DOMESTIC AND SEXUAL VIOLENCE AND ABUSE: FINDINGS FROM A DELPHI EXPERT CONSULTATION ON THERAPEUTIC AND TREATMENT INTERVENTIONS WITH VICTIMS, SURVIVORS AND ABUSERS, CHILDREN, ADOLESCENTS, AND ADULTS

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Sadly, Professor Catherine Itzin, the director of the Victims of Violence and Abuse Prevention Programme, and the designer of the Delphi consultation, died while work was being undertaken to finalise this report in March 2010. Professor Ann Taket and Sarah Barter-Godfrey have completed the finalisation, working, where possible, to Professor Itzin's original outline. We hope she would have approved of the way that we have shaped this final version.

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Executive summary

Introduction

This report presents the results of one piece of research conducted as a part of the Victims of Violence and Abuse Prevention Programme (VVAPP), namely a three round Delphi consultation. This Delphi consultation was undertaken to identify where there is and is not consensus among experts about what is known and what works in the treatment and care of people affected by child sexual abuse, domestic violence and abuse, and rape and sexual assault. It enables the identification of areas of agreement and disagreement about effective mental health service responses, and thereby contributes to the evidence base in this area.

The scope of the consultation

The consultation covered the ten different areas within the programme, (defined by different types of victim/survivor and abuser/perpetrator):

1 Children and young people who have been sexually abused
2 Child and adolescent victims of domestic violence and abuse
3 Child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking
4 Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults
5 Young people who perpetrate domestic violence and abuse
6 Adult victims/survivors of rape and sexual assault
7 Adult survivors of childhood sexual abuse
8 Adult victims/survivors of domestic violence and abuse
9 Adult perpetrators of domestic violence and abuse
10 Adult sex offenders

Round 1 of the consultation posed a set of mainly open questions for each of the above 10 programme areas in turn. The questions covered the following broad topics:

- Principles and Core Beliefs
- Effective Interventions
- Managing Safety and Risk
- Training
- Prevention
- Improving Outcomes
- Addressing Obstacles

The questions used in Round 1 are contained in Appendix 3. Participants in the consultation were asked to answer on the basis of their experience. Coverage of the research literature was reserved for the literature reviews that were carried out as a separate part of the VVAPP programme.

The respondents in the consultation

Participation was invited from all the different constituencies involved in the VVAPP programme, both experts by experience and experts by profession. The following sources were used:

- VVAPP specialist advisors;
- Members of the VVAPP expert groups and their nominees;

- Royal Colleges, professional bodies, and their nominees;
- Children's charities and their nominees;
- Survivor organizations and their nominees;
- Voluntary and independent sector organizations providing sexual violence or domestic violence and abuse services for victims/survivors or perpetrators, and their nominees;
- The police, through Association of Chief Police Officers (ACPO) leads on topics covered by the programme;
- NIMHE experts by experience network.

All invited constituencies were represented in the responses received in each of the 3 rounds. Responses were accepted from individuals or organizations. Respondents were invited to provide responses in relation to each of the programme areas in which they considered they had expertise.

There were 285 responses in Round 1, 130 responses in Round 2 and 91 responses in Round 3. Of the respondents, 68 responded in all three rounds; 23 responded to Rounds 1 and 3; 62 responded in Rounds 1 and 2 and 132 responded only in Round 1. The response rates in Round 2 and Round 3 were 46% and 32% respectively. Overall, 54% of the Round 1 respondents replied to at least one further round (i.e. in Round 2 and/or Round 3).

Findings – principles, values and core beliefs and issues across all programme areas (chapter 3)

In each round respondents were asked to comment on principles, values and core beliefs. Analysis in Round 1 identified five clusters of themes: power and responsibility; protection, safety and risk management; interventions; criminal justice; working together, providing and sharing information. A fair amount of commonality was identified across all 10 programme areas. Diversity, inclusion, equal treatment and basic human rights principles were strongly suggested as fundamentally important, suggesting that a human rights/equalities framework was a required basis for policy and practice, with explicit attention to gender, sexuality, ethnicity, and disability within this. A second over-arching theme was the notion of the importance of a victim/survivor centred approach (associated with characteristics such as empowerment, giving control and choice to victims/survivors); this was suggested, by some, to include choice for victims/survivors in terms of the gender, sexuality and age of the person they work with. Differences were identified in the way victims/survivors were viewed compared to abusers/perpetrators.

The use of a wide variety of therapeutic approaches was also something common across all programme areas. This was reinforced in the responses to the list of therapeutic approaches provided in Round 1 (see question 4 in Appendix 3), where in each of the programme areas each of the approaches was reported as useful/helpful by some respondents.

Respondents were asked to comment on two existing sets of guidelines that were mentioned frequently in the responses to Round 1. The respondents were generally supportive of both the BACP Ethical Framework and the Respect Guidelines, with high percentages agreeing that they are the most appropriate guidelines presently available (Round 2; 72% and 81% of respondents respectively).

Findings within programme areas (chapters 4 and 5)

Within each programme area, respondents were asked to comment on which therapeutic approaches might be considered helpful, and analysis of these responses identified the most frequently chosen approaches for each programme area. Respondents were also asked to indicate their position of agreement or disagreement in response to a variety of statements about interventions, approaches, training and treatment of clients. For many items there was a clear majority position (of agreement, neutral or disagreement), which is defined as where the most frequently held of these positions was held by at least 20% more respondents than the next most frequently held position. For some items the majority position was less clear (i.e. there was less difference in the percentage of respondents holding the majority view and the next largest group), and in a minority of items, there was a unanimous response. Each of the ten programme areas identified at least one item on which all the respondents could agree or be neutral. As well as developing potential consensus, the method of re-assessing items in Round 3 also allowed respondents to re-position their views in light of previous findings and discussion. This did not occur in all programme areas, but where a clear majority position changed between Rounds 2 and 3, this is highlighted in the body of the report.

Respondents in Rounds 2 and 3 were asked to comment only in areas in which they had experience and expertise. By identifying which areas respondents had declared that they had experience in as a part of Round 1, it was possible to examine whether there were differences in responses between those who declared expertise in the area in Round 1, and those who had answered in the particular programme area in a later Round. For the majority of items, the declared-expert position did not vary from the overall respondent position. However, for a small number of items (8 out of 209 in Round 3) there was a difference between declared-experts and others. These points of contention have implication for developing policies that are both informed by experts in the area and acceptable to the broader expert group.

Adult victims/survivors of domestic violence and abuse (chapter 4.1)

In Round 1 there were 99 respondents, 83 in Round 2 and 54 in Round 3.

One item drew unanimous agreement/complete consensus in Round 3: ‘there is no single therapeutic approach that works best for every victim/survivor in this group’ (54 respondents).

Two further items received no disagreement in Round 3: ‘the approaches used should be needs-led and victim/survivor centred’ (53 respondents); and, ‘behavioural and cognitive approaches on their own are insufficient to meet victim/survivors’ needs’ (53 respondents). This may indicate that general principles are emerging about how to respond and conceptualise services provided for adult victim/survivors of domestic violence and abuse.

Diverse positions emerged, and were maintained throughout, in relation to: the role of medication in treatment; the use of conflict management techniques; the value and place of mediation; and the value of routine enquiry.

Children and adolescent victims of domestic violence and abuse (chapter 4.2)

In Round 1 there were 40 respondents, 75 in Round 2 and 51 in Round 3.

Three items generated no disagreement from the respondents in Round 3: ‘choice of therapeutic intervention should be needs led, guided by the age and maturation of the child and their individual experiences and degree of victimisation’ (49 respondents); ‘children need access to therapies without their parents present, abusive or non-abusive’, (49 respondents);

and, 'the child's therapeutic intervention (including its pace) should be considered independently from any therapy for the non-abusing parent' (48 respondents).

There was disagreement about engaging children in interventions prior to the end of the threat, or presence, of abuse. Declared experts indicated a clear majority position of disagreement with the statement that safety and separation are pre-requisites to therapeutic intervention, however for all respondents there was more discordance in positions with 56% in agreement and 40% in disagreement, with 4% neutral (Round 3, 50 respondents).

Adult perpetrators of domestic violence and abuse (chapter 4.3)
In Round 1 there were 37 respondents, 64 in Round 2 and 41 in Round 3.

Two almost completely polarized positions arose within the responses on this programme area, based on the use of two different definitions of domestic violence. The first of these positions was held by those who saw (or defined) domestic violence as being about the use of coercive control within an intimate relationship, and the second by those who saw (or defined) the term domestic violence as covering a much wider field of difficulties within an intimate relationship. Both positions recognized the existence of female perpetrators of domestic violence and abuse, and the existence of domestic violence and abuse in homosexual relationships (both male and female). Within the responses in all three rounds of the consultation, the first position was more common than the second.

Two items drew unanimous agreement from the respondents: 'there is no single approach that works best for every member of this group' (Round 3, 41 respondents); and, 'it is important to work in ways which are meaningful to perpetrators from different cultures and backgrounds' (Round 3, 41 respondents). For one further item, 'it is important to avoid collusion with perpetrators' justifications for their behaviour', there was unanimous agreement in Round 2 (58 respondents), and no disagreement, but one neutral respondent, in Round 3 (40 respondents).

There was some lack of consensus about the timing of group work. In response to the statement that 'group work should only be considered after successful individual therapy/ work' declared experts were split between agreement and disagreement, compared with a clear majority position of disagreement in all respondents (Round 3, 37 responses).

Young people who perpetrate domestic violence and abuse (chapter 4.4)
In Round 1 there were 11 respondents, 62 in Round 2 and 40 in Round 3.

On three items, there was unanimous agreement from the respondents: 'there is no single approach that works best for every individual in this group' (Round 3, 38 respondents); 'interventions that work best are multifaceted, tailored to assessed psychosocial needs, intensive and, usually, long term' (Round 3, 38 respondents); 'the engagement of the young person in the management of his/her problems is crucial' (Round 3, 36 respondents).

There was indication of moving towards agreement about where best to place young people who abuse others, with no disagreement (but some neutral respondents remained) in Round 3 with the statement that 'provision of residential settings for therapy are important for <u>some</u> young people in this group' (Round 3, 37 respondents).

For three further items, there was no disagreement: 'there is a need for the development of more specialist interventions for abusing children' (Round 3, 40 respondents); 'through specialist services, it is possible to work with this group both as offenders and as victims of domestic violence and abuse' (Round 3, 33 respondents); 'parents/carers should be assessed for their potential harm or support before being included in therapy for this group' (Round 3, 35 respondents).

For one further item, 'behavioural and cognitive approaches on their own are insufficient to meet the needs of this group', there was no disagreement with the position in Round 2 (54 respondents), however there was one respondent in Round 3 who disagreed (out of 37 respondents).

More than any of the other programme areas, there is a strong agreed message here about how to respond to young people who perpetrate domestic violence or abuse through flexible engagement in specialist services, and striking a balance between perpetrator and victim approaches.

Adult victims/survivors of rape and sexual assault (chapter 5.1)
In Round 1 there were 99 respondents, 103 in Round 2 and 73 in Round 3.

Two items about approaches within interventions produced no disagreement in Round 3: 'there is no single therapeutic approach that works best for every victim/survivor in this group' (71 respondents); 'the approaches used should be needs-led and victim/survivor centred' (71 respondents).

There was one area where a notable divergent position was maintained about whether men who are raped need to be offered services that are separate from female rape victims/ survivors, and whether therapies for men are distinct and different than those required for women. In Round 3, 51% of respondents agreed or strongly agreed that male services should be separate from female services, with 34% disagreeing and 16% neutral (63 respondents in total). In terms of whether distinct and different therapies are required for men and women, in Round 3, 30% of respondents agreed or strongly agreed while 48% disagreed and 22% were neutral (60 respondents in total). These are key issues for service providers in terms of accessibility and acceptability and may require further elaboration.

Adult survivors of childhood sexual abuse (chapter 5.2)
In Round 1 there were 123 respondents, 102 in Round 2 and 70 in Round 3.

Two items drew unanimous agreement in Round 3: 'there is no single therapeutic approach that works best for every victim/survivor in this group' (69 respondents); and, 'the approaches used should be needs-led and victim/survivor centred' (69 respondents). For one further item, there was no disagreement in Round 3, and two respondents who espoused a neutral position: 'behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs' (67 respondents).

There were a number of areas where no clear majority position existed, and divergent views remained in all rounds. The first of these was in relation to the use of three specific forms of therapy, namely: regression, hypnotherapy, and inner child techniques. The second area was in terms of whether therapy should always be offered on an open-ended basis. The third area was in relation to the necessity for qualifications and accredited training.

There was broad endorsement of person-centred approaches that are tailored to the individual client, though there remains debate about the role and appropriateness of some approaches for some clients.

Children and young people who have been sexually abused (chapter 5.3)
In Round 1 there were 60 respondents, 88 in Round 2 and 67 in Round 3.

One item generated complete unanimity in Round 3, namely that the ideal position is to be able to offer a choice of therapist gender (60 respondents).

Three items generated no disagreement from respondents: 'children need access to therapies without their parents present' (Round 3, 57 respondents); 'cognitive distortions which the child may possess can be explored either directly or through play' (Round 3, 25 respondents); 'cognitive distortions which the child may possess can be explored either directly or through the arts therapies/psychotherapies' (Round 3, 29 respondents).

For one further item, 'the approaches used should be needs led and victim/survivor centred', there was no disagreement in Round 2 (88 respondents), but this consensus was not present in Round 3 (1 respondent out of 65 disagreed).

Two statements indicated disagreement between the declared expert and overall respondent majority positions. Declared experts indicated a clear majority position of disagreement with the statement that 'therapeutic intervention is unlikely to be helpful (and may actually be harmful) if it is provided while a child is continuing to be sexually abused', whereas the overall group of respondents showed no clear majority position, 50% agreed, 44% disagreed and 6% were neutral (Round 3, 52 respondents). Declared experts indicated a clear majority position of disagreement with the statement that 'therapeutic work should not start until the safety of the child/young person is established', whereas the overall group of respondents showed no clear majority position, 54% agreed, 39% disagreed and 7% were neutral (Round 3, 56 respondents). These two points have serious implications for setting working practices that engage with children whilst abuse is ongoing, and may need further attention to address the diverging views within the overall respondent group.

Additional comments indicated that there is a need for therapeutic and educational services for non-abusing parents, and for work to be carried out with carers and family members as well as the children.

Child, adolescent, and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking (chapter 5.4)
In Round 1 there were 36 respondents, 72 in Round 2 and 49 in Round 3.

There was unanimous agreement in Round 3 that 'the approaches used should be needs led and victim/survivor centred' (47 respondents). There were three items where no disagreement from the respondents in Round 3 was expressed: 'there is no single therapeutic approach that works best for every victim/survivor in this group' (49 respondents); 'it is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual' (48 respondents); 'secure accommodation in offender institutions does not provide a suitable therapeutic setting for those who have been harmed by prostitution, pornography and trafficking' (47 respondents).

Although there was less agreement about the specifics of interventions, there was a general agreement that clients need flexible and adaptable interventions. Additional comments suggest that it is important that services are provided with flexible access routes.

Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults (chapter 5.5)
In Round 1 there were 31 respondents, 62 in Round 2 and 37 in Round 3.

Three items received no disagreement from respondents in Round 3: 'there is a need for the development of more specialist interventions for abusing children' (37 respondents); 'the engagement of the young person in the management of his/her problems is crucial' (35 respondents); and, 'provision of residential settings for therapy are important for some children/young people in this group' (30 respondents).

There was no clear majority opinion from respondents about the statement that 'all interventions should include/involve the young person's parents and/or carers directly', diverging positions were maintained throughout the consultation. In Round 3, 32% agreed, 43 % disagreed and 26% were neutral (35 respondents).

In both Rounds 2 and 3 there was a clear majority agreement with the statement that 'secure accommodation in offender institutions does not provide a suitable therapeutic setting for this group'.

Additional comments advanced that the label of sex offender is not suitable for children. In conjunction with the above positions on the role of family, secure accommodation, and residential settings, it is apparent that there is room for further debate about where in the system to place young people who display sexually inappropriate behaviour.

Adult sex offenders (chapter 5.6)
In Round 1 there were 33 respondents, 45 in Round 2 and 38 in Round 3.

Only one item drew unanimous agreement for this client group: there is no single approach that works best for every member of this group (Round 3; 34 respondents).

There was no clear majority opinion from respondents about the value of group work for offenders, the value of medication as an adjunct to psychological treatment, or about the involvement of family members in therapy/treatment for sex offenders. The split of views in these areas therefore merit careful examination.

Additional comments also suggested that there is a need for sexual dysfunction clinics and services for people who have no criminal record but are concerned about their behaviour or desire to act, and potential for confidential telephone lines for those who have sexual interest in children.

In conclusion

The Delphi consultation has produced a detailed synthesis of views, with a high level of consensus in relation to the topics of: principles, values and core beliefs; prevention; managing safety and risk; training; improving outcomes and addressing obstacles.

Within the topic of effective interventions in terms of therapeutic and treatment approaches, although areas of consensus exist (as detailed above), there is much more complexity within each of the ten programme areas. Across the ten programme areas there remained minority positions for most of the statements presented, indicating the breadth and nuances of the expertise explored within the consultation. However, for many of the statements, a clear majority position could be identified, and there were broadly coherent themes emerging from the responses, endorsing person-centred approaches, which are flexible and responsive to the individual needs, readiness and experience of the client. The experts have offered a broad range of knowledge and experience, and from this, in each programme area some clear messages about best practice and broadly acceptable approaches to service provision do emerge. There are a number of areas however, detailed above and/or in the body of the report, in which divergent positions are held, and were maintained throughout the rounds in the consultation.

Areas of movement and difference between declared experts and the broader expert group are particularly important to reflect on in developing guidelines, as well as in discussions on developing services and working practices. Emerging support for engaging with abusing partners may be controversial for some experts; there remains strong opposition to this and where there is strong conflict of opinion it is important for policy to offer the flexibility that was so widely endorsed throughout the programme areas. Additionally, there may not be space for coming to a consensus opinion about where in the system to place children and young people who perpetrate violence and abuse simply because there is no ideal place at present; reflected in the strong endorsement for developing more specific services. The findings from this consultation in terms of areas of non-consensus and movement, point to topics that require further scrutiny, against the backdrop of broad consensus about good working practices and service provision. **It is very important that in using the results of this consultation, reference is made to the full report, and not just to the contents of this summary.**

Limitations of the consultation

The consultation was carried out to a very tight timetable, within a strictly limited budget. This probably adversely affected the response rates, although the rates reported above can be considered good in the circumstances and adequate for the analysis presented here. It also meant that it was not possible to consider more than three rounds. Given the complexity of the issues addressed (and the breadth of the consultation), it is perhaps not surprising that many areas remained where consensus was not reached, at least part of this may have been due to the limitation to three rounds. Limitations of time and resource also constrained the analysis that it was possible to carry out. In addition, in relation to some of the ten programme areas, the number of respondents on particular points was small (less than 5). Care is therefore needed in interpreting percentages where the number of respondents is small. Throughout the report, numbers of respondents are given in the tables, so that the reader may see where caution is required in interpretation.

