7 COMPARATIVE ANALYSIS

7.1 Introduction

This section of the report outlines the main findings of our comparative analysis of best practice in respect to service provision for victims of trauma. In conducting our research we have analysed best practice from a number of perspectives, and the findings of our research are presented in this section as follows:

- Some practical examples of service approaches on an international basis;
- Some practical examples of best practice approaches to service provision for victims of the conflict, drawn from our analysis of current service provision in Northern Ireland; and
- A summary of the key learning points from our best practice analysis.

7.2 International Comparative Analysis

The comparative analysis of specialised trauma and support services for victims included desktop research of war-torn countries like South Africa, Israel, Bosnia, and areas of South America. Outlined below are some brief outlines of current methods of service provision in each of these countries.

7.2.1 South Africa

i) The Trauma Centre for Survivors of Violence and Torture (TCSVT)

The Trauma Centre provides services to individuals, groups, families, communities, and institutions that have experienced, or been affected by, violence and human rights violations. Through service delivery in counselling, training, and advocacy they continually seek to draw on professional experience to develop appropriate innovative services in order to facilitate healing and to build a culture that is sensitive to the needs and rights of survivors of violence. Their main activities include treatment through counselling and advocacy services, training in trauma counselling and management for training front-line workers in the community, and prevention (i.e. through various forms of advocacy, participation in victim empowerment structures). The Trauma Centre has a variety of sources of core funding and a multi-disciplinary team of health professionals. It offers a team comprised exclusively of clinical psychologists and clinical social workers available free of charge for counselling and psychotherapy.

ii) Trauma Clinic – Centre for the study of Violence and Reconciliation (CSVR)

The Trauma Clinic aims to alleviate the effects of violence through the provision of trauma-counselling services to adult and child survivors, and to contribute towards victim empowerment initiatives through training and capacity building, research and advocacy. The Trauma clinic provides group

therapy, individual counselling, play therapy, debriefing, court preparation, psychiatric management, psychometric assessments and parent counselling services. It also is involved in training and capacity building for key front-line workers, outreach activities, a volunteer programme and research.

iii) Themba Lesizwe

Themba Lesizwe is a national network of trauma service providers. The aim is to provide counselling, training, research and advocacy in order to meet the needs of survivors of violence in disadvantaged communities. The Programme for Survivors of violence (PSV) is one of the founding members, along with the Centre for the Study of Violence and Reconciliation (CSVR), National Peace Accord Trust (NPAT) and Trauma Centre for Survivors of Violence and Torture (TCSVT). Funding from the European Union allowed for expansion of this network.

7.2.2 Israel

i) NATAL – Israel Centre for Victims of Terror and War

This organisation was established in 1998 to treat Israeli victims of terror and war, and is striving to bring the subject of trauma and its treatment to wide public awareness. It is a non-profit, non-affiliated, a-political association. Its goals are:

- To provide emotional and social support to people who suffer from the Israeli-Arab conflict;
- To enhance public awareness to the subject of national trauma in general, and awareness of those at high-risk in particular;
- To enhance awareness to the subject among psychological health care professionals;
- To prevent post-traumatic reactions through education and preventive training;
- To encourage research about the prevention and treatment of trauma; and
- To document, collect and archive personal stories.

Natal's therapeutic model is based on a multi-dimensional concept which sees the mental injury caused by national trauma as influencing and being influenced by four levels, namely:

- **The Individual level:** The way the patient confronts and deals with his emotional, cognitive, behavioural and inter-personal reactions, stemming from their injury and its consequences.
- **The Family level:** The influence of the injury on the immediate family, the family of origin, and the familial patterns of behaviour and interaction in relation to the injury.
- **The Group level:** The patient's place among their peers, their colleagues at the work-place, and the social group he/she belongs to.

- **The Social level:** The recognition (formal or informal) by society of the injury, how society relates to it on the national level, and the subject of collective responsibility.

Through its multi-professional team, Natal offers a variety of services aiming at these four levels. Examples of therapeutic services would include short and long term Individual Psychotherapy, Couples and Family Therapy, Group Therapy for people with a feature in common, A Social Group during the day and late evenings, under professional supervision, Non-verbal treatments such as arts, body movement, music, yoga, etc., and the use of alternative therapies. Natal also offers a preventive aspect that includes psychological interviewing and debriefing, and programs aimed at enhancing the ability to cope with emergency situations and stress.

