina Hinfey; and the information and engagement officer, Sara Templer.

Mrs Anne Dorbie (Victims and Survivors Service): We are back today to present some information that we have gathered through our individual needs review process, which is about half of the cohort of individuals that we have reviewed at this time. With regard to how we have gathered that data, Chair, and as you mentioned, we were successful in an October monitoring round bid. It is as part of the information-gathering process that we put the bid to the Department and Ministers, so we are absolutely delighted that that money has come through.

Sara will make the presentation. As she works through it, you will see where our pressure points are, how quickly we were able to identify gaps in services and where we thought there were, perhaps, some geographic areas where there was a lack of service provision. As we go through the information, you will see the evidence on how we were able to support the bid. The purpose of the bid was to provide additional funding for psychological therapies, chronic pain, for which we have exceeded our estimated numbers, disability support and, potentially, some financial assistance.

The Chairperson: Sorry, Anne, I note that every page of this report is marked in bold red, "Restricted". Is that marking at your request? This is a public session. Therefore we must assume that all this information is in the public domain, as of now.

Mrs Dorbie: Absolutely. Thank you for that clarification, Chair. Sara will run through the presentation.

Miss Sara Templer (Victims and Survivors Service): As Anne said, the data that I will present relates to about half of the clients whom we have seen so far. It is important to note that it is probably the first comprehensive data set that we have had in relation to who victims are, where they are, and what their needs are, since 'The Cost of the Troubles Study' was conducted in 1999. This is the first data set that we have that tells us about the survivors.

The first set of tables in your papers demonstrates the age range of the clients who come to the Victims and Survivors Service. They range from 18 to 88, and the average age of our clients is 53. That indicates an aging population of victims and survivors. Paragraph 1·2 on page 4 shows the gender distribution. It shows that there is a slight majority of men attending amongst our clients. That is interesting, because, in typical help-seeking behaviours, women tend to come forward more readily than men. Indeed, women outnumber men by a significant majority in the group-based activities that we fund through the victim support programme. The relationship status of Victims and Survivors Service clients is important, because we can see that a large proportion of our clients are married. That puts an emphasis on the importance of considering the impact of Troubles-related events on families.

The employment status at paragraph 1·4 shows that a high proportion of the clients who come to the Victims and Survivors Service are unemployed, although we should not necessarily take that as an indication of economic inactivity. We will look at that later. There is data to support that.

Paragraph 1·5 shows the housing status of our Victims and Survivors Service clients. Housing status is important, not necessarily with regard to looking at where the majorities are, but recognising those important minorities that have registered with us as being homeless or being in temporary accommodation. That underlines the vulnerability of some of the clients who come to the Victims and Survivors Service.Moving on, paragraph 1.6 shows that a high proportion of VSS clients, in fact the vast majority, are in receipt of benefits. As I mentioned before, this is not necessarily an indication of economic inactivity. The table at paragraph 1.7 shows that a number of individuals are in receipt of jobseeker's allowance and working tax credits. A high proportion of our clients declare that they are on disability living allowance, however, and that relates directly to those who have been physically or psychologically injured.

The pie chart at paragraph 1.8 shows that a significant minority of the individuals who come to VSS responded no to the question:

> *"Are you confident with reading and writing?"*

That is borne out in the uptake of our education and training grants that we are able to make available under the individual needs programme. It also shows the value of those schemes and of the one-to-one interaction with the individual needs review that allow us to explore what particular education and training grant may be of benefit to individuals. It may not necessarily be a complicated high-level course but may, in fact, be assistance with literacy and numeracy. That has come through as a particular need.

In relation to paragraph 1.9, I would direct you to annex 1, which shows the residential post code district distribution of VSS clients. You can see that there is a good wide distribution, with clients in almost every post code district area. You may recognise your own.

The Chairperson: That is on page 100, members.

Miss Templer: OK. That information shows groupings in particular areas. We have correlated that with the health trust areas across Northern Ireland, and we can see that there is a concentration of victims and survivors accessing the service around the Belfast Trust, Southern Trust and Western Trust areas.

Annex 2 shows the year of the key incident that has led clients to identify as victims or survivors. This is important. It shows us that a majority of clients are identifying with events that happened more than 20 years ago. So, clients are identifying with incidents that happened in 1972 and in the mid-1970s. The right-hand side of the graph shows that many clients say that they identify with multiple incidents. Again, that tells us that we need to be alert to the incidence of multiple events and complex trauma.

The table at paragraph 1.12 sets out how those individuals who were asked define themselves under the Victims and Survivors (Northern Ireland) Order 2006. As we know, the 2006 Order declares that an individual is a victim or survivor if they have been bereaved as the result of a Troubles-related incident, have been physically or psychologically injured as the result of such an incident, or are a carer of somebody who has been physically or psychologically injured. It goes on to state, that, without prejudice to that definition, a person may be psychologically injured as a result of having witnessed an incident. So you can see that we have asked that question and given that option to the individuals who have come forward. We have included the "witnessed an incident" section, because it is a gentle way of starting a conversation about mental health and the possibility of psychological injury that is associated with a Troubles-related event. The table shows that individuals frequently identify with more than one category.