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Chapter 1 Background and Context

Domestic and sexual violence and abuse: a major challenge for mental health services

Domestic and sexual violence and abuse represent significant health and public health issues. According to the latest available analysis from the 2008/2009 British Crime Survey self-completion module on intimate violence (Roe 2010), for adults aged 16 to 59, 28% of women and 16% of men had experienced some domestic abuse (emotional, financial or physical abuse, sexual assault or stalking by a partner or family member) since the age of 16. Women were more likely than men to have experienced longer periods of partner abuse, repeat victimisation and injury or emotional effects as a result of that abuse (Roe 2010).

Sexual assault and rape in adulthood is slightly less common than intimate violence for women, with around one in five women aged 18 to 59 reporting this in 2008–09, for men of comparable age the comparable figure is around 1 in 35 (HO 2009).

Figures for prevalence of child sexual abuse are harder to establish. Community studies in the US and the UK have consistently identified 20–30 per cent of women and 5–10 per cent of men reporting sexual abuse in childhood. In the US, Finkelhor (1994) found in a meta-analysis of 19 prevalence studies that 20 per cent of women and 10 per cent of men reported child sexual abuse. In the UK, Kelly and colleagues (1991) found 21 per cent of women and 7 per cent of men reporting sexual abuse as a child, and the NSPCC study by Cawson et al. (2000) found 21 per cent of women and 11 per cent of men doing so.

Domestic violence and sexual abuse have enormous health impacts, both physical and mental, in the short, medium and longer term. This poses an enormous challenge to health services and in particular to mental health services.

The Victims of Violence and Abuse Prevention Programme (VVAPP)

The joint Department of Health and National Institute for Mental Health in England (NIMHE) Victims of Violence and Abuse Prevention Programme (VVAPP) was established under the direction of Professor Catherine Itzin in partnership with the Home Office in response to the high prevalence of domestic and sexual violence and abuse and the evidence of mental and physical ill health associated with it. The programme was announced at the Home Office National Victims' Conference on 28th April 2004 by Rosie Winterton, MP Minister of State at the Department of Health, and launched by her and Parliamentary Secretary for Public Health Melanie Johnson MP at the National Domestic Violence Conference on 20th October 2004 organised by Women's Aid with the Department of Health. The aim of the programme was to address the mental and physical health implications of child sexual abuse, domestic violence and abuse, and rape/sexual assault, for services and professionals identifying and responding to the needs of victims, survivors and abusers including children, adolescents and adults, both male and female.

This report presents the results of one piece of research conducted as a part of the VVAPP programme, namely a three round Delphi consultation. This Delphi consultation was undertaken to identify where there is and is not consensus among experts about what is known and what works in the treatment and care of people affected by child sexual abuse, domestic violence and abuse, and rape and sexual assault. It enables the identification of areas of agreement and disagreement about effective mental health service responses, and contributes to the developing evidence base in this area.

Other research within the VVAPP

A number of separate research projects were commissioned to complement each other and to provide a triangulation of findings and evidence within the VVAPP. One of these was a systematic review of reviews of the research literature published between January 2000 and April 2007 across all groups in the programme that examined epidemiology, impact, therapeutic interventions, protection and prevention.

The Violence and Abuse Care Pathways Mapping Project was developed in collaboration with victims and survivors of extreme and chronic abuse, and organizations providing preventive interventions with abusers. These included learning disabled people and physically disabled people, and the experience of those from black and minority ethnic communities. There were two separate strands of this work. The first looked at severe and chronic victimization and re-victimization and covered all VVAPP areas and groups with a particular focus on learning disabled people, physically disabled people, black and minority ethnic issues, and also organized paedophile and ritual abuse. The findings of this research will be published by the Survivors Trust during 2010. The second strand focussed on West Yorkshire Asian women and mapped pathways to and through the many agencies with which these victims and survivors had contact.

A number of other publications draw on, or report, various parts of the research carried out in the VVAPP program. McQueen et al. (2008) contains guidelines on Psychoanalytic Psychotherapy after Child Abuse, dealing with the treatment of adults and children who have experienced sexual abuse, violence and neglect in childhood. This was produced by a guideline development group comprising all of the relevant professional and training bodies together involving the Children's charities as well as clinicians, and the Survivors Trust representing adult survivors of childhood sexual abuse. It focuses on psychoanalytic treatments for children (and adults) who have been sexually abused and covers the nature and extent of the problem, its contexts, symptoms and effects in childhood, including children with disabilities, socially excluded children, child abuse linked to spiritual or religious belief, trafficked children, online abuse and adolescents and children who commit child sexual abuse, with discussion of attachment, trauma, dissociation and the developing brain.

Itzin, Taket and Barter-Godfrey (2010) present a social-ecological framework for understanding the issue of domestic and sexual violence and abuse, and, taking a life-course approach, the book explores what is known about appropriate treatment responses to those who have experienced, and those who perpetrate violence and abuse. Within the book, selected findings from the Delphi consultation are contrasted with those from the empirical research literature. Within the book, chapters by Siddiqui and Patel (2010) and Hanmer (2010) discuss race and culture, drawing on research into the experience of black and minority ethnic women supported by the VVAPP programme.

The scope of the Delphi consultation

The consultation covered the ten different areas within the programme, (defined by different types of victim/survivor and abuser/perpetrator):

1 Children and young people who have been sexually abused
2 Child and adolescent victims of domestic violence and abuse
3 Child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking
4 Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults
5 Young people who perpetrate domestic violence and abuse
6 Adult victims/survivors of rape and sexual assault
7 Adult survivors of childhood sexual abuse
8 Adult victims/survivors of domestic violence and abuse
9 Adult perpetrators of domestic violence and abuse
10 Adult sex offenders

Round 1 of the consultation posed a set of mainly open questions for each of the above 10 programme areas in turn. The questions covered the following broad topics:

a. Principles and Core Beliefs
b. Effective Interventions
c. Managing Safety and Risk
d. Training
e. Prevention
f. Improving Outcomes
g. Addressing Obstacles

The questions used in Round 1 are contained in Appendix 3. Participants in the consultation were asked to answer on the basis of their experience. Coverage of the research literature was reserved for the literature reviews that were carried out as a separate part of the VVAPP programme. Details of the design and implementation of the Delphi consultation are contained in chapter 2.

The respondents in the consultation

The Delphi consultation covered principles, values and core beliefs; theoretical models and therapeutic approaches; treatments; prevention; managing safety and risk; training; overcoming obstacles and improving outcomes. Participation was invited from all the different constituencies involved in the VVAPP programme, including leading academics and professionals from all disciplines, service providers from all sectors and organizations representing mental health services users. The Delphi thus included both experts by profession and experts by experience. The following sources were used for recruitment of participants:

- VVAPP specialist advisors;
- Members of the VVAPP expert groups and their nominees;
- Royal Colleges, professional bodies, and their nominees;
- Children's charities and their nominees;
- Survivor organizations and their nominees;
- Voluntary and independent sector organizations providing sexual violence or domestic violence and abuse services for victims/survivors or perpetrators, and their nominees;

- The police, through Association of Chief Police Officers (ACPO) leads on topics covered by the programme;
- NIMHE experts by experience network.

All invited constituencies were represented in the responses received in each of the 3 Rounds. Responses were accepted from individuals or organizations. Respondents were invited to provide responses in relation to each of the programme areas in which they considered they had expertise.

There were 285 responses in Round 1, 130 responses in Round 2 and 91 responses in Round 3. Of the respondents, 68 responded in all three rounds; 23 responded to Rounds 1 and 3; 62 responded in Rounds 1 and 2 and 132 responded only in Round 1. The response rates in Round 2 and Round 3 were 46% and 32% respectively. Overall, 54% of the Round 1 respondents replied to at least one further round (i.e. in Round 2 and/or Round 3).

The structure of this report

The report is set out in six chapters. Chapter 1 explains the background and context to the Delphi Consultation and outlines the work carried out in the Victims of Violence and Abuse Prevention Programme (VVAPP). Chapter 2 describes the methods and process by which the Delphi consultation was carried out.

Chapter 3 presents findings in terms of issues that are common across all forms of abuse. These include: principles, values and core beliefs underlying therapeutic and treatment interventions, views on existing sets of guidelines and principles; multiagency working; safety and risk; training; prevention and improving outcomes and addressing obstacles.

Chapter 4 reports findings from the analysis of responses about therapeutic and treatment interventions for domestic violence and abuse. This category includes all interventions aimed at healing or ameliorating the effects of domestic violence or abuse on victims/survivors, or at directly modifying violent or abusive behaviour. This includes separate sections on

- Adult victims/survivors of domestic violence and abuse (chapter 4.1);
- Child and adolescent victims of domestic violence and abuse (chapter 4.2);
- Adult perpetrators of domestic violence and abuse (chapter 4.3);
- Young people who perpetrate domestic violence and abuse (chapter 4.4).

Chapter 5 reports the findings from the analysis of responses about therapeutic and treatment interventions for sexual violence and abuse. This category includes all interventions aimed at healing or ameliorating the effects of sexual violence or abuse on victims/survivors, or at directly modifying violent or abusive behaviour. This includes separate sections on

- Adult victims/survivors of rape and sexual assault (chapter 5.1);
- Adult survivors of childhood sexual abuse (chapter 5.2);
- Children and young people who have been sexually abused (chapter 5.3);
- Child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking (chapter 5.4);
- Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults (chapter 5.5);
- Adult sex abusers and offenders (chapter 5.6).

Chapter 6 presents conclusions and implications from the Delphi consultation.

The appendices to this report contain:

- A key to the acronyms used by respondents and those used in this report (Appendix 1);
- The email invitation to participate in the Delphi consultations sent to VVAPP expert groups (Appendix 2);
- A list of the questions sent out in Round 1 of the consultation (Appendix 3);
- The protocol for the Delphi Consultation (Appendix 4);
- Differences on key topics across the 10 programme areas (Appendix 5).

Chapter 2 The Delphi Consultation – Methods

2.1 Introduction – the Delphi method

The use of Delphi method is becoming increasingly popular within medical, social and psychological research (Meyrick 2003; Hasson et al 2000). It tends to be employed where strong empirical research evidence supporting theory or knowledge are lacking but where 'experts' are thought to hold relevant information. The basis of the methodology is the development and administration of sequential rounds of data collection and analysis that seek to identify positions on which there is consensus, and those for which diverging positions or views exist. The original application of Delphi, developed in the 1950s, was to a forecasting problem (Dalkey and Helmer 1963), and this characterises most of the earliest applications in the 1970s and 1980s. However before long, the method was increasingly being applied to establish the nature and extent of 'expert' knowledge in a specific field (McKenna 1994).

The Delphi method is a process that facilitates group consultation, with the aim of finding common agreement between experts, on topics of uncertainty (Okoli and Pawlowski 2004; Meyrick 2003; Hasson et al 2000; Rowe and Wright 1999). In more practical terms, it aims to develop "consensus building, without all the meetings" (Howze and Dalrymple 2004: 174). In its classical form, a Delphi study has five key components (Keeney et al 2001; Rowe and Wright 1999):

1. the selection of participants on the basis of expertise, and the expectation that the participants will provide insight and specialised knowledge and can articulate informed points for discussion;
2. iterations or multiple rounds of data collection, usually in the form of questionnaires, which allow refinement of positions and arguments across the consultation process;
3. structured, facilitated group discussion that presents feedback and findings from prior rounds to the group, for further exploration;
4. anonymity of interactions between participants, to ensure that group discussion is driven by issues rather than social factors; and
5. numerical aggregation of positions, such as ranking or proportions of agreement, to support descriptive statistical analysis of the consensus building.

There have been developments to the technique, and individual studies may re-interpret the general design principles while keeping the spirit of structured facilitation of expert discussion, to identify specialised knowledge positions and points of agreement or contention. Its use and application allows for variation from the classical design (Meyrick 2003). A typical Delphi study will run for three rounds, but commentaries on Delphi design have indicated that between 2-10 rounds may be considered normal (Day and Bobeva 2005); similarly there is a wide range in the size of the expert panel, with small panels of fewer than 10 experts considered as acceptable as panels of around 100 (Skulmoski et al 2007). Appropriateness of the expert panel, willingness and commitment to participate, and congruence between the design, participant selection and the research question are generally considered more important to supporting rigour in Delphi studies than adherence to guidelines on sample size or number of rounds (Day and Bobeva 2005; Meyrick 2003; Keeney et al 2001).

For the Delphi study reported here, many features of the classical Delphi design were included. Participants were invited to participate on the basis of their expertise and on the assumption that they held specialised and informed knowledge that would contribute to the development of new understanding. All participants were quasi-anonymous[1] to each other, but not to the research team, and any identifying comments were removed when providing feedback and summaries in later rounds. In this study the interpretation of 'expert' included organisations, their nominees and specific individuals. 'Expertise' was also considered to be established by profession, employment within a relevant organisation, or by experience of being a client, victim/survivor and/or a perpetrator/offender across one or more of the ten programme areas. In this way the Delphi panel was unusually heterogeneous and inclusive of a range of forms of specialised knowledge about the social, personal and organisational context of the topic areas. Participants communicated in a safe space within which people on both sides of the professional/client and victim/perpetrator divides could engage in facilitated, structured discussion; ameliorating the usual power differences that would occur if the discussion had been organised through live interaction, or if their status or background was revealed. This was achieved by anonymising all of the participant responses and feeding back de-identified statements, so that interactions between participants were anonymous.

The number, length and extent of the iterations of data collection were decided on the basis of: the judicious use of the available resources; the richness of the data provided in the first two rounds; a respect for the participants and the demands that were placed on them in participating in each subsequent rounds; and the broad aim of the study to develop new, nuanced and substantiated understanding rather than pursue, or force, absolute consensus on every issue. As discussed in the next section, which outlines the design and analysis of the findings, a mix of qualitative and quantitative techniques were used across three rounds of consultation. As the report findings illustrate, descriptive statistical summaries (such as proportions of agreement) are only part of the richness, insight and understanding that emerged through the Delphi consultation. Conceptual principles, elaboration on points of principle, illuminative analogies and additional points for consideration are reported alongside more traditional quantitative findings, consistent with more recent developments in the Delphi technique (Day and Bobeva 2005; Meyrick 2003; Hasson et al 2000).

As Thompson (2009) points out, there is a lot of variation amongst the different studies that describe themselves as following the Delphi method, and his paper explores the possible implications of some of these. In the sections that follow, a detailed description of the process followed in the current study is given. Key characteristics of the current study include:

- Anonymity of the statements made by the experts, so that each position advanced by a participant can be considered on its own merits, separate from any weight or value that might be inferred from knowing who the participant was;
- No face to face discussion amongst participants occurred as a part of the process; this supports quasi-anonymity between participants and also the avoidance of disadvantages associated with more conventional uses of experts, such as round-table discussions. The aim here is to support independent thought on the part of the experts and to aid them in the gradual formation of a considered opinion. This allows for measured consideration of different views, without the danger of being swayed by persuasively, and/or persistently, stated opinions of others that can dominate in open discussion;

[1] The term quasi-anonymous is used since participants may well have discussed their participation in the study with each other in non-study settings; however their own particular responses were not identified with them within the Delphi questionnaires. Each of the participants obtained from the VVAPP Expert Groups and Specialist Advisors knew the initial list of invitees, but not exactly who participated.

- A first round consisting of almost completely open questions to gather wide ranging responses;
- No new participants entered the process in later rounds, keeping the group bounded for the study, although as is noted below, owing particularly to the timing of the rounds over the summer holiday season, not all participants responded in all three rounds.

The study aimed to identify areas where there is and is not consensus among experts about what is known and what works in the treatment and care of people affected by child sexual abuse, domestic violence, rape and sexual assault. Unlike a classical Delphi, the aim of this study was not restricted to achieving consensus or a unanimous position of best fit (Rayens and Hahn 2000); instead it aimed to explore where consonance could be identified *and* locate areas in which divergence persisted across the rounds of data collection. There were no pre-determined levels of consensus sought. As different positions emerged from the data analysis these were included as additional statements for comment in later rounds, which allowed further exploration of areas of divergence, a feature which also meant there was less opportunity for consensus to be facilitated as the number of statements of difference increased and newer statements had less exposure to comment from the participants. Although this part of the design was less adherent to the classical Delphi, in the context of this study it was a helpful addition to exploring a more nuanced range of positions and ideas.

2.2 Design of consultation

The protocol used for the Delphi Expert Consultation is shown in Appendix 4, and the questions contained in Round 1 are reproduced in Appendix 3. This section summarises the main elements in what took place.

Research ethics clearance

Ethics clearance for the consultation was gained as part of the ethics approval process for all the different research components within the VVAPP as required under the UK's Research Governance Framework for Health and Social Care, (second edition, 2005). The framework applies to "all research that relates to the responsibilities of the Secretary of State for Health. That is, research concerned with the protection and promotion of public health, research undertaken in or by the Department of Health, its non-Departmental Public Bodies and the NHS, and research undertaken by or within social care agencies. It includes clinical and non-clinical research; research undertaken by NHS or social care staff using the resources of health and social care organisations; and any research undertaken by industry, charities, research councils and universities within the health and social care systems that might have an impact on the quality of those services" (para 1.2). For the purposes of the framework, research is defined as "the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods" (para 1.10).

All research must be subject to independent ethical review and this can be by "an appropriate research ethics committee or an independent ethics reviewer" (para 3.8.7).

In the case of the VVAPP programme, which involved participants from a wide range of the public sector (health, social care, criminal justice), as well as the NGO and community sectors, there was a two part review process:

- The programme was reviewed for its scientific quality by the programme's expert groups.
- The protocols were sent to two independent reviewers, each with extensive experience as members of ethics committees, who both delivered a favourable ethical opinion.

Recruitment of Delphi participants

Responses were invited from all the different constituencies involved in the VVAPP programme, both experts by experience and experts by profession. The following sources were used:

- VVAPP specialist advisors;
- Members of the VVAPP expert groups and their nominees;
- Royal Colleges, professional bodies, and their nominees;
- Children's charities and their nominees;
- Survivor organizations and their nominees;
- Voluntary and independent sector organizations providing sexual violence or domestic violence and abuse services for victims/survivors or perpetrators, and their nominees;
- The police, through ACPO leads on topics covered by the programme;
- NIMHE experts by experience network.

All invited constituencies above were represented in the responses received in each of the 3 rounds.