7.2.3 Eastern Croatia, Bosnia and Serbia

i) The Coalition for Work with Psychotrauma and Peace (CWWPP)

The CWWPP sees the problem of psychotrauma in its area of work (parts of Eastern Croatia, Bosnia, and Serbia) as one element of the breakdown of society that resulted from the wars of dissolution of Yugoslavia. Other aspects are displacement of people from their homes, unemployment, destruction of physical infrastructure, increase in chronic disease, and poverty. The CWWPP's model for post-war social reconstruction and reintegration rejects a fragmented approach that gives attention only to one part of the problem. It also rejects a short-term "quick fix" approach. Rather, CWWPP has designed a "Complex Rehabilitation" strategy. This is an intensive, integrated, long-term approach that includes therapy, capacity building within the community, and research. The elements included in this approach are:

- Training of local professionals and non-professionals and the population as a whole in psychotrauma relief assistance (including peer-group counselling), non-violent conflict resolution, community organisation, critical thinking, and self-reliance as well as in such essential skills such as communication, organizational management and coordination.
- Training the population as a whole in skills of psychotrauma relief (including peer-group counselling), non-violent conflict resolution, community organisation, critical thinking, and self-reliance.
- Training activists and patients in essential skills such as communication, organisational management and coordination.
- Involvement of the population in making plans for the development of the community.
- Work on reconciliation at a speed appropriate to the situation and the people involved.
- Encouragement of the formation of local initiative groups, and the formation of coalitions among these organisations.
- Intensive study of the epidemiology of the mental and physical health epidemiology of the population on a long-term basis.

The organisation's work is to engage a group or a community in its own future and employ a multi-level approach to addressing problems. At the core of this approach is a strategy that emphasises the development of civil society institutions. These grassroots institutions, armed with the skills and training provided by CWWPP, give people the tools with which to solve their own problems. Part of this strategy is to work at the levels of the individual, the family, the group, the community and, eventually, the society.

7.3 Examples of Good Practice in Northern Ireland

In sections 3 and 4 of this report we outlined current health and social services provision to victims of the conflict. As part of this analysis we identified current models of service provision. This sub-section of our report seeks to identify which of the examples of service provision presented in sections 3 and 4 represent 'good practice' in respect of health and social services for victims. Our conclusions in this respect are drawn from the outcome of formal evaluations (where such evaluations have been undertaken), or based on our objective judgement.

Summary of Northern Based 'good practice' health and social services for victims of the Conflict

Service Model	Responsible Organisation(s)	Outcome of Formal Evaluation (if undertaken)
Dedicated counselling service for victims of the conflict. Service Provision located in the three HSS Trusts areas in the SHSSB. Counselling Services provided in conjunction with NOVA and Craigavon and Banbridge HSS Trust.	Recurrent funding from the SHSSB. Provision of service facilities by the three HSS Trusts in the Board area.	Core Evaluation Approach applied. Findings from evaluation indicate that those who accessed the counselling service experienced a positive effect from the outcome.
Child Bereavement Pilot Project. Project aims to provide support to children and their families in cases where the child has suffered a traumatic bereavement. The project included the development of a range of information guides including: Parent Information; Traumatic Grief Stress; Dealing with Traumatic Grief Stress; Schools and Traumatic Grief Stress; and Other Services i.e. the coroner	Eastern Area Trauma Advisory Panel.	No formal evaluation yet undertaken. Informal feedback on the project is very positive.

Service Model	Responsible Organisation(s)	Outcome of Formal Evaluation (if undertaken)
Effective CBT as a treatment for PTSD	Northern Ireland Trauma and Transformation Centre	International research and formal evaluation of the approach applied demonstrates the positive affect of CBT as treatment for PTSD. Initial research on the costs of non-treated PTSD demonstrates that significant financial benefits could be realised from treating the cause of CBT rather than symptoms (i.e. physical systems).
Provision of Family Therapy, Outreach Services (one with a statutory body and one with a voluntary agency) and support for other health professionals in respect of training and service development	Family Trauma Centre North & West Belfast HSS Trust Survivors of Trauma	Formal patient satisfaction studies conducted which demonstrate that the majority of service users report positive individual and family affects following therapy and treatment. Views from external stakeholders (who either refer to the Centre or have arrangements for outreach services) demonstrate satisfaction with the services provided.
Community Victims Support Programme Provision of self-help groups, capacity building, training and advice and awareness raising.	Sperrin Lakeland Trust	External evaluation of programme conducted in December 2001. Evaluation findings demonstrated the success of the programme.
Provision of Psychotherapy services and facilitation of CBT training in partnership with the Psychotherapy and Counselling Network	North and West Belfast Trauma Resource Centre Psychotherapy and Counselling Network	No formal evaluation has been undertaken, but informal feedback on the partnership arrangement is positive.
Provision of Trauma Centre facilities to provide structured adult work group for victims of conflict.	North and West Belfast Trauma Resource Centre Wider Circle Group	No formal evaluation of the service has yet been conducted, although informal feedback from service users is positive.