The table at paragraph 1.13 shows the responses to the question:

> *"Are you currently receiving, or have you ever received support from any victim/survivor support groups?"*

The chart shows that as many clients responded "In the past " or "Never" as responded "Currently". That suggests that, while a significant number of clients are accessing groups, the VSS is successfully engaging with victims and survivors who are not currently accessing victims or survivors support in any other context.

The chart at paragraph 1.14 shows the results when we asked clients whether they had ever had an engagement with a mental health professional. We can see that a slight majority of the clients who are presenting at VSS — just over 50% — have previously engaged with a mental health professional. This is important for mapping the way we provide services to individuals who have had a history of previous engagement.

Another important factor for mapping services is understanding the number of clients who have suffered brain injury in the past. The table at paragraph 1.15 shows that almost 10% of the clients who come to us have, indeed, suffered a brain injury.

Paragraphs 1.16, 1.17 and 1.18 contain information that gives us a very preliminary sense — an initial taste — of what mental health needs an individual may specifically have. The data relates to outcomes of standardised measurement tools called the generalised anxiety disorder 7 (GAD-7) questionnaire, the patient health questionnaire 9 (PHQ-9) and the trauma symptom checklist. Those are standardised measurement tools that are used commonly by general practitioners to ascertain levels of anxiety and depression and to detect symptoms of trauma, all for further investigation at a later stage in a proper psychological assessment. That gives us a flavour of clients' state of mind. In all those cases, more than 50% of our clients registered with moderate to severe symptomatology of anxiety and depression. Nearly all our clients show evidence of trauma.

It should be noted that all that information is just the facts. It is just the data that we have gathered. We are not imposing any kind of interpretation on it; that is not our role. However, when we say that we can detect trauma and can see evidence of it, it is important to note that these are individuals who are identifying trauma symptoms. They have not been diagnosed with post-traumatic stress disorder.

Paragraphs 1.19 and 1.20 detail important statistics. They show that the clients who are presenting at the Victims and Survivors Service are at a relatively high risk of self-harm and suicide. Those are very important factors for us to take into account as we deliver services to those individuals.

The chart at paragraph 1.21 is important in light of the publications from the Commission for Victims and Survivors. It shows the areas of need that were identified in the commission's comprehensive needs analysis. Individuals who come to the Victims and Survivors Service identify particularly with the areas of financial need, physical need and mental health needs. We should keep in mind that financial need is not necessarily about drawing down cash. It is also about availing themselves of assistance to meet the cost of disability support and pain management.

Finally, I turn to some data that is emerging from the monitoring of our scheme six financial assistance under the individual needs programme. The data was collated by means of a feedback survey that we issued to all those individuals who had received cheques at a certain point in the year. The key findings are helpful in that they show us that the majority of people are using financial awards to help pay for household bills.

The information is interesting, but it is also quite reliable as we had a response rate of over 70% to the surveys that we posted out. We got a lot of responses and were able to collate a lot of that. What was particularly helpful in this exercise, and what you cannot really see borne out in the charts, is that we got some very rich qualitative data from that. We were able to see that the people who gave us feedback had used their financial assistance to help pay for household bills, but others had used it to help manage a pain condition that has been ongoing for several years or to help pay for an education or training intervention or course of some kind that was of use to them. So, having been able to get that qualitative feedback about scheme six, we have been able to go back into that information and reconnect with some of those individuals to help them maximise the assistance that is available to them. We have gone back to them and told them that they may not be aware but that they could have availed themselves of assistance for education or training, respite or pain management through some of the other schemes, which perhaps people had not understood. We are going through that qualitative response feedback with a fine-toothed comb to enable people to maximise their awards in that way. That is what I have for you, Chair.

The Chairperson: Great, Sara. Thank you very much indeed.

I have a couple of questions. Just to emphasise, what you have done there is that you have gathered data but not analysed, because the research function statutorily lies with the commission rather than the service. You said that it is the first data set across the Troubles since Marie Breen-Smyth in 1999.

Miss Templer: Indeed. It looks comprehensively at who the individuals are, where they are and what their needs might be.

The Chairperson: But in the meantime, between 1999 and today we had the memorial fund.

Miss Templer: We did. That delivered services and collated information on the services that it was delivering.

The Chairperson: Was there no data from it?

Miss Templer: To our knowledge, there was none that has been presented in a systematic format like this with a view to offering it up for further analysis.

The Chairperson: I want to ask about a couple of specifics. In paragraph 1.4, you highlighted the number of people who are married, which was just below 350. However, if you add up those who are divorced, single and widowed, that is also just about 350.

Miss Templer: As you note, Chair, that is a matter for deeper analysis and interpretation. If we go through those numbers, we will certainly see that there is something to be said about the support networks around individuals who are living as victims.

The Chairperson: Paragraph 1.8 shows responses to the question:

> *"Are you confident with reading and writing?"*

What is the basis for that question and the use of the word "confident"?

Miss Templer: It came to our attention as individuals were going through the individual needs review that some were having a bit of difficulty responding to letters or written invitations to present at the service having made an appointment. It became clear that a relatively significant number of individuals were keen to pursue some kind of education and training, but were lacking confidence because of relatively poor literacy and numeracy skills. So the question was introduced to create the opportunity to begin that conversation with those individuals, and it has been taken up quite readily, as you can see by the number of people who state that in fact they are not 100% confident with it.