Invitations to participate were sent out by email wherever possible. The protocol for the Delphi consultation (contained in Appendix 4) was sent out to each potential participant as an attachment, with a statement of ethical practice, including a consent form, and a set of notes for participants, full contents shown in Appendix 4. The recruitment process started with email invitations to VVAPP specialist advisors and member of the VVAPP expert groups, the invitation email is shown in Appendix 2. Tailored versions of this invitation were sent to the other constituencies listed above. These invitations were sent out in September 2005. As soon as any suggested nominees were received, they were invited to participate. Nominees were accepted up until the end of December 2005.

Responses were accepted from individuals or organizations. No anonymous responses were allowed (the ethics clearance involved seeking explicit consent to participation, and successive rounds of the Delphi consultation required mail out to the same group as responded in the first round). Respondents were invited to provide responses in relation to each of the programme areas in which they considered they had expertise. Appendix 4 provides additional details on the information provided to participants at the point of recruitment and prior to the first round of data collection.

Data management and analysis

Responses were de-identified before entry into data analysis software. N6 (a qualitative data analysis package) was used for analysis of qualitative comments; responses in relation to particular questions and positions in Rounds 2 and 3 were entered into SPSS for analysis.

Analysis of qualitative responses received was carried out using multiple coders, repeated rounds of coding and code development, and a variety of consistency cross-checks in order to

identify the range of different positions present in the responses, and to group and structure them. In some places in this report, direct quotes from the material are used to illustrate positions; in others statements have been formulated in order to express positions succinctly and remove any details which may identify the respondent. When short statements drawn from responses are presented in the reports, the nature of the speaker (particular type of professional, victim/survivor, abuser/perpetrator) has been anonymised. This was done by removing some detail, and by expressing the statements in the abstract. This was done to ensure that the views of 'experts by experience' are treated on the same basis as those of 'experts by profession'. Quotes have been edited, where necessary, to remove material not relevant to the point or points being illustrated. All quotes from respondents have been edited to remove discussion of the research literature in line with the decision within the VVAPP to reserve the treatment of this for the literature review.

Within the report of Round 1:

1. a detailed analysis of responses was provided in relation to:
    a. Therapeutic and treatment interventions. This category includes all interventions aimed at healing or ameliorating the effects of violence or abuse on victims/survivors, or at directly modifying violent or abusive behaviour.
2. a high level synthesis was provided in relation to the other areas covered in the Delphi:
    a. Principles, values and core beliefs
    b. Effective interventions: other services and prevention
    c. Managing Safety and Risk
    d. Training
    e. Improving Outcomes and Addressing Obstacles

The choice of the areas to focus on in detail was made by the Programme Director in keeping with the priorities of the Programme. The emphasis in the Round 1 report was on reporting back the range of positions found in the responses and identifying areas of consensus and areas where there was a lack of consensus. The different positions were fed back in the form of statements (derived directly from Round 1 responses) on which rating and comment were invited in Round 2.

In analysing Round 2, SPSS (Statistical Package for the Social Sciences) was utilised to analyse responses to the statements. The comments were analysed separately in order to express additional positions that were fed back in the report of Round 2. Comments in relation to the different therapeutic approaches were included verbatim in most instances. Comments were numbered so that all respondents could refer to them if they wished in expressing their response in the final round, Round 3.

In Round 3, respondents were invited to assess/re-assess the different statements and positions, having seen the overall distribution of responses and read the comments of the other respondents from Round 2. Further comments were also invited.

The consultation was carried out to a very tight timetable, within a strictly limited budget. This adversely affected response rates, although the rates reported above are very good in the circumstances and adequate for the analysis presented here. Limitations of time and resource also constrained the analysis that it was possible to carry out. In addition, in relation to some of the ten programme areas, the number of respondents on particular points or statements was small (less than 5) and in some cases only 2 or 3. Care is therefore needed in interpreting

percentages where the number of respondents is small. Throughout the report, numbers of respondents are given in tables of percentages, as an aid against over-interpretation.

2.3 Responses received

Table 2.1 summarises the number of organisations/individuals that responded in each of the three rounds. Of the 91 responses in Round 3, 68 responded to all three rounds and 23 responded to Rounds 1 and 3 only. 132 organizations/individuals responded only in Round 1, and 62 responded in Rounds 1 and 2 only. The response rates in Round 2 and Round 3 were 46% and 32% respectively. Overall 54% of the Round 1 respondents replied to at least one further round (i.e. in Round 2 and/or Round 3). These rates should be considered as good in view of the time of year for Round 2 (summer holiday season), the relatively short time allowed for response, and the complexity of the response required. All invited constituencies however were represented in the responses we received in each of the Rounds. Everyone who participated in Rounds 2 and 3 had participated in Round 1; however, not everyone who participated in Round 1 completed both Round 2 and 3. Some participants missed out Round 2 to return in Round 3 and some completed Rounds 1 and 2 but not Round 3. There were no notable patterns in who chose to respond to one, two or three Rounds. The return of some participants to Round 3 who had previously chosen not to respond to Round 2 emphasised that the opportunity to opt back in to the questionnaire later in the process was a useful option for improving the inclusion of a wider range of participants. This echoes the findings of Brown (2007), who noted that allowing participants to opt out and in between rounds of data collection enables more flexible participation which does not place excessive pressure on individuals taking part and can ameliorate participant attrition. The final distribution of responses by programme area is shown in Table 2.2.

Table 2.1 Responses in the three Delphi rounds

Round	End point for responses	Number of individuals/ organizations responding
1	End April 2006	285
2	End July 2006	130
3	10th November 2006	91

Table 2.2: Numbers of respondents by programme area, total and organisational, in each Round

Programme Area: Total respondents (organisational respondents)	Number of responses Round 1	Number of responses Round 2	Number of responses Round 3
Children and young people who have been sexually abused	60 (9)	88 (2)	67 (2)
Child and adolescent victims of domestic violence and abuse	40 (5)	75 (2)	51 (1)
Child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking	36 (5)	72 (2)	49 (2)
Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults	31 (2)	62 (1)	37 (1)
Young people who perpetrate domestic violence and abuse	11 (2)	62 (1)	40 (1)
Adult victims/survivors of rape and sexual assault	99 (13)	103 (4)	73 (5)
Adult survivors of childhood sexual abuse	123 (16)	102 (6)	70 (6)
Adult victims/survivors of domestic violence and abuse	99 (9)	83 (4)	54 (5)
Adult perpetrators of domestic violence and abuse	37 (4)	64 (1)	41 (2)
Adult sex offenders	33 (4)	45 (2)	38 (3)

Note: This table is constructed according to respondents' self-declaration of areas of experience in Round 1 and their actual responses in Rounds 2 and 3

The volume of material received in each round was enormous and remains a testament to the commitment and experience of the Delphi respondents. In Round 1, taken together the responses contained over 56,000 lines. In Round 2, the responses comprised ratings of the specific position statements contained in the report of Round 1 plus some 36,000 lines of comment. In Round 3, the responses comprised ratings of the specific position statements contained in the report of Round 2 plus some 4,000 lines of comment.

2.4 Presentation of findings in this report

This report summarises the overall findings of the consultation, incorporating the results of the 3 rounds together. To keep this report to a manageable size, different parts of the analysis are reported in different levels of detail. Decisions about the sections to be reported in detail and those reported as only a higher level synthesis have been made by the Programme Director in keeping with the priorities of the Programme. Important areas that are not covered in as much detail in this report as the responses gave are: ritual abuse; people with learning disabilities; disabled people; eating disorders; women victims who are also perpetrators; homosexual relationships; and, cultural sensitivity in service design and implementation. The detail of the responses in relation to these areas will be reported separately as appropriate.

Many of the responses, particular in Round 1, made reference to the research literature, and this type of evidence was dealt with in a different component of the programme. Within the second and third rounds of the Delphi, to avoid complication and possible confusion, organisations/individuals were asked to answer from the basis of experience only. This report focuses solely on the results of the consultation.

Within the report, tables are used to present both the distribution of responses to the statements, in terms of the percentage of respondents[2] affirming different degrees of agreement/disagreement and any comments made about particular statements. The percentages may not add exactly to 100 due to rounding. On the lines giving the distribution of responses for each statement, the numbers of responses to the particular statement in Round 3 is given in the table. When examining the percentages given in the tables, readers are reminded to note whether these result from small numbers in particular categories; presentation of the number of responses for each statement enables this to be easily done. Where the content of the table is drawn from one Round in the Delphi consultation, this is stated in the table title; where no specific Round is given, this means the table relates to material drawn from all 3 rounds.

For many items there was a clear majority position, of agreement (including strong agreement), neutral, or disagreement (including strong disagreement). A clear majority position is defined as where the most frequently held of these positions was held by at least 20% more respondents than the next most frequently held position. For some items the majority position was less clear (i.e. there was less difference in the percentage of respondents holding the majority view and the next largest group), and in a minority of items, there was a unanimous response. There is substantial variation in what is considered ‘consensus’ in Delphi techniques, ranging for example from a cut-off of 51% agreement, i.e. more similar

[2] This is the number of respondents who expressed an opinion, excluding those who indicated don't know/not applicable to my experience.

than not, through to measures of interquartile deviance (Rayens and Hahn 2000; Loughlin and Moore 1979, cited McKenna 1994: 1222). In this study a frequency of 20% more than the next most common position was used to denote a *majority*, an assessment specifically chosen to denote agreement-without-consensus to ensure that positions of difference were not lost by enforcing a measure of consensus. Consensus was only perceived if there was a unanimous agreement. This places a slightly different emphasis on the role of consensus in the analysis compared to the classical Delphi; however this was seen as appropriate given the stated aims of the study, to identify both consensus and divergence.

For each statement in each round, where the largest type of response (strongly agree/agree, neutral, disagree/strongly disagree) was held by at least 20% more respondents than the next most frequently held position, these figures appear in bold on a grey shaded background. This enables the easy identification of where there is a clear majority position. A grey hatched background is used to identify statements where, leaving aside the neutral respondents, respondents either all agreed (agree or strongly agree) or all disagreed (disagree or strongly disagree). Hatched shaded entries can be regarded as the positions on which there was either complete consensus (no neutral respondents) or concord (some neutral respondents). There were 6 statements of concord in Round 2 and 33 in Round 3. For a smaller subset of these (1 in Round 2, 11 in Round 3) there were no respondents who selected neutral, these are the statements for which there is complete consensus.

As noted above, many respondents commented on a greater number of programme areas in Rounds 2 and 3 than they had provided answers for in Round 1, or declared expertise in (at the beginning of Round 1 responses). During the analysis of Rounds 2 and 3 responses, when group numbers were not too small for meaningful analysis (defined as 5 or fewer declared experts in total) it was checked whether this made a difference to the distribution of responses for each of the statements. In the majority of cases, it made no marked difference. The exceptions are identified in the sections that follow.

Within the responses to each of the ten programme areas, responses in Round 2 and Round 3 revealed a more nuanced and complex set of positions, emphasising the context dependent nature of different aspects of therapeutic intervention such as gender of therapist, use of touch, involvement of family members, and so on. Whereas many positions that were stated in the Round 1 statements were expressed in terms of ‘always’ or ‘never’, in Round 2 many more qualified positions were explicitly put forward. These were added as new statements included for rating in the next Round. While such statements only had one round in which to display consensus, the fact that they explicitly arose from within the consultation arguably makes consensus more likely. Most of the areas of disagreement noted in the Round 1 report for each of the programme areas remained in the responses to Round 2 and Round 3.

Within the different rounds of the Delphi consultation, statements put to participants for comment and ranking were numbered for ease of reference, the numbering has been maintained, and is shown within tables and quotes from Delphi participants, in order to permit easy cross reference. The relationship between statement numbers and programme areas in the VVAPP is as follows:

- Statements beginning S1 relate to children and young people who have been sexually abused
- Statements beginning S2 relate to child and adolescent victims of domestic violence and abuse

- Statements beginning S3 relate to child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking
- Statements beginning S4 relate to children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults
- Statements beginning S5 relate to young people who perpetrate domestic violence and abuse
- Statements beginning S6 relate to adult victims/survivors of rape and sexual assault
- Statements beginning S7 relate to adult survivors of childhood sexual abuse
- Statements beginning S8 relate to adult victims/survivors of domestic violence and abuse
- Statements beginning S9 relate to adult perpetrators of domestic violence and abuse
- Statements beginning S10 relate to adult sex offenders

Chapter 3 Key issues across all forms of abuse

In this chapter we report a high level synthesis of the major aspects emerging from the Delphi consultation that relate to all forms of abuse. Here the report draws on the syntheses generated from Round 1 Delphi responses, and then fed back to the respondents in Rounds 2 and 3 for modification and addition. The major form of comment made in Rounds 2 and 3 in relation to this material was the addition or amplification of points of detail.

This chapter focuses first on the question of principles and core beliefs; this is the largest section in the chapter as the discussion here was repeatedly referred to in all other sections of the responses. Chapter 3.2 covers responses in relation to two specific sets of guidelines, then chapter 3.3 covers multiagency working, chapter 3.4 covers safety and risk, with subsections on working practices, information and communication, and staffing. Chapter 3.5 covers training, chapter 3.6 prevention and chapter 3.7 improving outcomes and addressing obstacles.

3.1 Values, principles and core beliefs

The answers in relation to principles and core beliefs were very rich and detailed. Some respondents suggested that a third category, values, was also important and distinct. In analysing the responses it rapidly became clear that respondents did not share the same definitions of the three terms, 'principles', 'values' and 'core beliefs', this report therefore does not attempt to distinguish between these as different categories. Responses given to this section of the questionnaire also related quite strongly to those given in later sections on the characteristics that service providers should adhere to, and to elements of policy and practice. Many respondents gave their fullest answer to question 1, referring back to this in later sections of the questionnaire. Detailed findings from the analysis are first presented in two different ways. Table 3.1 below summarises the key themes raised in responses that discussed principles, values and core beliefs, and Table 3.2 shows the differences and similarities across the programme areas in relation to different issues.

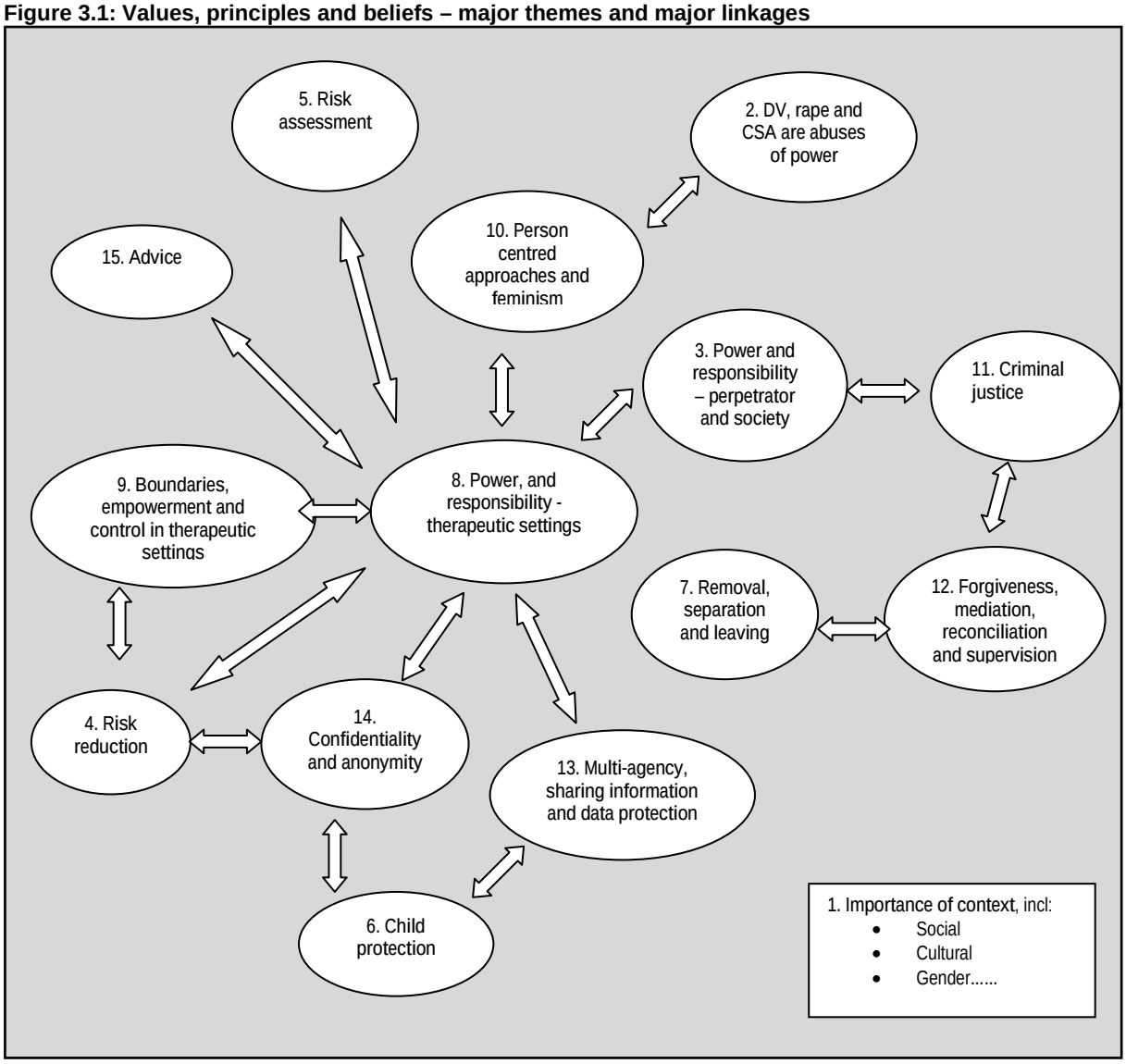
The analysis identified 15 different themes, each of which had a number of components. The major links between the themes have been used to group them into 5 clusters, as follows:

- Power, Responsibility and Challenges (Table 3.1)
- Protection, Safety and Risk Management (Table 3.1)
- Interventions (Table 3.2)
- Criminal Justice (Table 3.2)
- Working Together: Providing and Sharing Information (Table 3.3)

In Tables 3.1 to 3.3, for each of the 15 themes identified, the different positions associated with it are briefly outlined, identifying the areas of consensus and lack of consensus. Figure 3.1 depicts the major themes and their major linkages graphically.

A further set of tables, provided in Appendix 5, takes a different focus presenting positions that emerged on particular topics, and illustrating how some were shared across all ten programme areas, while for others there were marked differences between the different areas.

Figure 3.1: Values, principles and beliefs – major themes and major linkages



Diversity, inclusion, equal treatment and basic human rights principles were strongly suggested as fundamentally important, suggesting that a human rights/equalities framework was a required basis for policy and practice, with explicit attention to gender, sexuality, ethnicity, and disability within this. A second over-arching theme was the notion of the importance of a victim/survivor centred approach (associated with characteristics such as empowerment, giving control and choice to victims/survivors); this was suggested, by some, to include choice for victims/survivors in terms of the gender, sexuality and age of the person they work with.