7.4 Learning Points of Best Practice Research

Based on the findings of our comparative analysis and the collective analysis of all the information gathered during this evaluation there are strong parallels between the learning points of international experience and Northern Ireland specific experience in respect of provision of health and social services to victims. On the basis of our analysis we have produced an overall summary of the salient elements learning points in respect of services to victims. These can be summarised as:

- There is a need to inform/formulate strategies and policies by primarily developing an understanding of the origins and dynamics of violence within the specific context of the victims.

- Recognition is required amongst society of victim issues and collective responsibility for issues.
- Service provision should be based on needs assessment.
- Provision is required for short-term and long-term treatment and counselling for individuals and groups and communities.
- Different therapy approaches are required at different levels with complementary skills sets.
- Increasing use of complementary therapies.
- Prevention of re-victimisation of survivors and victims of violence through provision of training, advocacy and victim awareness.
- Trauma services for children who have witnessed or experienced violence. There is a need for a transgenerational focus and long-term planning. For example, the Trauma Centre in South Africa introduced a pre-school children's violence intervention programme.
- Interagency, community, collaborative and multi-level approaches are required.
- Partnership working between statutory and voluntary agencies is more likely to achieve an affect at the "grass roots".
- Use of community based approaches/community advocates to reach the "grass roots".
- Continuing need for research, funding and specialised, trained staff.
- On-line access for victims to resources on service provision and evaluation.
- The complexity of cases and need for staff to work as cohesive teams necessitates the design of case management systems, so as to address individual needs as well as to attempt to address the client's social circumstances and facilitated interventions through community structures.
- Interaction with schools and workplace per se.
- Need for victims to tell their story, e.g. Truth testimonies in Guatemala.
- Capacity building, research and education.
- Inter-agency training approaches to increase knowledge and foster trust across sectors.

8 EVALUATION THEMES AND GAP ANALYSIS

8.1 Introduction

This section of the report identifies the conclusions drawn by Capita on the evaluation of services provided by the HSSS to victims of the conflict in Northern Ireland. These conclusions are classified as themes which have emerged and gaps which can be identified.

8.2 The Role and Location of the Trauma Advisory Panels (TAPs)

The findings of the evaluation indicate that there is still a lack of awareness amongst some stakeholders of the TAPs and a lack of understanding of their role. In addition, the name of the TAPs does not automatically generate an association of the role of the TAP in coordinating services provided by health and social services to victims of the conflict. **There is a need to raise awareness of the TAPs, re-establish their role and consider a name change which more appropriately reflects their function.**

Membership of the TAPs is variable across Northern Ireland, but still more heavily weighted towards statutory sector membership. **There is a need to consider more innovative ways in which to encourage increased TAP membership from non-statutory sector groups which represent victims of the conflict.** It should also be noted that the ability of voluntary groups to be involved is also compounded by the individual group capacity issues.

Responsibility for victims' issues is cross-departmental and is not merely a health issue. The 'parent' NICS department of the TAPs is DHSSPS, with funding for the TAP Coordinator posts from OFMDFM. **It is our view that consideration should be given to most appropriate 'parent' NICS department for the TAPs. Paramount in this consideration is the need to raise cross-departmental awareness and ensure all departments share collective responsibility for victims' issues.**

In our earlier analysis we identified that the TAP based in the WHSSB area does not represent the interests of the entire population of the WHSSB, but rather covers only the Foyle area and does not cover the populations of Omagh and Enniskillen. **It is our view that this current structure is not in line with the SSI or Bloomfield report recommendations, which endorsed the view of creating a TAP to cover each HSS Board area. In addition, the current arrangement creates potential for a gap in service coordination, given that there is no formal forum for victims or victim interest groups/service providers to input to HSS service planning and coordination. It is our view that this potential gap in service coordination should be addressed as a matter of urgency.**

8.3 Structures which Underpin Services

The evaluation findings indicate there is a lack of clarity regarding the structures which underpin services to victims of the conflict. In particular this applies to the roles of the Victims Liaison Unit, the Victims Unit and the Interdepartmental Group. With particular reference to the interdepartmental group those consulted were unclear about the membership of the group or its responsibilities. **It is therefore our view that greater clarity is required with regard to the central structures which underpin services to victims and the manner in which these structures interface with the TAPs, specialist services and mainstream service providers.**