The Chairperson: OK. This is very sensitive, but it is in the same ballpark. Paragraph 1.20:

> *"Have you ever had thoughts about attempting suicide?"*

If you are vulnerable and you are going to a new service, and you are not really quite sure about the service and what it is going to do for you, is there not a temptation for the individual to think, "I better answer 'yes' to this question"?

Mrs Dorbie: I will call Katrina on that one.

Ms Katrina Hinfey (Victims and Survivors Service): It is important to put it in the context of the initial needs reviews and exploring mental health and well-being with the client. The approach to that is a very layered one, which is facilitated by healthcare professionals. They are invited to walk their way through building up a picture, starting off very clearly with where that client is today and how they feel, in terms of any past experiences or any difficulties that they might want to discuss around their well-being and mental health. It continues to build that picture up, in consultation with the client, as long as they are happy, to understand just exactly where they are in terms of their well-being. That is where the GAD and the PHQ-9 come in. The clients are invited to engage in that; it is not mandatory. They can opt out of it at any time. Using that scoring in terms of managing risk at source, the clients are then invited to explore their feelings, mental health and well-being. It is only then that they approach "harm to self or others", and that would be done in a very delicate way. It is really about safeguarding the client and our duty of care to the client there and then.

The Chairperson: So there is a whole process behind where you get to in 1.20?

Ms Hinfey: Yes.

The Chairperson: OK, that clarifies it.

Mr Spratt: First of all, maybe you could tell me the length of time that the report took and the cost of it. My understanding from the last briefing is that the vast majority of staff have come from the memorial fund and the Community Relations Council etc, and have been TUPE'd across, so you should know what the problems are. It should come as no surprise that 56% are suffering from mental health needs or chronic mental health needs, another 10% are suffering from brain injury or surgery, and a lot more are suffering from pain needs as a result. I am more interested in what you have not presented today, given your admission the last time you were here, and given that various reputable, cross-community organisations that have been dealing with victims for many years are still reporting long delays in assessments and in processing claims. You have admitted to failing to answer telephones and e-mails and to making people produce three months' bank statements when, in fact, they have already been in receipt of awards and benefits in other areas that were financially assessed, and have obviously proved their point.

Victims do not need to hear any more about surveys and needs. Victims' needs must be dealt with, but they are not being dealt with. Clearly, that is what the Commissioner and the victims' groups are saying. It appears to me that there has been friction between your outfit and the Commissioner. That is not something that we need to get involved in, but it is quite obvious that there are issues there that need to be dealt with. That may be more for the Department, and we will come to that in due course.

Quite frankly, you are still not delivering. You are still making victims feel that they are being reassessed. Whenever we go into the area of mental health needs, I am reminded of my time on the Northern Ireland Policing Board when I, along with two or three others, was appointed to a group to look at reassessments of police officers' pensions and medical evidence. The deputy Chief Medical Officer sat on the same group; there were only four or five of us. We have low numbers of psychiatrists etc, and sometimes people have to wait a long time to see those specialist medical professionals. What the medical professionals said in relation to bringing people back for reassessment time and time again was that it sometimes takes a psychiatrist six, seven or eight years to deal with and make progress with a victim. Bringing them back to an assessment retraumatises them; that is a theme that comes through consistently from all sections of the community.

What advice have you sought on that from the medical professionals? You have told us about this survey. What advice have you given the Department? If, as I suspect, you have got the advice that that particular committee received, I suspect that you would get similar advice from the health professionals concerned. What have you done to make the Department aware of how people can be so quickly retraumatised, putting six or seven years' good work down the tubes in the space of a couple of minutes?

It appears that, even through telephone assessments, you are retraumatising people as well. You need to start getting your act together because, quite frankly, for too long it appears that victims have been made promises with no delivery. You are not helping the situation, Anne. That is what is coming through from very reputable groups. You need to get your act together. Maybe you will tell us what changes you have made to the managerial system for telephones and e-mails etc, because that was clearly a management issue. Now is your opportunity to update us and tell us what you have done in the past three weeks.

Mrs Dorbie: I will pick up on your point about how the individual needs review process came about. You may be aware that a transition group was set up for the development of the service over the course of last year, and various working groups looked at the process.

Mr Spratt: Working groups do not deliver. These people need delivery.

Mrs Dorbie: Absolutely. I am going to get to that —

Mr Spratt: They are sick of listening to reports and statistics.

Mrs Dorbie: The Department's representatives are here today, and they will explain in much more detail about the project board that has been set up to look at all the issues that you raised that day, and indeed other issues that have come to the table since. Everybody is there; the Department, the commission and the service were absolutely willing to look at all those issues and address them in due course. I know that the Department is here to talk about some of the terms —

Mr Spratt: How long is a piece of string? How long is that going to last?

Mrs Dorbie: We are here, and we will react as soon as we possibly can. We have already looked internally at our own services, and we have drafted a service implementation plan for ourselves. It is important that that project board is given the opportunity to discuss those issues. I can assure you that we take them extremely seriously. As soon as we have anything, we will have it implemented.