Tensions were apparent in the responses in relation to a number of issues:

- confidentiality versus safety and child/victim protection;
- whether full healing/recovery for victims/survivors is always possible, this may be explainable in terms of the difficulty of defining what this means. It also linked closely to the support of openness and honesty in the course of the therapeutic relationship, while being mindful of the need to identify the most appropriate ways of working with victims/survivors in the course of the therapeutic relationship;
- whether behaviour change for perpetrators/abusers is always possible.

Table 3.1: Power, Responsibility and Challenges and Protection, Safety and Risk Management

Power, Responsibility and Challenges	Protection, Safety and Risk Management
1: Importance of context • Social context • Social inequalities perspective • Gender inequality framework • Cultural factors, culture as a descriptive of the norms and acceptances of society • Age • Ethnicity • Religion • Class • Sexuality	**4: Risk reduction: risk of harm, suicide prevention, public protection, safeguarding** • Suicide and harm prevention • Assessment and planning, employing strategies to minimize risk • Part of therapy to address and recognise suicide and self harm risk • Understanding why self harm might *occur (re-enact or symptomatic of trauma)* • Public protection *"duty to warn" overlaps sharing information, mandatory reporting* • Safeguard *Used in family setting agencies in place of managing risk or ensuring safety. Majority "safeguard children", plus minority "safeguard family members".* • *Family members' protection very closely overlaps confidentiality* • *Child safeguard overlaps child protection.* • *Pseudo legal term (reference to Safeguarding children from exploitation act), possibly acts as a proxy term for responsibility without power or authority to actually protect individuals*
2: DV, rape and CSA are abuses of power • Consensus that DV, rape and CSA are abuses of power and should be defined as such, as opposed to anger management or illnesses. Non-medicalising violence, maintaining choice and criminality of offences, so bridges both feminist and Criminal Justice approaches	**5: Risk assessment, risk management and safety planning** • Safety planning *Overlaps but is not identical to risk assessment, as only refers to victim/survivors* • Risk assessment *Content of risk varies depending on area of intervention – risk of harm, risk of suicide, risk of abuse, risk of re-offending* • Manage risk *Managing risk is partly a criticism of risk assessment as insufficient risk assessment and safety planning as process rather than event, also management of risk as practical application of assessment*
3: Power and responsibility and challenges for change: perpetrator and society • *Underlying principles of causation and therefore routes to prevention and redress: individual vs societal creation of problem.* • Perpetrator responsibility *Consensus, it is the perpetrator's responsibility and need to guard against some therapeutic approaches which are seen as diminishing/diluting responsibility* • Responsibility of the system/ society *Power and context of abuse: the way power inequality is defined (society or individual responsibility) infers/assumes where the responsibility for causation comes from* • Power as a social issue/ inequality • Challenging perpetrators *Challenging as confronting perpetrators. Commentary points out that challenging is both necessary but rather upsetting for them* • Challenging the system/ society *Also approached from education perspective, awareness and not tolerating/ ignoring violence*	**6: Child protection** • Child protection as an aim, an outcome, an ethical principle and a responsibility, and also as a defence for breaking confidentiality • Consensus that child protection is key, but there are differences in interpretations of how to get it and maintain it **7: Removal, separation and leaving (breaking links between victim/survivor and perpetrator/abuser)** • Removal of child from abusive situation - *linked to child protection, risk reduction* • Removal of offender • Leaving *Encouraging/ promoting leaving situation, links to advice: but never insist that someone has to leave as promotes guilt* • *Managing leaving (safe separation), linked to safety planning* • *Previous attempts to leave, links to be increased risk* • *Threat or risk of returning after leaving*

Table 3.2: Interventions and Criminal Justice

Interventions	Criminal Justice
8: Power, responsibility and challenges in therapeutic settings • Power and responsibility in therapeutic settings • Responsibility of the therapist/ worker *Boundaries, confidentiality, risk, harm, honesty, not making things worse* • Power in therapeutic settings *Split between need to recognise power of therapist/ medical examiner/ prescriber and actively outlining ways of returning power to client within the therapeutic setting* • Challenges for therapists/workers *Material they work with is challenging, upsetting; need for debrief and clinical supervision* • Clinical/worker supervision *Consensus as a good and necessary feature of therapeutic settings and organisational structure*	**11: Criminal justice, prosecution, punishment Vs rehabilitation, re-offending** • *Underlying principles of how to treat offenders and in part how violence and abuse can be prevented in the future* • Prosecution • Increased likelihood of prosecution • Mandatory prosecution • Offenders' registers • Changes to evidence proceedings (including prior domestic history as submitted evidence) • Minimise risk of re-offending: Punish and deter • Minimise risk of re-offending: Rehabilitate and change
9: Boundaries, empowerment and control in therapeutic settings ***Separating control from responsibility in therapeutic settings, to create a discrete theme of consensus*** • Empowerment, empower, empowering • Validation, validate, validated • Believing the client • Accepting the client • Being flexible • Being dynamic • Being empathic, empathy • Being understanding • Working in partnership with the client - *See also person centred approaches* • Power sharing in therapeutic settings • Professional relationships, Boundaried therapeutic relationships • Client responsible for the pace of the therapy	**12: Forgiveness, mediation, reconciliation and supervision (maintaining links between victim/survivor and perpetrator/abuser)** • In favour of forgiveness *Mostly tempered with "if the client wants it"* • Against forgiveness *Suspicion of agendas that promote forgiveness, especially the religious slant on it, plus forgiveness as a personal issue and therefore should not be promoted within therapeutic settings* • Supervised visits/interactions between perpetrator/abuser & victim/family *Generally considered to be undesirable, re-traumatising, reinforcing imbalance of power (links to couple mediation, reconciliation themes) – but difference emerge here between programme areas* • Restorative justice *Mostly seen as re-traumatising, not to be encouraged, risky* • Couple mediation, couple therapy *Almost consistently referred to negatively, also risky for returning to abusive situations*
10: Person centred approaches and feminism • Person centred approaches, see also aspects of responsibility and control within therapeutic settings (flexible, dynamic etc) • Pro-feminist *Usefulness of Duluth model, non-medical approaches, person centred, non-blame of victim aspects as well as power and control concepts* • Critical of feminist approach or philosophy *Caution about simplistic aspects (esp. Duluth, over emphasis on men as abusers, society as source of abuse), some comments about man-hating, comments on ideology being forced on clients by therapists* • Counter narrative to the "medical model", criticism of medicalising or pathologising victim/survivors	

Table 3.3: Working Together: Providing and Sharing Information

13: Multi-agency, sharing information and data protection

- Need for interagency/multi-agency response *Consensus: value in inter- or multi- agency responses and training*
- Inter-agency *Consensus: sharing information is of value*
- Intra-agency *Good to share some information, but countered with privacy and confidentiality issues*
- Between client and service provider *Consensus: the more information that is shared, the better. See also advice as information, advice as help and support, specialist advice*
- Not sharing information *overlaps confidentiality within service provision and data protection*
- Data protection *Not sharing certain information*
- Statutory reporting, mandatory reporting *All except one reference to this was in favour, but many did not refer to it at all*

14: Confidentiality and anonymity

- Confidentiality is considered important but tempered by protection, reporting and prevention issues. The limits to which a perpetrator can expect confidentiality are much less than an adult victim, though in some cases are equal to a child's entitlement to confidentiality from the mandatory reporting point of view

15: Advice

- In favour of advice *Mostly for non-therapeutic settings and for general public bodies*
- Against advice *Mostly for therapeutic settings, links to non-directional/non-judgmental themes, empowerment, pace*
- Active advice: directive *Specialist, legal and "practical" advice*. *For professionals and also some reference to directive or coercive advice to offenders/likely offenders*
- Passive advice: non-directive information *For victims/families*
- Help and support – including advice *For victims, especially children and young people, and families*. *Ambiguous as to the limits of its directiveness*

One further analysis of the responses is shown in Table 3.4 which summarises the positions put forward in terms of the different views offered on victims/survivors and adult abusers/perpetrators; this draws on the detailed findings set out in Appendix 5. For two of the programme areas (children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults and young people who perpetrate domestic violence and abuse), such distinct positions could not be identified, and these groups were viewed through positions representing a mixture of the two set out in Table 3.4.

Table 3.4: Difference between victims/survivors and abusers/perpetrators

Victims/survivors:

- Are individuals
- Are not responsible for their abuse
- Need empowerment
- Need to set their own goals, and define when they are healed
- Should not be assumed to have pre-existing mental pathology

Abusers/perpetrators:

- Can be categorised into types
- Are fully responsible
- Need help
- Need to reach externally determined standards of safety or behaviour boundaries, are assessed by others whether they are healed
- Might be better medicated
- Are labelled in psychiatric/deviant terms (especially sex offenders)

These views were reflected in overall views on interventions aimed at healing or ameliorating the effects of violence or abuse on victims/survivors, or at directly modifying violent or abusive behaviour. There was a strongly supported view on the victim/survivor side that therapy choice should depend on both the individual and the context, and that the quality of the therapeutic relationship is particularly important. Connected to this was strong support of the use of integrated or mixed approaches, the view that there is no single approach that is best for everyone, and that different approaches each have their place in a staged process of intervention (without however implying simple sequential ordering in this process). Integration also applies in terms of the need to integrate therapeutic and treatment interventions with other services that may be required. The quality of the relationship with

the therapist was also emphasised as particularly important. Although these views are present on the perpetrator/abuser side, they are much less strongly expressed, particularly in the case of adult perpetrators/abusers.

3.2 Existing sets of guidelines and principles

In a number of responses in Round 1, two already existing sets of guidelines/principles were suggested as providing a suitable basis of service accreditation or standards for practice:

- The BACP ethical framework, which includes guidelines for practice was suggested as relevant in responses from the six programme areas that deal with victims/survivors.
- The Respect guidelines were suggested as being suitable for accrediting services provided in relation to the provision of services for perpetrators of domestic violence and abuse. It was also suggested that some re-examination of these was necessary.

These were included in Round 2 and respondents' views on their suitability were sought. In Round 3, respondents were asked for any additional comments on the BACP and Respect guidelines and principles in response to the table summarising the Round 2 assessment and the comments made in Round 2[3].

In addition, other respondents made reference to the desirability for adherence to suitable/ relevant professional standards; there was no attempt to include all of these in detail for comment in Round 2. Specific sets of practice guidelines that were mentioned were:

- Health Professions Council practice and ethics guidelines;
- RESPOND, the psychotherapy service for people with learning disability who are/have experiencing/experienced sexual abuse/violence;
- British Association of Social Work Code of Ethics;
- General Social Care Council Code of Practice;
- Association of Child Psychotherapists ethical guidelines;
- Women's Aid Code of Practice for member organisations[4].

Throughout the responses in the 3 rounds views were expressed about the importance of clear guidelines/codes of ethics and practice, however, there was no agreement as to whether these should be profession specific and/or specific to violence and abuse, or even different types of violence and abuse. Some respondents called for specific guidelines in relation to different groups such as BME communities. Some respondents raised the concern that treating abuse as a separate case (through separate guidelines) could have the effect of isolating the sufferers even more than they are already, arguing that part of the healing is about normalising and not putting abuse away from other life experiences. Another important point was the need to ensure that those receiving therapeutic intervention have knowledge of the relevant guidelines; as one survivor commented, in relation to the BACP guidelines: "as a client I did not realise just what guidelines were in place but having read the report I can state that if they were consistently adhered to they would be acceptable". Many respondents noted the importance of the system for monitoring/assuring adherence to guidelines/codes of ethics and practice (something that was not explored in detail in this consultation). A number of respondents noted that all sets of guidelines require regular re-examination.

[3] Since the full guidelines were not circulated again in part 2, we did not ask for a re-assessment regarding agreement in Round 3.
[4] The respondent also noted that Women's Aid was developing national service standards for refuge and community based domestic violence services at that time.

BACP ethical framework

Overall views on the BACP ethical framework from Round 2 are shown in Table 3.5. This expresses a fairly strong agreement of the value of this framework in the context of the VVAPP programme as a whole, with 72% of respondents agreeing or strongly agreeing that the guidelines are the most appropriate available.

Thirty respondents in Round 2 offered comments on the BACP ethical framework in addition to providing ratings as shown in Table 3.5. Thirty respondents in Round 3 offered further comment.

The general points summarised at the end of section 3.2 were also raised in specific response to the BACP ethical framework. Comments in relation to which parts of the framework needed to be re-examined were made in both Round 2 and Round 3 (details not included in this report).

Table 3.5: Views on BACP ethical framework, Round 2

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
G1. The guidelines are the most appropriate that we have for this area (responding to the needs of victims/survivors of sexual violence and domestic violence/abuse) at the moment	**15**	**57**	20	6	2	95
G2. The guidelines need a complete re-examination	4	6	27	**56**	**7**	82
G3. Parts of the guidelines need to be re-examined.	12	20	41	24	3	74
G4. I think these guidelines are also applicable to other areas	16	23	50	11	0	62

Respect guidelines

Overall views on the Respect guidelines are shown in Table 3.6. This expresses a fairly strong agreement of the value of these guidelines in the context of the domestic violence perpetrator programmes and associated women's services, with 81% of respondents agreeing or strongly agreeing that the guidelines are the most appropriate available at the moment. No statistically significant differences were found in between responses made at the beginning of Round 2 and responses made in the two later sections (3.9 and 3.10) of the Delphi questionnaire in Round 2[5].

[5] We therefore do not report these in the current report.

Table 3.6: Views on Respect guidelines, Round 2

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
G5. The guidelines are the most appropriate that we have for this area (domestic violence men's perpetrator programmes and associated women's services) at the moment	**29**	**52**	11	7	1	75
G6. The guidelines need a complete re-examination	5	9	25	**51**	**11**	65
G7. Parts of the guidelines need to be re-examined.	10	15	44	25	6	52
G8. I think these guidelines are also applicable to other areas	6	16	**63**	10	4	49

Twenty respondents in Round 2 offered comments on the Respect guidelines in addition to providing ratings as shown in Table 3.6. Sixteen respondents in Round 3 offered further comment. The Respect guidelines are very specific in relating to men's perpetrator programmes and associated women's services only (as stated in the introduction). The introduction goes on to state that: "however, many of the principles and standards will also be of relevance to those working with same-sex domestic violence, female perpetrators and family violence." Many of the comments expressed the view that considerable modification, or even a total re-write, was required for these other contexts of work.

The general points summarised at the end of section 3.2 were also raised in specific response to the Respect guidelines. Comments in relation to which parts of the guidelines needed to be re-examined for this area (domestic violence: men's perpetrator programmes and associated women's services) were made in both Round 2 and Round 3 (details not included in this report).

3.3 Multiagency approaches

It was emphasized that victims/survivors often needed services of more than one type, and that often, more than one agency would be involved. Recognition of the need for multiagency responses was strongly supported and the need for improved interagency co-ordination stressed. The importance of service integration was strongly supported. Challenges in achieving the necessary coordination were recognised as severe including:

- Tension to be managed between criminal justice and therapeutic interventions: For example, a police officer may have to ask probing questions during a rape investigation, whereas someone who works as a counsellor or an organisation such as Rape Crisis may not. A common approach can be advanced in terms of empathy, support, willingness to provide advice when it is sought and being able to work in an informed manner. This requires those people who work with survivors to be educated about rape/sexual assault and to understand victim reactions. Such understandings should take account of the specific needs of male, as well as female survivors of sexual violence and other victim groups - those from ethnic minority and gay, lesbian, bisexual and transgender populations.
- More provision for those with multiple problems – drug/alcohol abuse, debt, unemployment, depression etc. to ensure a more integrated approach is achieved.
- Guidance for all groups of involved professionals needs to be clear and consistent

- Those providing apparently unrelated care (e.g. sexual health services, dentists working inside a person's mouth), need to be aware of the possible effects on survivors i.e. a large number of their patients and provide care accordingly. Hospitals need trained staff to assist patients who are very traumatised by routine procedures or reject treatment because of unresolved abuse issues.

System/inter-agency issues

Respondents raised issues about working within the wider system setting and the challenges of inter-agency working. Particular issues raised included:

- Effective work-place policy on violence.
- External accreditation for intervention programmes.
- [Multi-agency] plan in place for affording the client protection from the abuser or themselves (self-harming including suicidality).
- Good partnership working arrangements between agencies.
- Having access to specialist legal advice in relation to conflicts of interest involving child protection principles (which may suggest disclosure of reports) and confidentiality (which may suggest non disclosure of reports). These are very complex matters and practitioners need to know their limits in terms of interpretation of different pieces of legislation and guidance including Human Rights law, the Children Act, the Data Protection Act etc.
- Specialist courts, specialist prosecutors and defenders.
- Courts need to deal severely with perpetrators who break bail conditions, recommendations that they ought to give a prison sentence in these circumstances.

3.4 Responding to diversity

Throughout the responses to the consultation, the need to recognise diversity in terms of factors such as culture, ethnicity, dis/ability, sexuality, age and gender was strongly emphasised. These factors are important in understanding how and why different groups in the population experience heightened risks of violence and abuse, experience particular issues in relation to disclosure and accessing services and require specific consideration in order to shape appropriate service responses to the particular needs of these groups. Detailed coverage of all these aspects is beyond the scope of this report.

Therapeutic and treatment responses to both victims/survivors and perpetrators need to be responsive to all these factors. Specific points to be born in mind include:

- There needs to be much more general awareness that boys too are abused and for GPs to consider this when they come with mental health difficulties, bedwetting, eating problems etc.
- Need for specialist services for learning-disabled people and people on the autistic spectrum and training for generic services so they can work effectively in this area.
- Need to recognise particular issues for lesbian, gay, bisexual and transgender people in relation to Domestic Violence.

3.5 Managing Safety and Risk

A high level synthesis of results on this topic was presented to respondents in Round 2 of the Delphi. Twenty seven respondents offered some comment on this section in Round 2, and twenty three in Round 3. Of these some just gave explicit confirmation that they agreed with the synthesis reported in Round 2 and had nothing further to add. A second group of 15 affirmed their general agreement (in whole or part) and added some further amplification on particular points. A number of suggestions were made for additional points/areas requiring coverage, which have been included here.

Responses overwhelmingly emphasized the importance of risk assessment and appropriate means for minimizing risk and prioritising victim/survivor safety (both in terms of actual victims/survivors and potential future victims/survivors). This was one area in which responses did not differ markedly across the ten programme areas. It was suggested that it is helpful to separate out risk assessment from safety planning, and to consider the latter in terms of a division into crisis, short-term and longer term planning. It is also important to distinguish between different levels of management: individual client; family; community; support-worker; supervisor; organisational context.