8.4 Culture and Climate of Services

Stakeholders consulted during this evaluation indicated that their perception (having worked with victims of the conflict) is that Northern Ireland still suffers from a culture of denial in respect of victim issues. Whilst the profile of victim issues has undoubtedly been raised by the *Bloomfield Report, Living with the Trauma of the Troubles* and the publication of *Reshape, Rebuild, Achieve,* much still requires to be done to increase awareness of victim issues and encourage a culture of acceptance. This prevailing denial culture does not encourage victims to access services provided by HSS. In addition, health and social services for victims can still be 'politicised' and many of the stakeholders consulted with during this evaluation expressed the view that service provision decisions are often politically, not need based. **Future health and social services to victims must encourage a culture of acceptance and should also demonstrate transparency in service decisions, which should be need based.**

8.5 Progression of Service Developments

The findings of this evaluation have indicated that services for victims provided by HSS have developed at different rates across Northern Ireland. In many cases the profile of services across health and social services Boards is influenced by historic service commissioning and service provision decisions. There is significant variation in the provision of services locally and this could in some cases create inequity. **Future health and social service provision to victims should consider the need to ensure equity of service access and regional standards in respect of service provision.**

8.6 Service Provision

The evaluation has demonstrated that there are a number of layers in the current methods of service provision for victims of the conflict. Whilst the terms of reference for this review required the Capita team to focus more specifically on the specialist services, it would not have been possible to do so without reference to mainstream services, particularly given the high levels of service user access to mainstream services. In our view the main layers of service provision are:

- Primary Care;
- Mainstream Services (either acute or community based);
- Specialist services; and
- Voluntary and Community Group services.

Each of the above play a vital role in provision of health and social services to victims. However, the focus and activities of each are quite different. It is our view that all of the above have an equally important role to play in service planning and delivery**.** However, the evaluation has indicated that not all staff in each layer are properly equipped to provide services to victims of the conflict i.e. due to lack of awareness or skills. **The future service delivery model for victims of the conflict should aim to differentiate between the services which can be provided by each layer of service provision. In addition, a clear understanding is required of the relationships and interfaces between each of the above. This should be complemented by methods of increased partnership working and awareness of victim issues across all of those involved in the planning and delivery of services. It is also our view that consideration should be given to the methods which can increase the overall coordination of services to service users. This approach should not be restricted to health and social services only, but across all services with a role to play in meeting victims needs.**

The evaluation process has demonstrated that there is a lack of agreement across stakeholders in respect of the priority and location of regional services. The current profile of specialist services in Northern Ireland means that inequity of service access may exist in some localities. **Consideration should therefore be given to the manner in which future specialist service provision can promote equity of access across the entire population of Northern Ireland.**

8.7 Partnership Working

The findings of the evaluation have demonstrated some valuable examples of partnership working in practice. **However, consideration should be given to increasing this approach, particularly as a means of ensuring the individual skills and strengths of each layer of services is maximised.**

8.8 Specialist Skills and Training Resources

The evaluation findings have highlighted the high demand for training resources to support the provision of services provided to victims by HSS. Such training is required right across all service layers from general awareness raising and competent worker skills to CBT training. **It is our view that consideration should be given to the most appropriate methods to increase training resources. In addition, there is a need to address issues associated with accreditation and standards in the provision of training. There are also particular difficulties associated with the numbers of specialist skilled staff (i.e. Family Therapists). Future services should consider how the use of such specialist resources can be maximised.**

The future skills and resources of health and social services in Northern Ireland should also reflect the changing patterns of victims who now access services. For example, we are experiencing a move away from single large-scale incidents towards increasing numbers of incidents related to interface and intimidation issues. **It is our view that skill mix and training resources should reflect the service needs demanded by the changing pattern of victims presenting to health and social services.**

8.9 Research and Evaluation

The findings of the evaluation have indicated that much research has been conducted into the effect of the conflict on the population of Northern Ireland. However, to date no large-scale research has been conducted to evaluate the health and social needs of victims of the conflict. In addition, were smaller-scale pieces of research has been conducted to inform needs assessment, service development or as part of evaluation, research results are often not widely disseminated.

It is our view that future service provision models should be evidence based with processes established to facilitate the dissemination of research and evaluation findings.

8.10 Service Planning

Many of the stakeholders consulted during the evaluation felt that service planning decisions are ad-hoc and short-term, without adequate consideration to overall service provision in Northern Ireland and without reference to a long-term plan. **The transgenerational nature of victim issues means that a long-term plan for service provision and development is required.**

8.11 Funding

Health and social services are subject to continuing funding constraints. However, the majority of the stakeholders consulted during this evaluation highlighted insufficient funding as one of the key barriers to effective service delivery. Whilst we must take cognisance of other funding pressures and budgetary constraints **we do endorse the need to secure recurrent funding to underpin future service provision decisions in respect of HSS to victims. In addition, urgent funding decisions are required in respect of specialist services. Future funding issues are further compounded by the fact that other non HPSS funding (via NIO) has been provided to establish the NICTT and the current North and West Belfast Trust bid to BRO to establish the Trauma Resource Centre.**