Mr Spratt: There is also frustration with your staff refusing to speak to some of the very reputable victims' organisations concerning a client, despite the fact that a client was actually present. Why is there a problem? Many times people come into my office when they need a person to liaise on the phone with doctors or whoever, because they are not mentally up to doing it themselves, but they identify the fact that they are there, etc. I am sure that that happens to many others round the table. Why re-traumatise people? Why not try to help some organisations such as WAVE?

Ms Hinfey: I recognise that that was an issue. There was anxiety around client confidentiality and sharing information. I joined the service in June and, since then, I have realised that a lot of effort had been put into working with the groups around strategic stuff and funding, and where we needed to go, then, was building relationships with the groups in terms of managing the client journey. I have started to engage on a regular basis with some of the larger movements now as I continue with the other groups in terms of how we can channel queries about clients and make sure that the processes and systems are seamless to the client and that we are all working to the same end. That work has started.

Mr Spratt: I hear what you say but, apart from a group set up, we have not got very many answers about what happened two or three weeks ago. That is disgraceful, to say the least. I do have to say to you that, in terms of some of the other areas — and you mentioned the various streams — whenever an assessor is assessing somebody, it may well be, as I think you pointed out, that they may well be able to get assistance from one of the other schemes. Why does your end not say, "Well, you need to apply or we need to put you into this scheme", and do the whole thing at once, instead of bringing people back and back to continually re-traumatise them?

Mrs Dorbie: I am not aware of that specific issue, but if it is happening, I am sure that it will flow through to the project board —

Mr Spratt: I suppose one might be pain, one might be help with mental needs, one might be help with — as you mentioned — household bills, and stuff like that.

Mrs Dorbie: The individual needs review is designed to do that.

Mr Spratt: Is it doing that?

Mrs Dorbie: Yes, we have examples of where it works very well in being able to provide that care package. If it is a psychological need, we can work with a victims group to do that. You will see from some of the information that Sara has provided that around 50% of the people who come to us do not want to go to a victims group, so we have to be able to respond to it in that way as well. It is about tailoring that package, and that is resource-intensive. That is something that I have learnt, and it is different from the memorial fund. The memorial fund was transactional in the way that it dealt with individuals; this is more resource-intensive, because it is about tailoring packages to suit a particular person's needs. That is more resource-intensive and it does take more time. It is about matching those services, whether that is in the statutory sector, funding from us, or one of our partner service organisations.

Mr Spratt: One final point. In some areas, clients are reporting delays in processing claims and then long delays between assessment and receipt of the full award. What is the average time from when the client makes the application, given that some of them have been getting payments for years? I would be more interested in that than some of the statistics that you have given us. What is the length of time in getting payment out to individuals who are in real need? If you were watching the television last night, I think that you would have seen some of that. It should come as no surprise that people from 20 or 30 years ago are now coming forward with their needs as they get older. So we need to move forward, and move much more quickly. What is the average time from assessment to the award going out to the individual? Is it one month, or is it nine months?

Mrs Dorbie: There are two different issues there in terms of scheme six. The financial assistance scheme is slightly different because you apply into that. It is not based on assessed need; there is a means test attached to it. I do not have the exact futures for that. However, 1,400 individuals are currently in receipt of that and have had their June and September award. Katrina has the statistics on the individual needs review.

Ms Hinfey: On the basis of the conversation we had last time, Mr Spratt, I did a little bit of work on compiling statistics and giving some context around that. As of last Friday, there are 718 clients waiting for assessment. The average number of requests for appointments, taken over a four-week period in September, is 81 a week; the number of individual reviews completed in that same period was 241, which is 60 a week; and, unfortunately, we have about nine did not attends (DNA) a week. The average waiting time for an individual appointment is sitting at 23 working days.

Mr Spratt: For the record, Chair, I am not sure I heard an answer. You said that you were getting a high volume of telephone calls — 400 or 500 a week, or daily, or whatever it was. There was also a failure to answer e-mails. What improvement has been made around that area in the past three weeks?

Mrs Dorbie: Katrina and I have drafted a service implementation plan. Certainly, I can assure you that —

Mr Spratt: I am not interested in plans. That is not a question I asked you, Anne. I asked you if you were now dealing with the telephone calls that you admitted to failing to answer, three weeks ago. Given that you have 37 staff, I think it is, are you dealing with 100% of the telephone calls that are coming in? Are you answering e-mails within an eight-hour period, or 24-hour period, or whatever it is?

Ms Hinfey: We absolutely took on board your very relevant points from the last meeting. One of the things that we realised very quickly was that our phone system was not set up in the best possible way to allow people to gain access. We have put a multi-skilled tier one team at the front of the organisation. What was happening was that there were multiple requests for information, and they were bouncing around the office: finance was here and individual needs were there. So, we have gathered together a team that can answer the majority of queries that come in. We have asked staff to do a same-day return. Even if we have not got the full answer on that date, we have asked them to keep the communication lines open and to make sure that the clients know that they are a priority at the top of our list.

Mr Spratt: Is that not a quite normal managerial response and one that should have been implemented from day one?

Ms Hinfey: I take that on board.

Mr Spratt: Thank you.

The Chairperson: What does a tier one team at front of office mean in real terms?