A synthesis of the responses is given below in four subsections, on: working practices, information and communication, staffing and system/inter-agency issues. Table 3.7 summarises components specific to particular programme areas.

Table 3.7 Managing safety and risk: Components specific to particular programme areas

Programme Areas	Component
Sexual violence	• Managing safety and risk of sex offenders has to be a whole community approach • Prior to embarking on a treatment programme, everything possible should be done to ensure that: the content and length is right for the participant's treatment needs and learning style; the participant is in a safe place emotionally and physically to do the work; plans are in place to cope with possible distress following sessions; the participant will be able to complete the work being embarked upon. This is a particular problem in relation to women offenders and to young people within the YOI system.
Domestic violence	• Managing safety and risk of DV perpetrators has to be a whole community approach • Establish procedures for safe routine enquiry. Policies and protocols for domestic violence should 'address clearly those areas in which there is to be routine enquiry … and those who should be approached through a case finding approach'. The policy should require staff to be appropriately trained before implementing routine enquiry, and identify who is responsible for asking the questions. • Have a clearly defined person taking a lead role (i.e. a full-time officer at a senior level) designated to lead on services related to domestic violence. • Women and children should be given all the support to remain at home safely, and the perpetrator excluded. • The topic of domestic violence should be addressed in induction training sessions • Victims need to have access to alarm systems. They need to know that when they ring the police they will come out quickly. • More agencies to ask about perpetration of domestic violence, and to refer on to services that challenge men's behaviour
Children and young people who display sexually inappropriate behaviour or who	• Those providing treatment, care and support need to be fully informed about a young person's history, risks and needs. They should be active members of any intervention programme and planning group. Close liaison between all those involved is essential.

sexually abuse other young people, children or adults	• Young people who engage in inappropriate sexual behaviours should be assessed for their own child protection needs as well as in relation to their abusive behaviours and the risk they present to others.
Children and young people who have been sexually abused	• Child protection issues and safety of a placement must be addressed before any ongoing therapeutic treatment is practicable and ethically acceptable
Perpetrator/offender groups	• Need to consider potential role of newer interventions such as tagging, tracking and polygraphy

Working practices

Respondents raised a range of issues and challenges that need to be considered in supporting and delivering appropriate, safe and effective working practices. Key components of good practice and considerations for those managing working practices included:

- **Risk assessment:** Need to undertake proper risk assessment, and to ensure the existence of a safety plan, importance of recognizing that assessing risk/safety planning is a process not an event.
    - Constantly check in and review level of safety in any therapeutic work so the client is not re- traumatised and work is kept within a level that client can manage and function. Some suggested that accreditation was needed for risk assessment systems in use. Some suggested that it was important to use common risk assessment/management tools to facilitate effective inter-agency working.
    - Risk assessment for victims/survivors needs to include assessment of the risks the client faces from themselves (self-harming, including suicidality) as well as from the abuser/perpetrator. Include assessment of victim/survivors support networks and factors affecting their health such as eating and sleeping habits.
    - Multi-agency risk assessment conferencing.
    - Each case is treated individually and the victim/survivor (whatever their age) included in examining their own safety and examining potential ways of maximising safety and minimising the harm to others.
    - All public protection plans are centred around the person who is the problem. It is essential that an understanding of the needs of that individual are assessed in order to establish a problem profile.
    - Each victim (adult and child independently) should have a safety or risk management plan.
- Important to understand the ways that abusers operate. Important to understand that professionals can be groomed too.
- Lone working policies for protection of supporters.
- Clear protocols and guidelines especially on confidentiality (see Figure 3.2), responding to suicidality and self-harm (see Figure 3.3), boundaries and limits of staff's role and responsibility, and documentation.
- Use of the local and national guidance and protocols covering child protection. Child protection arrangements need to be explicit and clear, both on a policy/protocol level and in terms of who will do what and how the young person will be involved in this process.
- Clear referral pathways.
- Audit adherence to key standards, for example on documentation.
- Be aware of what sex the perpetrator is, it may be more beneficial for the survivor to be supported by someone of the opposite sex to the perpetrator.

- Therapists monitor the clients and try to help them to build external support systems to prevent relapse. Possibility for clients to increase contact with therapist in times of crisis or to access a helpline for additional support.
- Contracting should be comprehensive and constructed to ensure that the client is given as much information as possible regarding what the therapist can offer, how the therapist works, what the client might expect, what counselling is, and how it might help the client. Contracting should be both verbal and written and the therapeutic situation should be constantly reviewed.
- Understand survival strategies.
- Identify support networks.
- Meeting in safe venues. Provide a safe environment and offer a choice of venues to meet (particularly relevant to our large rural areas).
- Removal of victims/survivors from the immediate geographical area may be something that has to occur swiftly.
- Perpetrators need to be prosecuted and removed from the home when they live with victims.
- Care must be taken when involving the perpetrator that no assumptions are made that this is automatically appropriate especially in cases of denial or minimisation; contact with family member perpetrators of abuse is not always appropriate.
- Build in service user feedback.
- Need to balance the harm that can result from removing a child from a non-abusing parent who has chosen to stay with the perpetrator, with the potential harm that can result from exposure to abuse.
- Acknowledge perpetrator's own experience of abuse if present but not collude that this is the cause of their own violence.
- Provision of advocacy for victims/survivors in relation to legal, police, social services processes.

Figure 3.2 Confidentiality – positions espoused

'Complete confidentiality cannot always be offered owing to child protection issues, this must be openly acknowledged with the client'.

'No confidentiality is offered to abusers or in situations of life and death i.e. overdose.'

'Confidentiality is not offered to children or young people who are abusers themselves.'

'Because an abusive man's contact with a perpetrator programme has enormous implications for his partner/victim, we also keep the women fully informed about her abusive partner's attendance and about the nature of his engagement. Maintaining the integrity of the family unit is not our concern. We support women and gay partners who wish to remain in a relationship but our primary task is to improve victim safety: we do not work to maintain the relationship or the integrity of the family unit.'

Figure 3.3 Sensitive and appropriate responses to suicidality and self-harm

'Many survivors/victims are suicidal and have lived with those feelings for many years; panicking and 'taking control' of their life by rushing in to Section them is, in many cases, unnecessary and the antidote to their desire to die is a stable, caring, boundaried therapeutic relationship. Many survivor/victims find it hard to tell professionals about their suicidal feelings because of this panic on the behalf of professionals in the past and are therefore isolated further with the pain and distress they suffer as a result of their sexual abuse. Many survivors self-harm in order to cope with the overwhelming feelings and to divert the pain from the emotions to their physical being. Again, calm exploration rather than panic and rushing in to stop them is most often the best way ahead – respect, care, patience, enquiry, inquisitiveness on the part of the psychotherapist/counsellor, Doctor or Psychiatrist can go a very long way to help the survivor/victim recover in the way they want to recover. A feminist approach to self-harm is to respect this action as a coping mechanism and not to pathologise it as such. Again many survivor/victims find it hard to tell professionals about their self-harm because of this panic on the behalf of professionals and further isolates them with their memories, secrets and distress and self-hatred.'

Information and communication

Elements raised were:

- Need to keep the victim/survivor fully updated with information about any case including court dates or prison release dates.
- Open/honest communication about child protection issues, risks, limits of ability of agencies to protect so that a false sense of safety is not created.
- Client should be aware of, and confident in confidentiality issues i.e. regarding child protection.
- Use of explicit contracts between clients and service providers, which include explicit coverage of actions that will be taken in different circumstances.
- Very clear and tight boundaries agreed with the client, however, there were different views on the amount of flexibility and on what needs to be in place for a crisis.
- Survivors need a leaflet "What to expect in counselling/therapy" and "How to complain".
- Carers need to know what the victims/survivors already do to make themselves safe and how abusers operate.
- Need to have multi agency support (i.e. police, social services etc.) both to protect the adult victims/survivors and children and to provide the relevant help they need.
- Safe information sharing procedures.
- Clear thresholds for information sharing and effective electronic messaging pathways. This is required to facilitate communication and to transfer robust information recording and Case Management Systems linked to multi-agency search facility utilising IT networks.
- Documentation – thorough, to appropriate standards for both treatment/intervention purposes and for any court proceedings, and securely kept.
- Good multi agency partnership working and risk assessment conferencing.
- Comprehensive, accurate information about the client and their history (but note also the view that it is inappropriate to pressure survivors regarding disclosure of details).
- Systems for recording contact with adult/child/young person and monitoring progress.
- Protocols for sharing information and intelligence need to be very robust.

Staffing

Points raised were:

- There must be a rigorous selection process and thorough training for workers and volunteers.
- Trained and experienced staff with appropriate support and supervision.
- Appropriate ongoing supervision should be provided for all professionals who offer support to those who have experienced sexual violence or domestic violence; this needs to include provision for all staff in children's homes and foster carers.
- Staff support structures should acknowledge and address the likelihood that practitioners also encounter violence and abuse. Policies on violence in the workplace should have: mechanisms defining response to employees disclosing domestic violence; protecting employees experiencing domestic violence from their perpetrator at work; internal or external mechanisms for responding to staff who are perpetrators; confidential help for employees to deal with their personal experiences of being abused accessed through Occupational Health.

- All therapists should belong to a professional body with disciplinary procedures[6].
- Potential therapists need to be screened to assess for core competencies required.
- Staff who do not deliver high quality work should be deselected, and not work with either victim or perpetrator.
- Appropriate systems in place to ensure safe practice by professionals and early intervention in any abuse by professionals of their clients.

3.6 Training

A high level synthesis of results on this topic was presented to respondents in Round 2 of the Delphi. Thirty three respondents offered some comment on this section in Round 2, and twenty three in Round 3. The responses in Rounds 2 and 3 reflected the same areas of diverging views as in Round 1. Some respondents offered explicit confirmation that they agreed with the synthesis reported and had nothing further to add. A further group affirmed their general agreement (in whole or part) and added some further amplification on particular points. A number of suggestions were made for additional points/areas requiring coverage, and are included here.

Round 1 elicited very rich answers here, going into an incredible length of detail on all aspects of the question. Clear distinctions are available in terms of statements about different levels of training, making the distinction between:

- **Primary level** - what needs to be known by **all** professionals in a wide range of sectors, health and social care (including both statutory and voluntary agencies), education, police and criminal justice system. There was a strong view that there is a common core of information and skills that need to form a part of all relevant basic curricula so that every professional should be able to provide information, offer key messages, know how to contact services and be able to offer help in making contact.
- **Secondary level** – training necessary for a variety of second level functions encompassing provision of information, support or advocacy to victims/survivors. At this level there is more variation in the nature of the training required according to profession and job role.
- **Tertiary level** – training necessary for the delivery of specialised therapeutic/treatment interventions to victims/survivors or abusers/perpetrators.

Training should be integrated into all levels of professional training with the level of complexity linked to the level of training and should go through diploma, undergraduate and into postgraduate professional qualifications. Many responses mentioned the need, particularly at secondary and tertiary levels, for regular clinical and case work supervision (this was also mentioned as a key factor in managing safety and risk and in delivering effective interventions). The need for ongoing training/updating in various forms was highlighted.

Diverging views were expressed on the nature of training required for therapeutic work at the tertiary level (as well as in terms of its delivery, how and by who), and in particular about the qualifications, experience and accreditation necessary to practice at this level. Some respondents put forward the position that all clinicians must undergo their own intensive long-

[6] This however necessitates adequate funding being available to agencies such as grass roots and community based voluntary groups where counsellors are often voluntary or only paid for a few hours a week.

term therapy in order to understand their own emotional and relational history, and responses to clients. Further details are shown in Tables 3.8. to 3.10, Table 3.8 deals with topics common across all programme areas, and Table 3.9 with items that are more specific to particular programme areas. Table 3.10 deals with training methods, distinguishing, where necessary, between the different levels and the different programme areas.

In addition, training crops up in each of the sections in chapter 4 and 5 on particular programme areas, where a divergence of views is found in relation to the necessity for use of only trained professionals, the use of accredited training and the use of training involving formal assessment of competence rather than merely attendance.

Table 3.8 Training content

- Training needs to have an understanding of the dynamics of violence and abuse at its centre.
- Trauma, its effects, principles of and approaches to its treatment.
- Listening skills, skills to challenge the priorities of organisations and institutions, patience, asking the 'right questions' and how to overcome one's own fear of opening a can of worms without recourse to solutions.
- Confidentiality and its limits, privacy and content.
- Safe documentation practices.
- Relevant protocols and guidelines, legal responsibilities.
- Implications for practice of prioritising safety.
- Awareness training regarding other agencies and how they work.
- Training for supervisors, managers and team leaders, which must address the secondary effects of violence and abuse, vicarious traumatisation, supervision of trauma work, policy development and implementation, audit systems, workplace policies.
- Training to enable sound gender-sensitive, anti-racist practice and to work competently and confidently with minoritised people experiencing sexual violence or domestic violence. Such a strategy should enable workers to understand the inter-sectionality of racism, sexism, sexuality, disability, class and other oppressions (on themselves and others), contextualising issues of 'culture' and sexual violence and abuse within these structures, developing ways of working which neither privilege culture over gender, or gender over culture.
- All training should include knowledge and skills in working with people with intellectual disabilities.
- Training in working with young child victims must include an understanding of the importance of the context for the child and the age-related attachment dynamics which prevent or facilitate disclosure.
- Service users should be consulted on various aspects of planning any training and invited to participate.
- Mental health professionals to receive detailed specific training on violence and abuse as part of core curricula.
- Therapist training (tertiary level) should incorporate modules dealing with attachment, trauma and dissociation.

Table 3.9 Training methods

- Training should be grounded in where one is working (health, criminal justice, education and so forth)
- As well as forming a part of basic curricula, training should also be delivered as part of continuing professional development.
- Regular follow-up trainings or reflective practice groups. Delivered in teams and professional groups as far as possible so the culture of team is developed.
- Inputs into training should be provided by victims/survivors (both male and female) and by relevant specialists and specialised agencies.
- Training should contain both theory and experiential aspects.
- Face-to-face component essential.
- A group setting provides space for in-depth exploration and enables teachers to help unpick strongly held misperceptions.
- Shadowing is a good way to help the training process as well as observations but this has to be balanced to the needs of the victim/survivor.
- Use of observation, monitoring and mentors throughout training.
- Every agency should be able to access a modular system which complemented others. Some modules could be suitable for multi-agency delivery, while others may be role specific.
- Training should involve assessment – both during and at the end of training.

Table 3.10 Training content specific to particular programme areas at tertiary level

Programme Areas	Topic
Sexual violence, pornography, prostitution and trafficking	Nature and process of the sexual exploitation of children and young people. Grooming and sexual exploitation of women and children; their impact and effects on victims and their families. Training on current legislation and policies on prostitution, pornography and trafficking. Legislation and policy implementation in specific agencies. Ritual abuse including the impact on the victims and professionals who work with them. Effects of rape and sexual assault on men and women.
Children, especially young children	Training in how to talk to and understand communications (including non-verbal) with a child. Developmental aspects of young people's emotional, social, and physical health, including lesbian, gay and bisexual young people's development.
Adult sex offenders	Certain types of personality disordered offenders require practitioners who have a much more sophisticated understanding of mental health and personality disorder. Generally, there seems to be no reason why criminal justice agencies should not provide the majority of programmes, but it does seem reasonable that such practitioners and agencies should have access to forensic mental health support, consultation and advice. There are very particular difficulties posed by psychopathic sex offenders, who largely require interventions delivered within an institution, and practitioners require much more specific training around the management of psychopathy.
Childhood sexual abuse	Training needed in the mental health consequences of childhood sexual abuse. The links with mental health difficulties including self harm, suicidality, depression, eating disorders and 'psychosis'. Survival strategies including dissociation, derealisation. Therapy models for trauma recovery including Herman's model of trauma therapy, Briere's model of trauma therapy, survivor models, group-therapy. Self Harm (including eating disorders, drug/alcohol abuse). Dissociation/flashbacks. The recovered memory debate. Working with male survivors of abuse: need a gendered understanding of masculinity and men in addition to trauma based psychological treatment approaches, plus understanding of paedophilia and how paedophiles work so as to understand how they would have groomed their victims. Working with sex issues in the therapy room e.g. sexual transference and counter transference, bestiality, sex addiction, gender issues, ritual abuse etc.

3.7 Prevention

A very wide ranging set of options were discussed, with considerable level of detail in some cases. There was a lot of overlap with the answers under question 8 and question 9 in Round 1 (on improving outcomes and addressing obstacles).

Sexual and domestic violence and abuse need to be made public health issues, with a public awareness campaign stressing personal responsibilities and rights. Much more openness and acknowledgement of levels of sexual violence and abuse is needed. There needs to be an engagement with the media to ensure a balance between airing of the sensational/ confrontational aspects of abuse (which attracts good audiences) with the important but softer informational/educational content that those who are quietly or secretly living with memories prior to disclosure need. Awareness and information sessions need to be provided in schools as part of the Personal, Social and Health Education curriculum. Sexual and domestic violence and abuse need to be made priority issues for education services, with additional support for teachers who are supporting pupils who disclose.

The need for application of a basic public health model (of identifying risk factors and strengthening protective factors in the individual, the family, the community and society within various age bands) was emphasized. Prevention needs to be approached as any other major public health campaign, with appropriate components for primary, secondary and tertiary prevention:

- Primary prevention – work in all sectors (schools, youth settings, workplaces) aimed at changing attitudes to all forms of violence and abuse. Large scale public awareness programmes aimed at changing attitudes to violence and abuse, to include understanding of what consent means; need to be carried out at general population level and within all cultural/ethnic communities involving women in the community and community leaders. Stronger sanctions against perpetrators. Perpetrator focussed media campaigns. Work within particular groups upholding practices that are violent and abusive, examples include forced marriage, female genital mutilation and gang cultures supportive of rape and abuse of women.
- Secondary prevention – better risk assessment. Effective interventions by criminal justice system to hold perpetrators to account. Specialist prosecutors. Better targeting of those that are vulnerable to abuse or be abused including service provision, help lines, support work etc. and engaging adults in abuse prevention. Training and building skill capacity within a wide range of statutory and voluntary agency workers in order to begin to address the problem when it does present itself to services. Early identification and intervention with families (to be carried out in a range of different settings, e.g. GPs, mental health, maternity, A & E departments, social services, schools). Appropriate systems (information sharing and intervention protocols) in place to ensure early intervention in any abuse by professionals of their clients.
- Tertiary prevention – therapeutic support for survivors, effective treatment and accountability for perpetrators.