8.12 Raising Awareness

The findings of the evaluation clearly indicate a need to increase awareness of victim needs and availability of services. In particular our analysis has determined that awareness of victim issues is lowest in the primary and

secondary care sectors. **One of the key challenges facing health and social services in the future is the manner in which awareness can be raised, whilst still managing the expectations of service users.**

9 EFFICACY OF SPECIALIST SERVICES TO VICTIMS

9.1 Introduction

This section of our report seeks to specifically address the efficacy of specialist HSS services to victims of the conflict. In this respect our evaluation is focused on the services provided by the Family Centre.

Sub-sections 9.2 to 9.4 present our analysis of the efficacy of the Family Centre. In this regard we identify the budgetary, funding and financial expenditure patterns of the centre. This is followed by our findings in respect of the effectiveness of the Centre with respect to meeting its objectives.

9.2 Financial Analysis of Family Centre

Table 1 below outlines total direct revenue expenditure and income for the Centre over the last 4 years. Other indirect overheads such as central administration costs are not included.

Table 1 – Summary Financial Statements

	1999/00 Actual £,000	2000/01 Actual £,000	2001/02 Actual £,000	2002/03 Actual £,000
Expenditure				
Salaries	227	279	319	305
Goods & Services	71	41	33	49
Gross Expenditure	**298**	**320**	**352**	**354**
Funding Sources				
EHSSB Funding	75	91	123	115
NHSSB Funding	91	91	93	96
SHSSB Funding	68	68	70	72
WHSSB Funding	64	64	66	67
Other Income	0	6	0	4
Total Funding Sources	**298**	**320**	**352**	**354**

Expenditure mainly comprises staff salaries and wages, with the remainder made up of general running costs. Gross expenditure has risen by £56,000 or 19% since 1999/2000, an average increase of 5% per annum. The increases in gross expenditure can mainly be attributed to increased salary costs and training costs.

9.2.1 Salaries Expenditure

Salaries expenditure, which typically accounts for between 75% and 90% of gross expenditure has risen by £78,000 or 34% over the last 4 years - an average of 8.5% per annum. In 2002/2003, salaries are expected to account for 86% of gross expenditure, up from 76% in 1999/2000.

Over the period w.t.e staff numbers have risen from 8.9 to 13.5 (with a difference of 4.6 w.t.e staff (51%)). Thus the average annual cost per w.t.e. has fallen by £3,000 per annum, to £23,000. It should be noted that this is due in part to the difficulties experienced by the centre in filling vacant posts. The centre currently has 4 vacant posts. Due to long-term funding uncertainties the vacancies are advertised with fixed-term contracts and as such are less attractive to potential applicants.

The average cost per w.t.e is shown in Table 2 below.

Table 2 – Average Cost per WTE

	1999	2000	2001	2002
Salary Cost (£,000)	227	279	319	305
No. of w.t.e staff	8.9	9.9	12.7	13.5
Average cost per w.t.e. (£,000)	26	28	25	23

9.2.2 Goods and Services Expenditure

Goods and Services expenditure has fallen from £71,000 to £49,000 over the same period and will account for approximately 14% of gross expenditure in 2002/2003. In 1999/2000, the opening year, goods and services costs were unusually high due to the initial set up costs of the Centre such as furniture and furnishings and special revenue. Since then, expenditure has fluctuated from £41,000 in 2000/2001 to £33,000 in 2001/2002 and will rise to £49,000 in 2002/2003 if the Centre continues to spend at the current rate.

The main areas where expenditure patterns have changed in the current year against previous years are in Training, Building Maintenance Schemes and General Services. During 2000-2002, training costs were approximately £20,000 per annum, or 6% of gross expenditure. In 2002/2003 it is forecast to be £4,000, or 1% of gross expenditure. The average cost of training per w.t.e. is shown in Table 3 below:

Table 3 – Average cost of training per WTE

	1999	2000	2001	2002
Training Costs	12,137	20,012	21,812	3,604
No. of w.t.e staff	8.9	9.9	12.7	13.5
Average cost per w.t.e. (£,000)	1,364	2,021	1,717	267

Training costs per w.t.e have historically been between £1-2,000 per annum. In 2002/2003 they are forecast to fall to £267 per w.t.e.

Expenditure on Building Maintenance is a new expenditure line and is forecast to be £19,000 or 5% of gross expenditure. General Services expenditure was previously very minor, at a few hundred pounds per annum. In 2002/2003 it is forecast to be approximately £4,000 or 1% of gross expenditure.