Ms Hinfey: It is a customer service-type help desk, so that there is a channelled journey through the organisation. Somebody looks after the client from when they enter; no matter what their request is, the staff member takes responsibility for getting back to them.

The Chairperson: They are people who know what they are doing.

Ms Hinfey: Yes.

The Chairperson: Can I go back to paragraph 1·13, members? This was the question:

> *"Are you currently receiving, or have you ever received support from any victim/survivor support group?"*

It is clear from the three columns that the majority are currently receiving support or have done so in the past. That leads to this question, which is about the tension between your duty to ensure that public money is spent effectively and efficiently and directed to the right people, and your recognition that whatever the process you put in play, it has the inherent risk of re-traumatising people by asking them to go through certain questions and responses. Given that the majority may have already received help from the memorial fund, for example, and, therefore, had their data stored, did they have to go through the same process as the people who had never presented before?

Mrs Dorbie: Not always, Chair. When somebody made a booking with us for a needs review, we endeavoured to get that information from the memorial fund as quickly as we possibly could. Those files are transferring only this week from the Northern Ireland Memorial Fund. It had to hang on to those files until it closed down — it closed down this month — in terms of the transfer of data. So, yes, we did endeavour to do that.

It was not always possible, but, quite often, we found that people were willing to share their story with the assessor, regardless of having that information on file. So we did try to do that, and we were able to say that the individuals had availed themselves of x, y and z from the fund, and we asked them if we could continue that therapy for them. Say for complementary therapies, if somebody got that from the fund, we continued it without any break in the therapy. We were able to tell them to get their therapist to provide us with a schedule, the cost and the type of treatment. That went along with pain management also. We tried our best not to have any break in service between ourselves and the memorial fund. That was achieved for the majority of clients.

Mr Lyttle: Thank you for your presentation. As Jimmy has said, a lot of the issues are well known, to a certain extent, but it puts the seriousness of the issue that we have to try to help with in very, very clear, stark information terms.For what it is worth, I acknowledge that victims' groups have welcomed the introduction of the client manager to the service. I also acknowledge that the service has been responsive to individual cases that I have raised with it on a constituency basis. That does not mean that all of those cases have been resolved — there are difficult issues to work through — but I raised a lot of concerns at our last meeting, so I want to make sure that I acknowledge the good work that is happening on record as well.

The data that is being produced shows that the average age of a client is 53. So, as we well know, we do not have a whole lot of time to get this right. That informs a lot of our urgency in relation to this. Around 70% of people have expressed financial need, and 70% of people surveyed in relation to the financial assistance regular allowance responded to that survey. That is a really high response rate, which, I would hazard, means that that assistance means a heck of a lot to people. One of my major concerns was the way that that scheme had to be capped at the end of June this year. The concern over how that scheme will be reactivated and properly resourced for you to be able to extend it to people is as much one to put to the Department as it is the service. How will all of these findings help to inform future service delivery?

Mrs Dorbie: As the Chair quite rightly pointed out, it is for the commission to provide advice to the Department and Ministers and it is for Ministers to decide on the policy. Why was it so important for us to gather this data set, which was done internally by our staff? It is about mapping service provision and looking at the complexity of needs. The policy of having no caps for chronic pain is working really well; it is a really good benefit of what happened at the memorial fund and means that we can respond to more complex needs and that there is a lot more flexibility around how we do so. Sara already alluded to the fact that the level of post-traumatic stress disorder (PTSD) and mental health needs is not a shock to many people around this table. However, what is coming through is the complexity of that. How can we get the supply to meet the demand that we can so clearly see? On occasions, that can mean outsourcing, because some individuals do not want to go to victims' groups.

In the service, we are very clear that, for the service to work and be effective over the coming years, the interventions must be tailored at three different levels: the individual level, the family level and the community level. It is good that the service has the funding streams and can gather the evidence around those three pillars. We can provide assistance through therapies, and that is wonderful, but if the individual comes out and is not supported by their family or community, the assistance will not work. So, we have to make sure that we tailor the packages to those three levels and provide good information to the commission and the Department about making those decisions. We are very clear around that.

Certainly, we have some work to do around family, and some of this information shows how people are, or are not, supported at those three different levels. It is really important that when we are giving information for policy to the commission, looking forward from 2015 on, we consider what the programmes are likely to look like. So, that information is very important at this level.

Mr Lyttle: Obviously then, there is a need for the Victims and Survivors Service to work closely with the Victims' Commission and the Department. The Victims' Commissioner offered to facilitate a round table between the Victims' Commission, the Victims and Survivors Service and the Department. I think that members of this Committee would like to participate in that as well. Are you committed to engaging in that type of work to make sure that all the organisations that are working for victims work together to achieve better outcomes?

Mrs Dorbie: We are absolutely committed to that, Mr Lyttle. As I said earlier, the Department will explain a little bit more about a project board that has been set up. We are very keen to get that feedback, and we are very keen to implement anything that flows from that.