Children and young people are most likely to be safe and keep safe if they; understand their right to be safe, have been helped to develop the confidence to speak out if they feel danger, or don't like what is happening; have a secure base within family or substitute family; there is at least one adult they can talk to. Therefore building children's self esteem and self worth and listening and taking them seriously should be at the core of all universal services. It should

also be part of a strategy in say PHSE for equipping children to grow safely and healthily, with an understanding of healthy relationships and consent. Education of people with learning disabilities about sexual activity and relationships is also required.

Organisations need to proactively 'model' non abusive and empowering behaviours, and workplace bullying and harassment policies have a role to play here.

A less punitive and more therapeutic approach is required toward the perpetrators who must be treated firmly and appropriately and not let off or cautioned. Adequate resources to be able to offer and strongly encourage the uptake of treatment must be available. There must be zero tolerance of this kind of behaviour.

Other elements mentioned included:

- Good public information services, especially for teenagers about safe dating.
- Good public transport, especially in rural areas.
- Make it easier to report crimes and reassure victim about how they will be supported
- An increase in the availability of advice to those who know they have a sexual interest in children, such as confidential freephone numbers.
- Need to have facilities available for those who have no criminal record but who are concerned about their behaviour/desires.
- Sexual dysfunction clinics.
- Good checks on staff working with children.
- In relation to internet, need further understanding of the criminogenic properties of the medium.

One issue on which diverging views were apparent was whether domestic violence/abuse and sexual violence/abuse should be separated for prevention work or not.

Table 3.11 summarises responses that were specific to different programme areas.

Table 3.11: Prevention: interventions specific to particular programme areas

Programme Areas	Component
Adult sex offenders	• Primary prevention: If attention were paid to boys in particular who were exposed to violence and emotional neglect within the home, and who perhaps were consequently sexually abused by either family members or individuals outside the family context, then it may be that intervention at this stage would reduce the sub group of such boys who go on to become perpetrators. • Primary prevention: there is a need to ensure that the skills in assessing and treating adolescent sex offenders are improved and services are made more consistent across the country, so that the small sub group of adolescent sex offenders who are likely to pose a longer term risk of perpetrating future sexual offences are identified early on. This sub group, though only a small component of the group of adolescent sex offenders, does represent in later adulthood some of the most entrenched sex offenders who cause repeated harm to others. • Secondary prevention: in terms of the prevention of re-offending, very strong societally driven control and consequences for behaviour to deter some sex offenders, who recognise that they are at risk of receiving very lengthy custodial sentences or even life sentences should they re-offend. • Address the social exclusion of sex offenders (from engaging in work and social activities that other offenders might have access to) and counter misperception that risk is located outside the family when in fact children are most at risk, as are women, from relatives and friends. • Sexual Offenders leaving custody still pose potential danger to the public and the current legislation provisions (in particular to places of residence) are not sufficiently robust.
Child protection	• The Internet can provide a primary prevention platform (and therefore effective intervention tool) in the world of child protection. For the first time ever we can proactively identify offenders and potential offenders before they have come into the system.
Childhood sexual abuse	• Further use of campaigns like ‘Stop it now!’ and ‘Full Stop’. • We need specific help for disabled individuals including learning-disabled children/young people who are more dependent on caregivers and so at more risk of abuse. They need specific plans to protect themselves from, and be able to report, sexual abuse from adults and from peers. • Specific sex education and information and assertiveness training for disabled young people tailored to their individual needs and level of impairment. • Providing instructional stories, DVDs, and videos to children to teach them the difference between good touch and bad touch, a good secret, and a bad secret - See for example the instructional story: The Secret of the Silver Horse http://canada.justice.gc.ca/en/dept/pub/ssh/index.html. • Providing guidelines for reporting on CSA cases, or producing a "media handbook" could be a good starting point for enlightening journalists on the sensitive issue of CSA.

3.8 Improving Outcomes and Addressing Obstacles

A high level synthesis of results on this topic was presented to respondents in Round 2 of the Delphi. Thirty seven respondents offered some comment on this section in Round 2, and twenty two in Round 3. Some of these offered explicit confirmation that they agreed with the synthesis reported and had nothing further to add. A further group affirmed their general agreement (in whole or part) and added some further amplification on particular points. A number of suggestions were made for additional points/areas requiring coverage, these are included here.

A very wide ranging set of options were discussed, with considerable level of detail in some cases. A lot of overlap was found with the answers given under question 7 (on prevention) and some parts of questions 2 and 4 on helpful interventions. There were also marked similarities between the answers generated by the experts in the different programme areas.

The issues of lack of funding, lack of political will, lack of priority and lack of public visibility and the need for societal wide action come through in every single programme area – along with support for a broad public health approach and the need for an integrated high profile national strategy (with some differences about the extent to which integration is possible/desirable). It was emphasized that policy-makers need to resist the temptation to impose unitary solutions to the huge diversity of different situations and recognize that the keys to successful policies are likely to be sensitivity and flexibility.

A number of responses noted the lack of a joined-up approach at national level, suggesting that this be addressed through a comprehensive national strategy that recognizes the need for action in all sectors of society. Particular components that were stressed were:

- Need for widespread change in public attitudes and knowledge about the extent and nature of abuse – keeping an appropriate balance between the coverage of 'stranger danger' and abuse by known and trusted adults, and recognition that men are also victims/survivors of sexual violence and abuse. Need for government departments to work with the media to give clear messages that people can recognise and take appropriate action about abusive behaviours.
- Need to "Challenge the silence about sexual abuse".
- Need to challenge the problem that abuse is not seen as relevant in NHS settings e.g. not a 'mental health' issue. This relates to services still being organised around diagnostic categories and medical models of care where links are not made between experience of abuse and presenting distress or 'symptoms'. Once a person has a diagnostic label (e.g. ADHD, Personality Disorder', OCD etc.) there is no need to ask any more questions, which inhibits disclosure.

In terms of funding, the need for long term funding for all different sectors and in particular retaining NGO expertise was emphasized, since not all victims/survivors feel safe to access statutory sector services, (assuming that such services exist).

Table 3.12 summarises the specific suggestions that were made in response to these questions that were not specific to particular programme areas, while Table 3.13 summarises suggestions that were specific.

Table 3.12 Improving outcomes and addressing obstacles: Specific suggestions

- A very high profile advocate – preferably someone who was completely committed and well-informed.
- There needs to be a greater emphasis on the need to financially stabilise voluntary sector services.
- If the VVAPP programme is itself time limited, the Department of Health fails to meet its commitment to implementing its intention to mainstream women's mental health and to improve outcomes in health for women
- Having a commitment to address violence as a key policy area that sits above or alongside targets/PSAs
- A continued dialogue and debate fed by accurate knowledge and statistics, from the UK and elsewhere, on the scale of the problem and evidence of effective intervention and effective prevention. An annual conference bringing together the various perspectives to fuel the above.
- Clear legal framework and implementation for violence prevention programme, with political and community leaders committed to condemning all violence and promoting non-violence.
- Needs a summit to discuss international approaches and deportation of perpetrators.
- There should be a standing government committee set up to monitor progress on various abuse related initiatives; This standing committee should be mandated to ensure the national implementation of the agreed recommendations for service, policy & research development; There should be clear inter-departmental lines of communication to allow for the above to occur and this should include communication with the Cabinet Office and the Treasury to ensure that there is political and financial backing, at the highest level, for any agreed recommendations; The Children's Commissioner should be appointed to the standing committee to ensure that the rights of abused and abusing children in the community, in care and in custody, are represented independently.
- To tackle lack of political will try a programme of education or awareness raising for key, senior politicians in each of the three political parties. Such a programme could be achieved through a series of non party political Expert Seminars, held in Westminster. Such Expert Seminars would need to include a 'carrot & a stick' approach to ensure that MPs attended, so political lobbying including, perhaps, leafleting of local constituency party organisations to ensure that their MP attended to hear about new developments in relation to abuse in their constituencies (or similar strategies) would be necessary. In addition to MPs, it could make sense to involve those members of the House of Lords with an avowed interest in child protection and abuse prevention, in these Expert Seminars since independently minded peers are able to address these issues more freely in the House of Lords and elsewhere and they may outlast MPs so that initiatives can be carried forward.
- Government should actually take down and dust down the very many published reports and reviews in relation to abuse, delinquency etc, funded over the last thirty years or more and should then distil the main messages from this already funded work. A list of the key recommendations from all this existing work would make a good basis for current policy initiatives.
- The development of hub-and-spoke type services, whereby the specialist expertise can inform the appropriate range of community services in maintaining (often intensive) effective intervention and support with young people over the long term and in different life situations.
- Compulsory Child Protection training of at least one week's duration for all politicians at local and national level, also all police officers (not just specific units), all health staff, teachers, social workers (current training for them is one day), counsellors, youth workers, judges and magistrates.
- More robust use of Civil Court orders by Statutory Agencies to protect victims removing the onus of responsibility from the victim.
- An increased provision of separate representation for children in private law family proceedings
- Acknowledgement that many victims/survivors would rather be seen by the voluntary sector and that that sector needs greater resources.
- Need special prosecutors to improve conviction rates.
- NHS commissioning policies for mental health services that recognise the value of direct commissioning from the voluntary sector.
- A national sexual violence forum, drawing on the expertise of the voluntary sector and specialist health services, education and the criminal justice system.
- Obstacles that prevent improvements are factions within the psycho-analytic disciplines, this could be overcome with Guidelines on psycho-therapeutic interventions in response to the needs of domestic and sexual violence and abuse.
- Attention to advertising standards

Table 3.13 Improving outcomes and addressing obstacles: Suggestions specific to particular programme areas

Programme Areas	Suggestion
Sexual violence and abuse	• Need to address lack of researchers who are intimately involved with treatment initiatives. • Sex Offenders should not be allowed to live near their victims or where they are close to places frequented by children. While subject to legislation, the responsible authority should be able to dictate licence conditions on Sex Offenders. • More provision of treatment for unconvicted abusers. • It would be of great benefit to the management of Sex Offenders if the Police were able to disclose a nominal's status to those that needed to know (i.e. new partners, family etc).Currently a referral is made to Social Services, who then request the information from the Police before visiting the person and then pass on the details of their Schedule 1 status. This may take weeks/months. • Need to find a high-profile 'advocate' in this area (a Jamie Oliver figure?) to present some facts and demand some better solutions. • A rolling media campaign (as with drinking and driving) which needs to be on prime time television, using regular hard hitting adverts, to get across the scale of the problem and its effects "it is a crime to sexually abuse your children" "Child rape carries a life sentence". • Needs a specific National Service Framework.
Child sexual abuse	• Greater commitment from across industry to come up with and commit to providing technical solutions to prevent child abuse on the internet (e.g. all computer manufacturers to pre-install safety software on all new PCs). • Address concerns about what is happening to children in private law family proceedings involving allegations of child sexual abuse, where orders for unsupervised contact may be granted because the resident parent (usually the mother) is unable to prove that the child has been sexually abused by the father or is at risk of sexual abuse.
Domestic violence	• 'Go orders' (police having the ability to order the perpetrator to leave the home, for example, the provisions under the Austrian legislation) and third party applications for protection orders all demonstrate the state taking responsibility for the protection of victims. • Systematic literature review in the field of therapeutic interventions for adult perpetrators of domestic violence. • Set up an academic board which fully represents current thinking on domestic violence to evaluate the existing research and to secure funding to carry out further research where needed. • Set up a similar board for clinicians which should be drawn from those working with violent offenders (not just domestic violence offenders) to identify programmes currently available. • All domestic violence interventions should be rigorously evaluated and those that do not evidence efficacy should be discontinued. • All interventions should be controlled and certified and referrals not made to any which are not. • More use of restraining orders and sexual offences prevention orders with domestic violence related convictions.

Chapter 4 Domestic violence and abuse

Chapter 4 reports findings from the analysis of responses about therapeutic and treatment interventions for domestic violence and abuse. This category includes all interventions aimed at healing or ameliorating the effects of domestic violence or abuse on victims/survivors, or at directly modifying violent or abusive behaviour. This includes separate sections on

- Adult victims/survivors of domestic violence and abuse (chapter 4.1);
- Child and adolescent victims of domestic violence and abuse (chapter 4.2);
- Adult perpetrators of domestic violence and abuse (chapter 4.3);
- Young people who perpetrate domestic violence and abuse (chapter 4.4).

Responses in these four programme areas were complicated by the use of different understandings/definitions of the term 'domestic violence'. There were almost completely polarized positions that arose within the responses on this programme area. The first of these positions was held by those who saw (or defined) domestic violence as being about the use of coercive control within an intimate relationship (with one partner as the perpetrator and the other as the victim/survivor), and the second by those who saw (or defined) the term domestic violence as covering a much wider field of difficulties within an intimate relationship, including also relationship difficulties, conflict characterised by bi-directional violence or abuse, referred to by some as 'common couple violence' or 'mutually abusive relationships'. Both positions recognized the existence of female perpetrators of domestic violence and abuse, and the existence of domestic violence and abuse in homosexual relationships (both male and female)[7]. The first position is illustrated in Figure 4.1. The second position is illustrated in Figure 4.2. Within the respondents in all three rounds of the consultation, the first position was more common than the second. Within this report the term 'domestic violence and abuse' is reserved for that part of the spectrum where the abuse is characterised by coercive control (Figure 4.1), and the term 'mutually abusive' is used for that part of the spectrum that does not involve coercive control of one partner by the other.

Figure 4.1 First position on domestic violence

'Domestic violence is a pattern of controlling behaviour against an intimate partner or ex-partner, that includes but is not limited to physical assaults, sexual assaults, emotional abuse, isolation, economic abuse, threats, stalking and intimidation. Although only some forms of domestic violence are illegal and attract criminal sanctions (physical and sexual assault, stalking, threats to kill), other forms of violence can also have very serious and lasting effects on a person's sense of self, wellbeing and autonomy.

Violent and abusive behaviour is used in an effort to control the partner based on the perpetrator's sense of entitlement. This behaviour may be directed at others – especially children – with the intention of controlling the intimate partner.

Social and institutional power structures support some groups using abuse and violence in order to control other groups in our society e.g. institutional racism, heterosexism, parents' violence to children. The unequal power relations between men and women account for the fact that the vast majority of domestic violence is perpetrated by men against women rather than vice versa. '

Taken from Introduction to Respect guidelines

[7] A range of different beliefs about the relative prevalence of different types of difficulty in intimate relationships were set out, this however is not something that is explored further in this report.

Figure 4.2 Second position on domestic violence

'[It is important to make] distinction between different types of relationship in which domestic violence is used. … clients [belong] in one of 4 quadrants, either 'unilateral severe battering', 'mutual severe battering', 'unilateral common battering/high conflict violence', 'mutual common battering/high conflict violence'. Perpetrators in each quadrant have different causal factors, relationship dynamics and treatment needs … approximately 50% of domestic violence relationships involve mutual violence …. Asking about both partners' use of physical aggression is imperative both to understand the relationship dynamics and to design appropriate intervention strategies.'

'distinction between 'intimate terrorism' perpetrators and 'common couple violence' perpetrators. The former are characterised by controlling behaviours displayed over a long period of time and the latter by anger motivated occasional aggression which is often of reduced impact with regards to physical injury. Intimate terrorists are those requiring the most intense treatment and challenging of normative beliefs. Common couple perpetrators, however, have a usual need for focus on emotional management. The key issue here really is attention to the motivation behind the behaviour as opposed to a focus on the type of aggression (e.g. physical, verbal, sexual, indirect, psychological).'

'Tailoring interventions to individual needs, offenders can be offered one or more of the following: same-sex batterer group work, individual therapy, couples counselling, couples group work, multifamily couples groups, and/or anger management/conflict resolution skills. What is imperative is that perpetrators are screened at intake and their inventions tailored to their specific offending pattern.'

4.1 Adult victims/survivors of domestic violence and abuse

For adult victims/survivors of domestic violence and abuse, the quality of the therapeutic relationship emerges as being of greater importance than positions about individual therapeutic approaches. Therapists working with this client group need to be able to employ a 'toolkit' approach and develop the service/s they provide to suit the needs and readiness of their clients. The role of the therapist takes on an active contribution in the client's healing process, rather than remaining a passive facilitator, both in terms of the service provision and the role of the client-therapist relationship as a model for rebuilding social and interpersonal skills for the client (see Figure 4.3).

Figure 4.3: The active role of the therapist in supporting adult victim/survivors of domestic violence/abuse

'The therapist has a critical role in creating positive experiences and affirmations.'

'… therapeutic work needs to be provided in the context of a secure attachment relationship with the therapist, who will act as a witness to the trauma'

'[the therapist] may have a role in helping her [the client] to review what is happening and offering an alternative perspective.'

'…the client was damaged in the context of a relationship and the process of recovery should take place in the same context.'

There is a strong agreement that being in a domestically abusive situation is never the fault of the victim/survivor, and that for some, leaving the relationship is not possible or would not be sustainable until they have developed skills, confidence and awareness through therapies and other information service providers. The difficulty of leaving a DV situation is viewed by some respondents as another example of the outcomes of the abuse. Similarly, negative or harmful coping strategies that the client may have used/developed are viewed as what has 'got them through' to the point where they are able to look for help and therefore should not be dismissed or controlled, for example through contracting. For some respondents it was important to describe these as 'symptoms' that need to be addressed through psycho-

educational and CBT style approaches, within the broader context of healing the underlying causes. For other respondents, the importance was to treat these as normal reactions to traumatic situations and to approach them from a PTSD/trauma framework.

All of the therapeutic approaches listed in the Delphi questionnaire in Round 1 were reported useful/helpful by some respondents. Table 4.1 shows a summary of the responses to questions on effective interventions, both in terms of what is helpful and what should not be used. Many of the approaches listed in the questionnaire also received mention as to what should not be used; the most notable of which were mediation and restorative justice. Respondents were uneasy with any approaches that required contact between perpetrators and their victims, particularly in settings where the victim/survivor has moved location, developed new social structures or created a new life that is separate from the person they have left.

This programme area had the highest proportion of respondents advocating a feminist/pro-feminist approach. This position was represented in a range of responses that emphasised both an individual client-level need for person-centred, empowering, gender aware, anti-racist, anti-marginalisation, anti-medicalisation approaches; and, also on a societal/cultural level, with the client benefiting from their own and also from their therapist's understanding of the role of gender and power inequality in abusive intimate relationships. Alongside this emerged a position that a social and gender inequalities framework was important for understanding how abusive relationships develop and exist within society. Some respondents outlined how the therapist should provide empowering approaches: person-centred, talking therapies (as opposed to medication) and thought and skill therapies (such as CBT) as empowering through the development of emotional and behaviour responses. This position explicitly recognized the existence of male victims of domestic violence/abuse and female perpetrators.

An extension of the general position to empower and support the client through therapeutic interventions was the position that supported the use of solution focussed therapies, emphasising the role of resources, skills and capabilities to both heal psychological trauma and also to re-build a non-abused life. For some respondents there remained a concern that the use of solution focussed, skill based and cognitive behavioural interventions may occur at the expense of longer term, "deeper" or affective therapies.