9.2.3 Income

Income is mainly derived from funding provided by the 4 health boards with a small additional amount being raised independently by the Centre. The Northern, Southern and Western Boards each make a contribution that is fixed at the start of each year leaving the Eastern Board to fund the residual balance at the year-end. The overall trend in Board funding is that the Eastern Board's contribution has risen from 25% (£75,000) to 33% (£115,000) whilst the other Board's total contribution has fallen from 75% (£223,000) to 66% (£234,000) since 1999/2000.

In detail, the Northern, Southern and Western Boards contributed £223,000 in each of the first 2 years of the project, leaving the Eastern Board to make up the residual balance of expenditure. In 1999/2000 the Eastern Board's contribution equated to £75,000 or 25% of gross expenditure. In 2000/2001 the balance required from the Eastern Board was £91,000, or 28%. In 2001/2002 the 3 Boards contributed £228,000 or 65% of gross expenditure, leaving the Eastern Board to contribute £123,000, or 35%. In 2002/2003 the 3 Boards will contribute £234,000 or 66% of forecast gross expenditure. In this case the Eastern Board's contribution will be £115,000 or 33% or gross expenditure.

9.2.4 Unit Costs

Based on the activity figures included in section 5 of this report it would appear that sessions undertaken by the centre are increasing i.e. the figures illustrate a projected 9% increase between 2001/02 and 2002/03. The average unit cost per session has been steadily reducing from £275 in 2000/01 to £256 in 2001/02 to a project cost in 2002/03 of £228. Typically sessions are 1hr in duration, although this is subject to variation. It should be noted that these unit costs are estimates which are based on total sessions undertaken and the gross costs of the Family Centre. The unit costs do not therefore take account of the percentage of staff time spend on clinical treatment activities as opposed to other activities such as training, consultation etc. In addition, a session could be with one individual or several family members. On this basis the unit costs provided should be treated with caution. However, the estimated unit cost per individual has also fallen from £165 in 2001/02 to £148 (projected) for 2002/03.

Table 4 - Breakdown of Unit Costs and Gross Expenditure 2000/01 – 2002/03

Year	Gross Expenditure	Estimated Unit Cost Per Session	Estimated Unit Cost Per Individual
2000/01	£320,000	£275	Not available
2001/02	£352,000	£256	£165
2002/03	£354,000	£228	£148

It is difficult to directly compare the unit costs per session of the Family Centre with other similar services (given that the Family Centre services are specialist by nature). However, it is interesting to compare these costs against some of the estimated costs for untreated trauma i.e. the public health cost. In work undertaken by NICTT in conjunction with the University of Kent the total cost of untreated trauma per individual per annum is estimated to be in the region of £8,100. This estimation is based on real-life case studies and was developed using cost indicators including that of contacts with GPs, inpatient hospital days, community mental health team services, prescribed drugs, lost working days etc. The NICTT have also recently undertaken some work to estimate the average cost of a CBT session. The most recent estimates of NICTT indicate that an average unit cost per CBT session is approximately £160. Based on current treatment regimes most clients require on average 10 sessions, with 2 follow-up sessions.

9.3 Effectiveness of Family Trauma Centre

Section 5.2 outlined the role of the Family Trauma Centre and its service provision and section 9.2 above outlined the financial expenditure patterns of the centre. This sub-section of our report is specifically concerned with evaluating the effectiveness of the Centre, and in particular comparing our findings against the Centre's objectives.

The centre was originally established with the remit to provide a regional specialist trauma service for children and families affected by the conflict. The specific focus of the Centre was developed from earlier work undertaken by the Young Peoples' Centre in South and East Belfast HSS Trust. The Centre's objectives are:

- Provision of Psychological treatment for those suffering from trauma using a wide range of treatment modalities;
- Provision of a consultation service, via a telephone on-call service or face-to-face;
- Delivery of training to staff (statutory, community and voluntary sector) in contact with those suffering from trauma. This training includes awareness raising, workshops and facilitation of training placements for psychology students etc.; and
- Undertaking research, evaluation and clinical audit.

In addition to the above the Centre has developed its role as a 'resource centre'. This has mainly been facilitated by the provision of library and the development of psycho-educational materials.

9.3.1 Family Centre Treatment Services

In section 5.2 we provided a profile of the use of the treatment services of the Family Centre. This profile was illustrated by the number and pattern of centre referrals and sessions/contacts[2]. Our earlier analysis illustrated that during 2001/02 and based on profiling 2002/03 activity to date, approximately 88% of the sessions/contacts undertaken by the centre are with EHSSB residents. During 2001/02 and 2002/03 (to date) the sessions undertaken with NHSSB residents is 10% and 11% respectively. During 2001/02 and 2002/03 (to date) there are only a negligible number of SHSSB and WHSSB residents treated by the centre.