Mr Attwood: I broadly agree with the sentiment expressed by Jimmy Spratt. Virtually everything I have heard since the last time you sat there has confirmed my view. I have to be honest with you and say that. It is also confirmed to me by some of the language and tone in the letter that you sent to the Committee, which concluded that, because of what happened at the last hearing, people who may have come forward to avail themselves of services for the first time in many years may now have withdrawn as a result of the events of last week. I have met victims who have withdrawn because of events in the weeks and months beforehand. To put as your concluding comment, as your flourish, that people are withdrawing, which they may well have done, because of the events at the Committee hearing, without acknowledging that people withdrew previously, is not the full picture and is a partial commentary, which does not reflect well on the VSS. I would have thought that, coming into this Committee, you would have some commentary to make in that regard. Just as you indicated in your letter that you were contacted by victims who were distressed, a range of groups contacted after those hearings were distressed at the evidence that was given by the VSS.

Coming back to the survey, I will try to draw out concerns that structurally exist around the service. The Chair quizzed you about the skills of those who use your service. A number had relatively poor literacy skills, for example, which you referred to Miss Templer. If that is what you picked up in your survey, how do you ask people, after they engage, to fill out a monitoring form with questions that verge on the ridiculous? I am getting multiple complaints that they are being asked to fill out a monitoring form with questions that seem to have no relevance in any shape or form to what is happening, such as, "Do you find it useful to have a day out?" Why are you asking people those questions at all; and why are you asking people those questions when your own survey indicates that there could be poor literacy skills?

Mrs Dorbie: I think that you are referring to the monitoring and evaluation that is part of any process that we have to go through to ensure the outcomes. We are measured; the Department sets us targets as well. Monitoring and evaluation was highlighted as an area that needs looked at. I assure you that that is on the agenda of the project board. We are happy to look at it. A working group was set up to —

Mr Attwood: Do you recognise that the form that you are asking to be completed has questions that are simply not relevant and are actually causing distress? Whatever the level of monitoring that you are required to conduct, this is asking people time and time again, after engagements with your service, questions that really do not inform anybody about anything.

Mrs Dorbie: I think that the best thing for us to do is to take that away. It was highlighted and is absolutely on the agenda of the project board in terms of the overall monitoring and evaluation.

Mr Attwood: Do you acknowledge the point that I am making, as opposed to, "I am going to go off and look at it"?

Mrs Dorbie: Yes, absolutely. I acknowledge the point that you are making.

Mr Attwood: Do you think that it is a valid point?

Mrs Dorbie: Yes, I do.

Mr Attwood: You indicated that the survey revealed levels of mild to severe depression and that people were evidencing trauma. You will know that a lot of people differ with you about the specialist interventions for people suffering with mild to severe depression and trauma. You have to have a fully supportive environment for those who need specialist support. I am being told, and not by one or two individuals, that the services that you direct people to, whatever their value, whether cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR), are not in many instances the models that are required here, when the scale and circumstances of trauma are different from those models, which may work in other contexts, for example following car crashes in Britain, where they were piloted. How do you deal with that question?

Mrs Dorbie: I am not a clinician, Mr Attwood. I can say that we operate to the NICE guidelines, which talk about EMDR and CBT being the front line services for PTSD. Katrina can tell you a bit more. Our stage 2 assessments are carried out by a clinical psychologist. So, they are perfectly well qualified to make those judgements.

Mr Attwood: Will you deal with the specific point that the growing view among victims and in victims' organisations is that, whatever the value of those models — I am not saying that they lack value — they are not the models that need to be deployed in a range of victim cases? That is because the character and background of trauma here differ from those where the models were piloted. I am not a clinician, although I may have some questions about your clinicians shortly, because that is something else that I am picking up on. They may comply with NICE guidelines, but do you accept that there is a good view, and an authoritative view from clinicians as well, that many victims and survivors require therapy beyond and different from those models?

Mrs Dorbie: Before Katrina comes in, I will say that, again, that is something that the project board will be able to look at around the types of interventions going forward. I assure you that we get the best possible advice. It is one of those situations where people can differ in terms of any therapy that is recommended.

Ms Hinfey: I agree that it is not a one-size-fits-all. It is important to note that it is business as normal for our group partners when it comes to people who want to access any type of support or counselling there. People who go through the stage 1 assessment and are offered the opportunity to engage with a clinical psychologist and want that will go on to the next step. If they do not want to continue, they are free to return to their group or to disengage —

Mr Attwood: Is it not the case that there is a sense around the VSS that the preferred model of therapy is CBT and EMDR, which also happen to be the specialisms of one of the people who advises your organisation, Michael Duffy, who was here previously, and that is actually a one-size-fits-all approach?

Mrs Dorbie: Michael does not perform any therapies for our organisation. May I bring you back to the fact that the commission has given advice to Ministers on the issue of mental health, and it recommends both those treatments for front line PTSD, in accordance with NICE guidelines? I think that it is a debate that is bigger than just here. The psychological therapy strategy in the Health and Social Care Board is taking forward these issues as well. Your point is absolutely valid and something that we should encourage the project board to look at.

Mr Attwood: I will come back to the project board in a second. Will the extra money allocated be spent by services for which there was no full public tender?

Mrs Dorbie: No. It is bolstering the schemes that we are already supporting, and we have exceeded those targets.

Mr Attwood: Is it not the case that the contracts were awarded without tender?