In line with the position that integrated, 'toolkit' approaches are necessary for this client group, many respondents also outlined a need for staged approaches, using different therapies at different parts of the process. Stages were typically conceptualised by the respondents as three phases, which may not be simply linear in practice: 1) establishing safety and stabilising, 2) dealing with traumatic memories and addressing psychological harm, 3) reconnecting and rebuilding a post-DV life (see Figure 4.4).

Although there was predominant agreement for a staged understanding of recovery from DV, the specific techniques used in each phase indicated some disagreement. Some respondents felt that the use of anti-depressants and similar were appropriate methods to working towards stabilising the client, others opposed medication as a hindrance. Some respondents proposed that skills and resource centred techniques were essential for stabilising; others placed such approaches as more appropriate in the later, rebuilding phase. Most of the tensions here were resolved when respondents reflected back on the need to tailor the therapeutic process to the needs, resources and readiness of the client.

Figure 4.4 The staged approach to providing support and therapy

Getting safe from domestic abuse is a process not an event and in my opinion the only effective interventions mirrors this with careful timing and pacing. The needs of a woman change dramatically over time. For example, women may need help and time to review and understand their options in the early stages of contact with services when she may have recently disclosed what is happening to her (and her children) at home.

Acute physical health needs must be assessed throughout this process. As she moves through this and towards making decisions a practical, supportive advocacy model is most appropriate. However, once safety has been achieved and stabilised (this as we know can take some time) the mental health and possibly chronic physical health aspects of her difficulties may achieve greater prominence as she attempts to make sense of her traumatic experiences. The model, which I believe is most useful to conceptualise this process, is 'The 3 Stage model'.

Stage 1: Safety and Symptom Stabilisation
Survivors of chronic abuse do whatever they need to survive the physical and psychological pain of their abuse. This can include psychological defences such as dissociation, denial or self harm or the use of substances such as alcohol, drugs or food to dull their experiences. If these 'defences' are acting efficiently for the woman they may impair her ability to make clear choices for herself and any dependents. In addition, abusers often utilise complex psychological mechanisms such as what can only be described as 'brainwashing' of the survivor to his views to help enmesh the survivor into her role. [The therapist] may help to clarify if this is happening in a given situation.

The second part of stage one is symptom stabilisation. I tend to conceptualise them [symptoms] more as the normal consequences of prolonged exposure to stress and trauma or alternately as the bodies creative attempts to cope with those experiences. For example, flashbacks and nightmares are explained to be the unintegrated memories of a trauma, which lack a 'narrative' or story and are thus easily triggered. Other 'symptoms': Anxiety & panic, Depression, Sexual difficulties, Flashbacks and nightmares, Anger difficulties, Dissociation (to varying degrees of severity), Self esteem difficulties, Self image difficulties, Alcohol/drug abuse, Self harm, Relationship difficulties, Obsessive compulsive difficulties, Eating disorders. This is not an exhaustive list but gives a sense of the difficulties, which need to be assessed for.

If necessary, approaches such as cognitive behavioural therapy, behavioural therapy, schema-focussed interventions, dialectical behaviour therapy, psycho-education and bibliotherapy [may be used]. However, the underlying theme is not understanding these 'symptoms' is isolation but in terms of what the survivors has lived through.

Stage 2: Processing the memories

Once a survivor has achieved stability, that is they are able to cope with their emotional distress without using coping skills that are damaging to her in the long term such as self harm, dissociation, alcohol, drugs or eating problems, they are assessed as being ready to participate in stage 2 work.

[A] reality of therapy is that the process is not linear but more resembles a spiral where the early contact may be focussed on dealing with the 'symptoms' such as depression and panic attacks but as therapy progresses more and more traumatic material does emerge. As this happens it may be necessary to intensify stage one interventions, in order that the emotional distress that is triggered can be coped with. Stage 2 work relies more heavily on the strength of the therapeutic alliance between the therapist and the client.

The client in stage 2 is required to go back to the past in the safety of a current therapeutic relationship and both learn to cope with it without unhelpful coping mechanisms and to form a narrative of the events.

Stage 3: Reconnection
It involves the reassessment of the client's life goals and active working towards them. There may be support agencies which can help [with] this in the early days.

There was a strongly argued position that mediation and family preservation is not the aim of therapies for adult victims/survivors of domestic violence and abuse. The only exception to this was argued from the perspective that some perpetrators may also engage in their own therapy, separately, and that after an extended period of non-violence and personal therapy,

mediation may be considered. Couple counselling and reconciliation work was firmly opposed, in terms of client safety and confidentiality, as well as in terms of the need to separate from the DV perpetrator and their influences in order to regain control of their own lives. Confidentiality and privacy were considered as core tenets of the client-therapist relationship, only to be compromised in times of extreme danger, such as overdose, or for imminent child protection issues.

As well as a more mainstream delineation between perpetrators and victims in DV households, there was a small group of respondents who referred to mutually abusive relationships, where both partners are abusive and or violent. In such situations, couple or family counselling may be considered appropriate. The emphasis in these responses was on improving relationships, inter personal skills, and anger management techniques. This is in quite strong contrast to some respondents who only considered non-abusive victims of DV, where the position is one of opposing family dynamic explanations of DV and the use of anger management for adults in abusive relationships. This position is associated with a different definition of domestic violence, and a different use of language in conceptualizing the factors affecting a person's vulnerability to abuse.

Table 4.1: Views on helpful/useful approaches and on approaches that should not be used: adult survivors of domestic violence and abuse, Round 1

Helpful/useful approaches	Should not be used
• Psychotherapy • PTSD, trauma work • CBT • Solution focussed • Talking therapies (as opposed to medication)	• Couple or family counselling • Anger management • Non trauma-specialised counselling • Interventions that do not consider a social and gender inequalities framework

Tables 4.2 to 4.5 summarise the responses to specific statements assessed in Rounds 2 and 3 of the Delphi consultation.

Within Table 4.2 there was one statement on which complete consensus was reached in Round 3: ('There is no single therapeutic approach that works best for every victim/survivor in this group'). There were two cases of concordance, where there were some neutral responses: 'Behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs', where 9% remained neutral, while for 'The approaches used should be needs-led and victim/survivor centred', 2% remained neutral.

There were a number of areas in which diverse positions were advanced in Round 1, and maintained through the two further rounds of the consultation:

- Whether or not there is a useful role for emotionally modifying or psychiatric medication within the course of therapies for DV victims/survivors (see Table 4.3). Comments in Rounds 2 and 3 drew attention to the need for an individual and context based decision about the appropriateness of medication.
- Whether anger management and conflict resolution techniques are appropriate, or whether the use of anger/conflict techniques ignores the power and control issues underlying and propagating DV (see Table 4.4). Differences in positions held here were closely related to the use of the two different definitions of domestic violence discussed earlier.
- Whether or not there is a place for anticipating and facilitating mediation with the DV perpetrator (see Table 4.4).
- Positions both for and against routine enquiry for adult victim/survivors of domestic violence and abuse.

Table 4.2: Therapeutic approaches for adult victims/survivors of domestic violence and abuse, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S8.1 A 3 Stage model (Stage 1: Safety and symptom stabilisation; Stage 2: Dealing with the traumatic memories; Stage 3: Reconnection/Regaining a safe and fulfilling life) provides a suitable framework for responding to the needs of this group of victims/survivors	**9**	**66**	17	4	4	53
S8.2 It is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual	**35**	**54**	7	4	0	54
S8.3 There is no single therapeutic approach that works best for every victim/survivor in this group	**52**	**48**	0	0	0	54
S8.4 The approaches used should be needs-led and victim/survivor centred	**55**	**43**	2	0	0	53
S8.5 The approaches used should be victim/survivor directed	**37**	**39**	17	8	0	54
S8.6 Behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs	**45**	**45**	9	0	0	53
S8.7 Mutual support/self-help should only be considered after successful individual therapy/work	6	6	14	**60**	**15**	52
S8.8 Not all victim/survivors need long-term therapy or treatment	**28**	**59**	9	4	0	53

Table 4.3: Therapeutic approaches for adult victims/survivors of domestic violence and abuse – medication, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S8.9 Emotionally modifying or psychiatric medication can play a useful role within therapeutic intervention for DV victims/survivors	**2**	**54**	22	20	2	46
S8.10 Psychotropic medication is a hindrance to therapeutic intervention for DV victims/survivors	7	20	38	36	0	45
S8.11 Psychotropic medication could/might be a hindrance to therapeutic intervention for DV victims/survivors	**9**	**61**	24	7	0	46
S8.12 Clients with depression or anxiety symptoms are best supported using medication in the first instance	2	8	33	**47**	**10**	49
S8.13 If a therapist is aware that their client is taking psychotropic/emotionally modifying medication it is important that they make clear the potential effects that medication can have on the client being able to address their issues.	**16**	**68**	10	6	0	50
S8.14 If a therapist is aware that their client is taking psychotropic/emotionally modifying medication, it is important that the therapy programme assists the client in developing strategies that support coming off medication.	**16**	**32**	32	20	0	50

Table 4.4: Therapeutic approaches for adult victims/survivors of domestic violence and abuse – anger management, conflict resolution, couple counselling, reconciliation and therapist contact with partner, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S8.15 Anger management and conflict resolution techniques are not useful	8	23	21	48	0	48
S8.16 Anger management techniques are appropriate for mutually violent couples	**6**	**51**	19	21	2	47
S8.17 Within situations that can be characterised as mutually abusive, there is a role for anger management or conflict resolution techniques	**4**	**61**	22	12	0	49
S8.18 Conflict resolution techniques are important skills to teach victims/survivors of domestic abuse	**12**	**59**	12	16	2	51
S8.19 Couple counselling is appropriate for mutually violent partnerships	**2**	**47**	27	13	11	45
S8.20 Anger management and conflict resolution may be useful skills to develop in therapeutic settings, but should not be the basis or the main focus of therapy to support victim/survivors of domestic violence and abuse.	**39**	**53**	6	2	0	49
S8.21 If the client wants reconciliation with a previously abusive partner, the therapist should facilitate mediation wherever possible	4	8	17	**60**	**10**	48
S8.22 There is never a role for the therapist in anticipating and facilitating mediation with the DV perpetrator	**16**	**49**	4	29	2	49
S8.23 Therapists should have no contact with the abusive partner of any of their clients	**16**	**45**	20	16	2	49

Table 4.5 includes a summary of the views of respondents about the issue of qualifications and training. This demonstrates a lack of consensus. As can be seen, although a clear majority of respondents in Round 3 agreed that therapeutic interventions should be offered by suitable professionals, by those with suitable qualification, by those with relevant training and by those with accredited training; in each case there were significant minorities who disagreed. Note also however that a clear majority is found in support of the role for survivor peers in leading therapeutic interventions (working within suitable guidelines). Comments in this area emphasised the difficulty of establishing what are appropriate in terms of professionals, training, qualification, and accreditation.

Table 4.5: Therapeutic approaches for adult victims/survivors of domestic violence and abuse – power and control models, professionals and qualifications, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S8.24 It is important for clients in this group to understand power and control models and social inequalities frameworks, as part of understanding their own experiences	**41**	**45**	10	4	0	51
S8.25 Therapeutic interventions can be led by survivor peers working within suitable guidelines	**18**	**45**	8	27	2	49
S8.26 Therapeutic interventions should only be led by those holding a suitable professional qualification	**21**	**33**	13	25	8	48
S8.27 Therapeutic interventions should only be led by those holding a suitable qualification	**15**	**52**	8	17	8	48
S8.28 Therapeutic interventions should only be led by those who have completed relevant training	**26**	**55**	6	13	0	47
S8.29 Therapeutic interventions should only be led by those who have completed accredited training	**27**	**22**	18	22	10	49

4.2 Child and adolescent victims of domestic violence and abuse

For children and adolescent victims of domestic violence and abuse, victimisation and autonomy of the client are comparatively diffused, and three considerations emerge; the role of the child in a DV household; the role of the non-abusing parent; and, the role of the abusing parent. The overarching position is that there are no assumptions made about the type of therapeutic interventions that are needed by children and adolescent victims of domestic violence and abuse, and that service provision is predominantly needs led, guided by the age and maturation of the child and their individual experiences and degree of victimisation.

The child's role in a household where there is domestic abuse is recognised as ambiguous; they may be a primary or secondary victim, through direct experience or through witnessing acts of DV; they may have experienced persistent, sporadic or isolated DV incidents; they may have experienced DV from a number of household members, in series or from only one person; and, they may or may not have suffered from the compounding effects of the various potential mental health outcomes of the non-abusing parent. For some respondents it was possible to view children as "witnesses", but for other respondents it was important to emphasise children as social actors within the DV household, that had their own behavioural contribution to maintaining their own safety and developing coping strategies.

From this ambiguity there are two competing, but not necessarily incompatible, approaches to therapeutic interventions for children and adolescents with regard to the role of the non-abusing parent. First, the position that children should have access to information, confidentiality and legal help in their own right and make their own contribution to decisions made about their lives and therapies. Second, the position that the child's relationship with the non-abusing parent should be preserved, and its enhancement should be seen as an aim of therapeutic interventions. In this second position, it becomes harder to separate the child as an autonomous figure in the therapeutic process (see Figure 4.5), though there is an assumption that mutually acceptable decisions can be reached where there is a preference, or need, to be treated separately.

Figure 4.5 Children and non-abusing parents in the therapeutic setting

'On an emotional level, increasing communication and the capacity for respect and negotiation between mother and child is of enormous benefit. Opening up the channels of communication between mother and child is one of the key goals of the work.'

'Working with women and children together is a very valuable activity as it can be a safe way of opening up the channels of communication between them. Domestic violence is often a secret that women and children keep and which isolates them, even from each other.'

'For children we have found that developing a common language between themselves and their mothers enables there to be more open dialogue about the domestic violence and facilitates a better understanding of their children's needs.'

'Working closely with mothers and with relevant individuals in children's lives (e.g. teachers) to create positive cognitive and behavioural shifts is also important.'

'The importance of being able to both address the specific needs of children and the ways their experiences and future well-being are connected to their mothers should be recognised.'

'There may be some women (and or children) who prefer to work with a different psychologist and this should be arranged where it is possible and in the best interests of both mother and child.'

The role of the non-abusing parent is also essential in establishing a safe situation in which the child or adolescent is permitted to engage in therapeutic interventions; there is a forcefully argued position that safety and separation are pre-requisites to therapies. 'Safety first' approaches place the responsibility on the non-abusing parent and as such set the therapeutic pace at the level suited to the parent rather than the child (see Figure 4.6).

Figure 4.6 Safety first approaches to child and adolescent access to therapies

'Child protection issues and safety of a placement must be resolved before any ongoing therapeutic treatment is practicable and ethically acceptable; there can be pressure from the professional network for therapy to start a.s.a.p. and before the former has been resolved adequately.'

'Therapeutic intervention is not indicated when the external situation is unsafe. In this situation support and safety planning is indicated.'

'It is not safe to treat a child who is still at risk in their home environment, as this places the child in an impossible conflict, and more vulnerable to threats and abuse.'

'Women protection is the best form of child protection.'

Alongside the position that therapies can only be undertaken after the child is assured to be in a safe environment (usually through safe separation of the non-abusing parent from the DV perpetrator), there is a position that recognises the ongoing role that a DV abusive parent may take in the child's life, and subsequently that the DV abusive parent may also play a role in family therapies (see Figure 4.7).

Figure 4.7 Child protection and the role of the abusing parent in therapeutic settings

'If the perpetrator is able to remain part of the family safely (as in some cases of domestic violence), then family therapy can help in the delineation of responsibility in the family and the acknowledgement of the effects of past events.'

'Family therapy can address the impact on family dynamics and sometimes address the abusive system, if the perpetrator is motivated to work therapeutically.'

'Challenge the myth of 'any contact with fathers is worthwhile' that still informs major decisions over child contact with abusive men, even in the presence of 'evidence' to the contrary.'

All of the therapeutic approaches listed in the Delphi questionnaire were reported useful/helpful by some respondents. Table 4.6 shows a summary of the responses to questions on effective interventions, both in terms of what is helpful and what should not be used. Several of the listed approaches were identified by respondents as therapies that should not be used, most notably mediation, restorative justice and PTSD/trauma therapy. Some respondents were critical of any approaches that involved contact between the perpetrator/abuser and the child (mediation, restorative justice) and raised concerns about maintaining the safety of the child. Also some respondents discussed PTSD and trauma work as too severe for younger children who do not have the emotional or cognitive ability to process and engage in trauma focussed techniques.

Due to the heterogeneity of this programme area by age, extent and impact of victimisation, most respondents emphasised the need for assessment prior to intervention, both of the child's needs and their maturation and developmental abilities to engage meaningfully in therapies. As well as a general position that different children are suited to different interventions, Figure 4.8 outlines positions that specific interventions may be appropriate for different age

groups within the "child and adolescent" spectrum: younger children are better suited to play therapies and older children may benefit from more cognitive and psycho educational approaches.

Figure 4.8 Age appropriateness and choice of therapeutic approach

'I have found some aspects of CBT models/therapy for PTSD, Trauma and abuse helpful especially with adolescents where there has been distress caused by intrusions, nightmares, trauma re-experiencing and preoccupations with threat (i.e. associated mental health problems)… Non-directive, creative approaches (e.g. play therapy, art therapy, sandtray) have been helpful with younger children, where there is a difficulty in verbally expressing distress, where disclosure is recent or ongoing, and is containing/safe particularly for more difficult feelings.'

'Age appropriate assessment - Semi-structured interview (focusing on domestic violence issues, screening for anxiety, depression, PTSD) this may need to be carried out over a period of days (and completed within two weeks of arrival) with shorter and more frequent sessions for younger children; Cognitive and developmental assessments might also be necessary for child residents.'

'Cognitive behaviour approaches with a child [should not be used] (anger management or conflict resolution) when a child is not sufficiently cognitively developed and where therefore a play approach may be more appropriate.'

Table 4.6 Views on helpful/useful approaches and on approaches that should not be used: child and adolescent victims of domestic violence and abuse, Round 1

Helpful/useful approaches	Should not be used
• Integrative model • Child protection principles • CBT for adolescents • PTSD type work, modified for younger people • EDMR • Panic, fear and phobia work • Group work for young people • Age and developmentally appropriate peer support • Narrative therapy • Play therapies • Creative and media therapies • Non verbal approaches to describing feelings (e.g. feelings charts and drawings) • Attachment theory based approaches • Child psychotherapy • In depth counselling (where appropriate) • Family therapy in some cases where the violent parent is kept within the family setting • Use of text messages, emails, letters and phone calls for contact between children and sources of help and therapeutic assistance	• Mediation/reconciliation • Joint therapy with an abuser • Cognitive approaches that are not suited to the cognitive maturation of the child

Tables 4.7 to 4.9 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation.