It should be noted that in addition to treatment services provided at the centre's main building, the Family Centre also provide outreach services to North and West Belfast (in conjunction with Survivors of Trauma), a regular consultation service to Foyle HSS Trust and are currently working with Homefirst Trust to develop an outreach service in the Homefirst area. Activity in respect of outreach services is included in the figures provided in section 5 of this report.

The current 'Did Not Attend' (DNA) rate for the centre is 19%. However, higher DNA rates for services such as those provided by the Family Centre, can be anticipated (i.e. given that there is likely to be a high level of client anxiety and ambivalence). This is borne out by similar DNA rates with other international centres with which the Family Centre have links. Currently the Family Centre does not experience long waiting lists from referral to treatment, with an average waiting time of approximately 5 weeks. The numbers of those waiting for treatment at the end of each quarter is generally between 16-30.

Based on the historic and continuing patterns of referrals and sessions to the centre it is apparent that the centre has yet to attract significant referrals from across the entire region of N.Ireland, and is not yet meeting its original objective to provide a regional specialist trauma service. During this evaluation three of the HSS Boards (excluding EHSSB) expressed the view that the provision of services at the centre's headquarters in Belfast where not readily accessible to the majority of their population. It is our view that the services provided by the Centre have not been sufficiently flexible to facilitate equity of service access across N.Ireland. However, we recognise that the ability of the Centre to be flexible in this regard has been constrained by availability of resources. In addition, the Centre's ability to provide more flexible services is bound by it current remit to treat conflict related trauma referrals for children and families i.e. the Centre does not have the flexibility to treat adults (and no formal responsibility to treat non-conflict related trauma cases) and has not been resourced to provide such a service. It is our view that the current profile of service provision is not effectively targeting social need. It is also our view that increased outreach services (based on need) provided

[2] Sessions/contacts may include more than one individual i.e. several family members simultaneously

by the centre will improve the accessibility of regional specialist services, target social need and promote equity of access based on need.

Recent analysis of the type of referrals to the centre has indicated that approximately 20% of these referrals are now related to non-conflict related trauma. The staff of the centre recognise the need to treat such cases (even though it is outside the original scope of the centre's objectives), and as such treat such referrals where appropriate. In addition, it is often difficult to define clearly if a referral is conflict related or not i.e. in cases where there are multiple social and health related needs. It is our view that widening the scope of the centre's remit to include non-conflict related trauma would increase potential for the centre to be more closely integrated with mainstream services and in turn access new funding streams beyond those currently available.

We endorse the valuable work of the Centre in respect of the services it provides to children and families. However, It is our view that the effectiveness of the services provided by the centre could be further enhanced by extending service provision to adults as well as children and families. As it stands there is only currently limited HPSS funded services for the specialist trauma treatment of adults. It is our view (and that of the specialist staff of the centre) that the specialist skills applied to the treatment of trauma with children and families could also be applied to the treatment of adults suffering from trauma. In our view this would represent a more effective use of regional specialist skills, improve equity of access for the population of N.Ireland who require access to specialist trauma skills, and bridge a current service provision gap.

9.3.2 Family Centre Consultation and Training Services

The second objective of the centre is to provide a consultation service to all those in contact with clients who may be suffering from trauma (primarily conflict related trauma). This service is provided using either face-to-face consultation or an on-call telephone service. The service is available to the statutory, voluntary and community sectors. In addition, clients may contact the centre by phone for advice prior to making a decision in respect of referral. The centre has established a monthly/bi-monthly consultation service for Foyle HSS Trust. Other consultation services are provided based on demand.

The centre also provides a range of training services. These include information and awareness sessions, workshops, conferences, short courses etc. Training courses are open to all those in the community, voluntary or statutory sector who work with those who have experienced trauma. In 2002 the centre evaluated feedback from their annual conference, which was attended by 160 delegates. The feedback indicated that 89% of those who attended felt the conference was good or excellent and relevant to their work

The tables below illustrate the level of consultation and training services provided by the centre during 2000/01 and 2001/02.

Table 5 - Consultations and Training Provided by the Family Centre 2000/01 and 2001/02

Board/Regional	Number of Hours 2000/01	Number of Hours 2001/02	% Change
EHSSB	53	150	+35%
NHSSB	11.5	0	-3%
SHSSB	29	5	-16%
WHSSB	27	116	+10%
Regional	184	349.5	+53%
TOTAL	**304.5**	**620.5**	

The consultation and training services provided by the Family Centre have increased by nearly 50% from 2000/01 to 2001/02. In particular there has been a 35% increase in this service provided to EHSSB organisations, a 10% increase in this service provided to WHSSB and a 53% increase in this service provided to other regional organisations.