Mrs Dorbie: For psychological therapies, one direct award contract was approved. It went through procedures in accordance with all Department of Finance and Personnel (DFP) guidance and was signed off by the central procurement division.

Mr Attwood: I am just putting on the radar, Chair, that I think that there are questions to be asked about the award of contracts. Whatever thresholds were satisfied in DFP and elsewhere, there are questions about how those contracts were awarded.

Your answers today — Mr Spratt picked up on this — related to project boards, service implementation plans and processes. What worries me is that that comes across as technocratic in a situation where you are dealing with human needs that are immediate, emotional and real. That is where, I think, my sense of your organisation falls down; that that sense of the experience is not critical to elements of the work that you conduct.It manifests itself in all the different ways that have been rehearsed at length. I do not get the sense that that has been fully acknowledged yet.

Mrs Dorbie: Absolutely. The client journey is very important to us, as is the user perspective. We all engage with individuals regularly, every day, and we try to make the client journey the best that we possibly can. I think that it is important that we go back to those end users again and again and ensure that they have the best possible experience that we can give. We are looking at ways of doing that directly. Now that we are moving into the second half of the year, we will be able to spend more time doing that. It has been extremely busy. We have exceeded all of our estimated numbers, and it is extremely useful that we got the additional bid in order to meet further demand. However, I absolutely accept your point, and we will work harder at seeing it from the client's perspective.

Mr Maskey: I will follow on from what Alex suggested earlier. If somebody is suggesting that there are human problems, I do not think that it is enough to say that questions need to be asked; they should be asked. I think that it is unfair to everybody at the table to leave that hanging in mid-air.

Mr Attwood: There are officials about to come forward to whom we can put the questions.

Mr Maskey: That is fair enough. If questions are being suggested, they should at least be put so that the rest of us can deal with it. We all have responsibility here, so if somebody has information, suggestions or evidence that there is a problem, we need to be advised of that. That is why I am saying that it should not be left in mid-air as it was a minute ago. Thanks for that clarification.

I am loathe to get into questions and answers on all of this for a variety of reasons, but I have my own direct experience, I have listened to people, and I have raised some stuff here recently. First, I satisfied myself that the Department was going to get on top of this, one way or another. I was not suggesting that I was making a judgement for or against anybody. I know that that has been suggested behind the scenes, but I have my own views on it, and I am quite able to raise my views. I simply wanted to give the officials the opportunity to sort out what are clearly problems that have to be addressed. I satisfied myself that not only was the Department going to have a programme board that would meet monthly, but it will meet more regularly. It is now meeting fortnightly, and I am very pleased about that. I am very pleased with some of the officials who have been appointed, because I think that they are very highly recommended and efficient, so I am satisfied that we will get to the bottom of all this. Clearly, everybody here has their role and responsibility to service the needs of the victims and survivors out there. I hope that, at some point, we can get back to as positive and constructive an agenda as possible, notwithstanding the fact that we have to address outstanding problems.

I say to Anne and her colleagues that my direct experience with people who have engaged with the service over the past period is that it has been quite a negative one, and I am being generous. That is not to say that everybody's experience has been like that, but a number of people have come to me, groups and individuals, to express concern. That has been about everything, including being asked all sorts of questions, all over again, when they thought that the answers were already in the system — they should have been in the system. Some representatives of groups have basically been told to mind their own business, as it was nothing to do with them, or words to that effect. All of that has to be resolved and tackled. Katrina, you were explaining that some things will be done differently. I am not so much concerned at what happened in the past month or two months ago; I am more concerned about getting it fixed. I want to make that clear.

One thing that concerns me is that we are dealing with surveys and research, but I would have thought that it was the responsibility of the commission to conduct the research and advise accordingly. The officials will be here, and I am hoping to move quickly to the positive end of this, but I have a question for Anne. In designing the surveys and responding to victims' needs, there is the commission. I know that, the last time you were here, you referred to meeting the commission. I will not rehearse how you characterised it, but you acknowledged that meetings were going on. As regards those meetings, I am keen to know about how you develop and provide the service. What was the substantive engagement with the commission and groups such as the victims' forum? There is a service group within that that is to be represented; it has agreed protocols on how to handle the issues and represent itself collectively, albeit on the understanding that it knows that it does not represent all victims. Nevertheless, it is structured, set up and established as a bona fide group that represents victims and works through the commission. Has there been substantive discussion with the likes of the service group and the victims' forum, for example, as to how these things are designed, shaped and improved on, where problems have been identified?

Mrs Dorbie: We meet the commission every month. We met the forum service's working group, and we had a good, lengthy session in December. We presented at one of its meetings in January; the commission held a policy event in the Spires centre that focused largely on the individual needs review process. That has been at its most productive, if you want to put it that way, since April. We were due to meet the service's working group last month to talk about commission-based service modelling. That was to very specifically ask that working group, from the users' perspective, what that may look and feel like and what its views were. I am trying to remember whether we have had a meeting in between; I do not think that we had one since December until that point.

Miss Templer: They certainly gave us very helpful feedback on the wording of the literature that we distributed on the individual needs review process.

Mr Maskey: Given that there have been problems and complaints throughout the year, as you have acknowledged, do you accept that it might have been useful to proactively seek some of those engagements again?

Mrs Dorbie: Yes, absolutely.

Mr Cree: You have identified here, in your words:

> *"The indication of the prevalence of post-traumatic stress disorder".*

We know from the Health Minister that we have the highest incidence of post-traumatic stress disorder; "in the known world" is the term that he used. My experience of that area of work and trying to find satisfaction in it is that it is just rubbish. Have you identified that need? Is there a need for a dedicated centre here? Someone mentioned the pain clinic. I had to go to the Health and Social Care Board to get someone referred to a pain clinic; I think that it was in Bath. Do we need a dedicated service for that particular area of the work?

Mrs Dorbie: There is no doubt of the prevalence of post-traumatic stress disorder. It has been borne out by all the work that, as you will be aware, has been done by Mr Bolton and Dr Duffy and many others. We work very closely with Ciaran Mulholland and Dr Duffy, and we have had meetings with Gerry Leavey from the Bamford Centre for Mental Health and Wellbeing as well.

I work very closely with the Health and Social Care Board on these issues, and anything that we do dovetails with the psychological therapy strategy. Katrina has already mentioned the fact that demand outstrips supply, and that is a difficulty that we have. If I am being very honest, one of the issues that we want to bring to the project board is that, when you invite someone to a needs review and you flow them to a psychological assessment, there is an expectation that therapy will quickly follow through. We are trying to identify, through our skills audit that you will be aware of, where that capacity lies and the skills of the individuals.

There is a requirement to develop a lot more work in this area, particularly research. Again, we have already had conversations with the commission, the Department and others on that issue. However, that is not our role. All we can say is what we can see in presenting findings. I think that there is insufficient supply, but that will come as no surprise to anyone here.

You will note from the statistics that around 50% of the people who come through are already known to mental health services. We need to get a better handle on that. These are individuals who may have had CBT, EMDR and counselling or other therapy, and it has not worked. They are back with us, and they are expressing a psychological need again. A lot more work is required around the complexity of that PTSD.

Sara has told you about some of the things around multiple incidents, which, again, leads to complex grief. There are families who have had multiple bereavements, and we need to do a lot more work around that issue. Through the gathering of this information — the commission does have it, and we have shared it with others, particularly in the Health and Social Care Board and the Department of Health, Social Services and Public Safety (DHSSPS) — we need to get a bigger and better response moving forward. Certainly, as the service moves into the next year, that is something that we will be looking at. How do we open up those therapies for individuals and make sure that when we bring someone forward we can support them in that way? We work very closely with our partner organisations and many victims' groups in that area. As they have said, they are aware of individuals for whom they cannot provide a response in that area, so they come to us, looking for something around that.

Mr Cree: There are at least two dedicated units in England and one in Scotland. Considering that we have the highest levels, that is, surely, evidence enough that we need to be doing more than just talking about it.

Mrs Dorbie: I certainly support that view, given the complexity of trauma here.

The Chairperson: Anne, would it be possible for you to write to us? We are seeking a couple of specific answers on the survey, one of which was the cost. Jimmy, is the other question on the timeline?

Mr Spratt: The cost on the length of time that the survey took.

Mrs Dorbie: I can certainly do that. For this survey?

Mr Spratt: Yes.

The Chairperson: Sorry, Jimmy, do you mean the length of time that an individual had to sit to go through the survey?

Mr Spratt: I think that you should know the entire costings of the whole thing.

Mrs Dorbie: Of what has been submitted to you today?

The Chairperson: Yes.

Mrs Dorbie: That is a data set that we gathered, so it would be staff time. I can certainly get it for you.

The Chairperson: And, how long it takes an individual to go through the process.

Mrs Dorbie: Just so that I am absolutely clear going away, is it the individual needs review?

Mr Spratt: And the length of time.

Mrs Dorbie: For an individual needs review?

The Chairperson: Yes.

Mrs Dorbie: On average, it is an hour.

Mr Spratt: No. The report that you presented to us today.

The Chairperson: Do you mean how long it took to compile that report?

Mr Spratt: Yes, and the cost of it, while victims wait. That is what I want to know.

The Chairperson: Finally, there is a question that has been out there for a long time. We know that a large number, possibly the majority of victims and survivors, have never come forward to any group or the memorial fund, for reasons we do not know, but which could be very valid. How many of them do not come forward because they have made a conscious decision of looking at what is available and basically saying, "Thanks, but no thanks"? How many have not come forward because they do not know that there is something out there that would not only be of use to them but of which they might like to avail themselves? Are we getting any closer to understanding where the dividing line is between those two groups of people?

Mrs Dorbie: Of the 800 to 900 reviews that we have carried out, about 300 or 350 people have never been known to the fund or groups. They are coming forward for many different reasons, largely, I suggest, around psychological need. Again, they are people who may have been known to statutory services for a while, due to mental health needs.

Ms Hinfey: It is important to couch in reality the fact that only about 17% of the people who come forward for an initial assessment move forward into a stage 2 psychological assessment. Many people are already engaged with groups and statutory care. We know that 314 of the 1,952 people who have been through the process are completely new. We do not explore what obstacles or barriers might have presented to them before.

The Chairperson: OK. Sara, Katrina and Anne, thank you again.