The stakeholders consulted with as part of this evaluation expressed the view that the training and consultation services they had accessed with the centre were of a high standard.

It is our view that the centre has made significant progress towards meeting its training and consultation service objectives. However, the majority of this activity is generated by regional demand (i.e. the Institute of Conflict Research, CRUSE, TAPs, Northern Ireland Human Rights Commission etc.) or organisations in the EHSSB and WHSSB areas. It is our view that opportunities exist for the centre to focus on building capacity in this area with the SHSSB and NHSSB. In addition, given the growth in the regional provision of consultation and training services (much of which is provided to non-HPSS organisations) it is our view that the centre should review is 'charging' policy in respect of such services provided to non-HPSS organisations.

9.3.3 Research, Evaluation and Clinical Audit

The centre employs a full-time Clinical Psychological Research Assistant and undertakes its own research, evaluation and clinical audit. The centre database has been live since April 2001 and the information can be extracted from it to assist in these tasks. During 2001/02 the centre conducted a service user telephone survey which provided very positive feedback about the services provided by the centre i.e. 88% of adults reported the service to be very helpful, with 80% reporting that they were coping much better following treatment than before attending the centre.

The centre has also provided data for other pieces of research work such as the Belfast Child and Adolescent Mental Health Service Project. The centre is involved (either through consultation or direct input) in several research projects such as those undertaken by:

- The Centre for Child Care Research;
- Community Conflict Impact on Children;
- Institute of Conflict Research; and
- University of Ulster.

The centre continues to develop and maintain its links with other national and international centres providing similar services. During 2002/03 the centre was able to employ a social worker from the Trauma Centre for Survivors of Trauma and Torture in Cape Town. This provided an opportunity for skills development and knowledge transfer between both parties. The centre has also developed links with the Clinical Psychology Training Institute in Denmark and has provided a practice placement for a clinical psychology student from the Institute. In addition, the centre shares information and continues to develop links with other appropriate organisations in Norway, Johannesburg and New Zealand.

It is our view that the centre has made much progress towards meeting its objectives associated with research, clinical audit and evaluation. However, should the scope of the centre alter in the future (i.e. beyond that of conflict related trauma services to children and families) the focus the research, evaluation and audit activities of the centre should also reflect any such change.

9.3.4 Planning and Monitoring of Activities

The centre produces an annual service plan which outlines the following:

- Purpose of service;
- Major achievement in last 12-18 months;
- Operational effectiveness;
- Clinical and social care governance;
- Service issues; and
- Future developments

Development of the service plan is led by the centre manager in conjunction with other centre staff.

As referred to in section 9.3.3 the centre conducted a user satisfaction survey during 2001/02. This survey was used as a benchmark to monitor current service delivery and as indicator for areas of service improvement. It is our view that the centre should apply an annual user satisfaction survey process. The centre has a formal complaints policy, but to date have not received any complaints from service users.

During July 2002 Dr Vetere, Consultant Clinical Psychologist and Principal Lecturer in Systemic Psychotherapy at Tavistock in London, conducted a staffing review of the centre. This review highlighted the difficulty experienced by Trainee Family Therapists. None of these trainees had a

background in mental health and they found it difficult to learn about trauma and treatment of trauma and mental health and undertake a full training programme in systemic family therapy simultaneously. In addition, the centre experienced difficulty in meeting the needs of so many trainees and the needs of staff on placement. On this basis the centre have a current commitment to training those on training placements, with qualified staff being the core team. The findings of Dr Vetere's evaluation also included concerns regarding the need to prevent secondary traumatisation amongst the centre staff. The evaluation also recommended an expansion of the multi-disciplinary team with an individual trained in Cognitive Behavioural Therapy.

The centre also regularly provides activity information to each of the four HSS Boards. This information includes a profile of referrals and sessions undertaken for HSS Board residents. In addition, the Centre provides a regular quarterly monitoring report to DHSSPS and a quarterly expenditure and budgetary statement to South and East Belfast HSS Trust, who manage the Centre's financial administration.

The current planning cycle of the Centre is annual and does not reflect a long-term planning cycle i.e. 3-yearly. However, we recognise that the Centre's capacity to plan long-term is reduced by uncertainty regarding long-term funding arrangements. In addition, the current Service Plan does not include any financial planning information. It is our view that future planning processes for regional specialist services should reflect a long-term approach with robust financial planning proposals. Section 10 of this report addresses in more detail our specific recommendations with regard to the planning and monitoring processes which should support our recommendations with regard to future service delivery arrangements.