Within Table 4.7, one statement produced concordance in Round 3 ('Choice of therapeutic intervention should be needs led, guided by the age and maturation of the child and their individual experiences and degree of victimisation'), with 2% of respondents as neutral. Clear majority positions existed in favour of a staged model, with respondents in Round 2 and 3 commenting on the importance of not regarding the stage model as defining a rigid and sequential approach. There was also a clear majority affirming that 'behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs'. In relation to safety and separation, clearly split positions were evident here and a number of

comments emphasised the need for consideration of these separately[8]. Some argued that safety was the more important, and that separation was not as important. The dangers of separation were also noted, and the complexity of the issues involved, see Figure 4.9.

Table 4.7: Therapeutic approaches for child and adolescent victims of domestic violence and abuse, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S2.1 Choice of therapeutic intervention should be needs led, guided by the age and maturation of the child and their individual experiences and degree of victimisation	**78**	**20**	2	0	0	49
S2.2A 3 Stage model (Stage 1: Safety and symptom stabilisation; Stage 2: Dealing with the traumatic memories; Stage 3: Reconnection/Regaining a safe and fulfilling life) provides a suitable framework for responding to the needs of this group of victims/survivors	**11**	**54**	22	11	2	46
S2.3 Behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs	**52**	**39**	7	2	0	46
S2.4 Safety and separation are pre-requisites to therapeutic intervention [9]	22	34	4	32	8	50

Figure 4.9 Safety and separation

'The need for safety is paramount but separation is more complex. We must recognise the harm done to children by leaving them with abusing parents and must guard against being too naïve when assessing potential for change in an appropriate timescale for any child. Children may need support from outside the family during any period of upheaval but formal therapy may be more effective once major decisions have been made like where the child will live and who will have contact.'

'Services should be provided whilst living with abuse, but agree that there are questions about what is appropriate. However, since few children are ever totally 'safe' – since abusive parents are invariably given access, this is a question of degree.'

'I agree that safety is paramount; we have to look at the degree of "significant danger" that the child is in and this is down to child protection agencies. When it comes to separation, surly, this could be as damaging as the domestic violence that takes place in the home. Many children have never known life without witnessing DV. Support and education needs to be provided to help the child cope. If the parents choose to stay together removing the child may cement the belief that it is the Child's fault and also escalate the DV for the adult victims.'

Within Table 4.8 two statements produced concordance in Round 3 ('Children need access to therapies without their parents present (abusive or non-abusive)' and 'the child's therapeutic intervention (including its pace) should be considered independently from any therapy for the non-abusing parent'). There were two key areas in which spilt positions were advanced:

- Whether it is acceptable for the DV perpetrator and child to be included within the same programme of therapy and whether children should be engaged in family therapy where there is a history of DV, see also Figure 4.10.
- How group work should be handled, see also Figure 4.11.

In terms of whether it is beneficial for the child's therapeutic intervention and pace to be considered independent or inherently connected to the non-abusing parent's therapy, a variety of positions emerged see Table 4.8 and Figure 4.11.

[8] The use of different definitions of domestic violence is also implicated here.

[9] This was one statement were the analysis of views of declared experts only showed a slightly different pattern, with 5 out of eight experts disagreeing, and the remainder agreeing. Note however that the total number of declared experts here is still relatively small.

Figure 4.10 Family therapy

'Formal family therapy has the potential to maintain inappropriate power relationships where violence has occurred. The priority is to empower the children. Adults whose behaviour has been very frightening can suppress communication and leave children feeling powerless, unable to speak and frightened of the consequences if they do. There may be situations, however, where all members of a family have received help and where structured family sessions to facilitate open communication may prove useful so wouldn't rule out family therapy approaches altogether. They must be used with great care though where abuse and violence have been a feature.'

'Have concerns about use of family therapy – if used needs to take principal account of safety needs of non-abusive parent and child, and have real understanding of the risks involved – children may be inadvertently being used as bridges and inappropriate tools by either traumatised victim or manipulative perpetrator NB children's acute sense of responsibility.'

'A central point is that however much preparation and risk assessment is done children in families where there has been a high degree of violence or abuse have usually become accustomed to not being listened to. I am not convinced that this is an appropriate technique to be used with most families as I believe the power remains with adults and not the children. Risks are too high.'

'Family therapy involving the perpetrator of DV Should never be used as they could manipulate the sessions. We have to remember that DV is about power and control. It is also known that in a DV situation there is an increased risk of the child being sexually abused, family therapy involving the perpetrator could silence the child for ever.'

'S2.6 – strongly disagree – as a child of sexual abuse and dv, I would have been too compliant if my father had been part of family therapy. As a child I did not have sufficient self esteem or ability to voice my needs and thus would not have been able to benefit from a session if he had taken part.'

Figure 4.11 Groups and self-help

'Where abuse has occurred chronological age may be a misleading guide when selecting group members.'

'The group settings also depend on the children – do they have issues about gender? But also surely resources, since there may only be one group! Children say groups are the most important and helpful, so denying them access raises issues about victims' rights.'

'Groups need to be set up on a group by group basis and with the needs of participating children in mind. Therefore I think these positions are too prescriptive.'

Figure 4.12 Involvement of parents/family

'It is important that children are given opportunities for help that are separate from the potential conflicts between parents. Work to strengthen the bonds between child and non abusing parent is very beneficial but children should have access to their own help as well.'

'A flexible approach is needed. In our practice if abuse is suspected we try to see the child or young person on their own so that they have a chance to tell their story. This is one reason why family therapy alone should not be the treatment of choice. Confidentiality for the child or young person is also an issue. However, the best outcome for a child is that the parent who supports them is also part of the therapeutic process, either by working in parallel or with the child and the child's therapist.'

'While I believe the child and the non-abusive parent need support to develop their relationship and address the consequences of violence for each of them and their relationship, this process needs to address the possibility that the parent victim of violence may have been abusive to their child.'

'If a victim is to be reconciled with a previously abusive parent it is imperative that the victim has the chance to tell the abusive parent how the abuse has affected them. If this is done during therapy the two can work on their issues and come to a understanding of each other and the boundary's each may have. When this work is in a counselling setting the work is focused on the individuals needs, thus helping the victim to voice without fear their feelings to the previously abusive parent.'

Table 4.8: Therapeutic approaches for child and adolescent victims of domestic violence and abuse – family therapy, involvement of parents/family mutual support and self-help, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S2.5 Family therapy is always counter-indicated for families with a history of domestic violence	9	10	26	**43**	**12**	42
S2.6 There are some circumstances where the use of family therapy involving the abusive parent is warranted	9	37	14	19	21	43
S2.7 Family therapy should be used with great caution, and only after the therapist has established that the child/ren will not be placed in danger or be harmed by addressing issues with other family members present.	**51**	**35**	9	5	0	43
S2.8 Family therapy should take place after the therapist has had the opportunity to meet all members of the family individually, to assess their suitability and readiness for family work. Risk assessment should be carried out for each family member as a separate consideration	**43**	**23**	28	5	2	40
S2.9 Family therapy does not have to include the abusive parent	**42**	**44**	7	2	5	41
S2.10 Children need access to therapies without their parents present (abusive or non-abusive)	**71**	**22**	6	0	0	49
S2.11 The child's therapeutic intervention (including its pace) should be considered independently from any therapy for the non-abusing parent	**69**	**23**	8	0	0	48
S2.12 It is important that the relationship between the child and the non-abusing parent is strengthened during therapy	**34**	**43**	19	4	0	47
S2.13 Therapeutic intervention for children and non-abusing parent should always be considered as inherently connected	**9**	**53**	28	11	0	47
S2.14 When reconciliation with a previously abusive parent is considered, it is important that the children are included in family therapy sessions	**12**	**55**	26	0	7	42
S2.15 Mutual support/self-help should only be considered after successful individual therapy/work	7	20	15	**50**	**9**	46
S2.16 In group settings, it is more important that children are placed with others of a similar age than with others of the same gender	11	28	33	26	2	46
S2.17 In group settings, it is more important that children are placed in groups of the same gender than of similar age	9	18	34	30	9	44

Table 4.9 summarises the views of respondents about the issue of qualifications and training. As can be seen, although the clear majority of respondents in Round 3 agreed that therapeutic interventions should be offered by professionals, by those with relevant training, and by those with suitable qualification, in each case there were significant minorities who disagreed. In the case of views about whether training should be accredited, there was no clear majority position, 44% agreed, 32% disagreed and 23% were neutral.

Table 4.9 Therapeutic approaches for child and adolescent victims of domestic violence and abuse – professional qualifications and training, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S2.18 Therapeutic interventions should only be led by those holding a suitable professional qualification	**29**	**31**	17	15	8	48
S2.19 Therapeutic interventions should only be led by those holding a suitable qualification	**17**	**44**	13	24	2	46
S2.20 Therapeutic interventions should only be led by those who have completed relevant training	**31**	**48**	6	15	0	48
S2.21 Therapeutic interventions should only be led by those who have completed accredited training [10]	23	21	23	30	2	47

As reported in chapter 3, the Delphi respondents emphasised the multi-agency, multi-sectoral service response required to domestic violence and abuse, a summary of key components in relation to responding to young people and children who have experienced domestic violence and abuse is given in Figure 4.13.

Figure 4.13 Elements in the required multi-agency, multi-sectoral response for children and young people who have experienced domestic violence and abuse

1) The professional network needs to meet and have an agreed care plan which will need regularly to be reviewed
2) Children and young people need to be able to access support services designed specifically for them i.e. not just for the adult survivors. Support should include peer-mentoring schemes, counselling, group support work, proactive support in schools (e.g. learning mentors, anti-bullying workers, school nurses), protective behaviours training, full education within schools relating to different forms of abuse. Services for children should build on known protective factors within families, school and the community.
3) All professionals should/could help children with 3 simple consistent messages: 1. It is wrong; 2. It is not your fault: 3. How to stay safe.
4) It is important to ensure that children and young people are actively involved in designing and developing interventions.

4.3 Adult perpetrators of domestic violence and abuse

The different understandings/definitions of domestic violence and abuse discussed at the beginning of this chapter were associated with almost completely polarized positions within the responses on this programme area.

All of the specific therapeutic approaches named in the Delphi questionnaire were reported as useful/helpful by some of the respondents. A summary of the positions put forward in responses to the questions on effective interventions, both in terms of what works best and what should not be used is shown in Table 4.10.

Restorative justice, mediation/alternative dispute resolution and couple therapy/counselling were specific approaches most frequently mentioned as unhelpful or inappropriate. Some of the differences in views about what was helpful and what was unhelpful was explained in terms of particular approaches being unhelpful at particular points/stages, or in particular

[10] This was one statement where the response set was different between all those who responded on this statement in Round 3 shown in the Table above, and the answers of those who declared expertise in this programme area in Round 1. Restricting the analysis to only declared experts in this area produces an even split between those in disagreement and responding neutrally the statement, removing all those in agreement. The number of informants, at 8, is however relatively small.

circumstances, rather than the approach being totally counter-indicated. Some of those who viewed mediation or reconciliation as unhelpful in the short term considered that it did have a place in the longer term, but only after a long period of non-violence and therapy on behalf of the perpetrator. Couple counselling was viewed unhelpful by some only as a sole, or initial, method, it was something that could be considered at later stages. The need to screen for psychopathy prior to placement in group work was also suggested.

Table 4.10: Views on helpful/useful approaches and on approaches that should not be used: Adult perpetrators of domestic violence and abuse, Round 1

Helpful/useful approaches	Should not be used
• Feminist • Holistic • Gendered understanding • Integrated theoretical model • Long term psychotherapy • Psychodynamic psychotherapy • Person centred counselling • Social learning theories • CBT • Schema focussed • Relapse prevention • Educational • Group therapy • Structured group work • Role play, psychodrama • Skills rehearsal • Conflict resolution skills • Denial challenging • Erikson's theory of generativity • Ahimsa model • Positive action • Zero tolerance • Family systems • Emotional management • Anger management • Attachment theory based approaches	• Mediation • Restorative justice • Purely psychodynamic • Psychotherapy (danger of minimizing) • Couple therapy • Family therapy • Anger management • Counselling based interventions, or interventions without skill development • Purely or short term CBT • Art, drama or CAT therapies • Medication that suppresses the feelings central to rehabilitation • Feminist/Duluth models

In understanding the views about helpful and unhelpful approaches, the two definitional positions explained in Figures 4.1 and 4.2 account for some of the seeming contradictions shown in Table 4.10:

- Anger management was viewed as helpful only by those espousing position two (see Figure 4.2), and unhelpful only by those espousing position one (Figure 4.1).
- Feminist/Duluth models were regarded as unhelpful only by those espousing position two (Figure 4.2).
- Art, drama and CAT therapies were regarded as unhelpful only by those espousing position two (Figure 4.2).
- Couple work was considered as a possible initial approach by those espousing position two (Figure 4.2), but not by those espousing position one (Figure 4.1).

There were also tensions in the responses about:

- The need to challenge behaviour without however this resulting in drop out from treatment programmes.
- The degree to which an empathic supportive context can be provided for perpetrators.

Respondents discussed the complex response needed to tackle perpetration; the discussion was couched in terms of adult male perpetrators (but recognizing domestic violence and abuse

in both heterosexual and homosexual relationships). Figure 4.14 further illustrates the responses in this area, and the tensions.

Figure 4.14 Responses on the treatment of perpetrators

'Treatment programmes for men should include both individual work and groupwork, ideally for 12 months at the very least. Modalities should be involve a high level of responsivity and require multi-disciplinary approaches which go beyond educational and cognitive/behavioural principles. Radical personality change and gender deconstruction is a time-consuming and demanding activity which requires rigour and challenge by facilitators but also a high level of psychotherapeutic skill.'

'Whatever the theoretical orientation of the treatment this has to occur within a context of supportive understanding and conditional acceptance. Treatment without an empathic supportive context will only lead to entrenchment and denial. Within this the individual has to be allowed to tell their own story and narrative with the therapist seeking to clarify and elucidate relevant issues. The main theoretical model, which informs my work with perpetrators of domestic violence, is the CBT model incorporating schema therapy also. Beliefs and attitudes both about one self and others is crucial to understand many of the dynamics of domestic violence and addressing the invariable minimisations and denials that occur. However, some attention is also paid to more psycho dynamic principals of denial and projection and how ones own childhood experiences including various emotional states may be being played out within the current situation.'

'The feminist model recognises that external factors such as alcohol misuse, stress, etc may be contributory factors to DV, it is also emphasised that they are absolutely not uniquely causal. Therefore intervention work with perpetrators must not concentrate only on these external factors. Similarly, male power and access to power is a structural issue which has individual consequences, such as DV. However interventions should not pathologise individual men, who are otherwise in sound mental health. Instead interventions must regard the behaviour as constitutive of a model of society in which men are privileged and male entitlement is legitimated. Whilst some perpetrators may require interventions and support with mental health or alcohol problems etc this should not be at the exclusion of challenging the ideological gendered beliefs. '

'The four major factors in changing any criminal behaviour is to change pro-criminal attitudes, develop pro-social behaviour, This can be through helping the perpetrator to learn to identify their own dysfunctional behaviour, and through this accept the impact of their behaviour on the victim. Through role modelling, skills rehearsal, the perpetrator can practice non-abusive behaviour. However during the time between gaining internal controls, there may need to be external sanctions (or protective constraints) to prevent abuse. This means that the work with the perpetrator must always be integrated with information from the victim, and with information from the police or other monitoring agency who can provide intelligence about the perpetrator behaviour. ….[and] from a victim safety perspective this should be provided, to help them regain control of their situation and to help them determine when the risk they perceive outweighs the benefits of remaining in the relationship in the state it is in. It can also help them to judge when (if ever) to return to that relationship'

'Therapeutic group work is very effective in the treatment of perpetrators of domestic violence. When attendance is linked to the courts and probation, then this necessary rigid structure provides the control and motivation for the person to begin dealing with the issues underlying their problems with violence and aggression. There is also a strong need for fair but very firm boundaries about being on time, attendance, (and if appropriate payment). Addressing underlying substance dependency issues is also critical.'

'Cognitive based psychotherapeutic interventions. Group therapy in preference to individual therapy for aggression. Individual therapy may be useful to prepare for group therapy and address perpetrators experience of abuse. More creative therapies e. g. Art therapy may also give opportunity to uncover and address issues of violence esp if difficulties in expressing themselves verbally. Treat substance misuse, personality disorder or affective disorder if present.'

'My experience providing assessment and treatment services to perpetrators of abuse with learning disabilities has taught me the importance of seeing sexual abusing as an acting out of a deeply entrenched emotional trauma. Only once the trauma is worked with can we hope to enable perpetrators to manage their sexually impulsive behaviour. ….. Group therapy has proven to be a useful model when working with perpetrators of abuse who have learning disabilities, as it enables group to understand that there are effective ways of dealing with their sexual impulses, and that there are useful strategies to be learnt from others in moving on from the trauma they have experienced and enacted. All models working with perpetrators with learning disabilities need a solid understanding of the impact of the disability upon the functioning and the emotional life of the client.'

Tables 4.11 and 4.12 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation. Within Table 4.11 there was one statement that reached complete consensus in Round 3 ("There is no single approach that works best for every member of this group"). For one statement ('Couple counselling is appropriate for mutually violent

partnerships') strongly spilt positions were evident, it is likely that definitional differences are implicated here.

Table 4.11: Therapeutic approaches for adult perpetrators of domestic violence and abuse, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S9.1 There is no single approach that works best for every member of this group	**51**	**49**	0	0	0	41
S9.2 Behavioural and cognitive approaches on their own are insufficient to meet perpetrators' needs	**36**	**46**	10	5	3	39
S9.3 Anger management techniques are appropriate for mutually violent couples	**7**	**56**	22	8	7	41
S9.4 Couple counselling is appropriate for mutually violent partnerships	5	41	26	21	8	39
S9.5 It is important to teach conflict resolution techniques to this group	**12**	**51**	20	17	0	41
S9.6 Interventions for adult perpetrators of domestic violence are best delivered in group situations	**8**	**49**	19	24	0	37
S9.7 Group work should only be considered after successful individual therapy/work[11]	5	14	19	**60**	**3**	37
S9.8 Perpetrators should not be offered any form of confidentiality	8	13	15	**56**	**8**	39
S9.9 Offering limited confidentiality encourages disclosure and openness to interventions	**8**	**66**	13	8	5	38
S9.10 For the benefit of all group members, adult perpetrators should be assessed individually for their readiness and suitability for group work before being permitted to start group therapy.	**35**	**54**	5	3	3	37

In commenting on the statements on group work in Table 4.11, some respondents considered that these were too simplistic in not reflecting the practice of individual sessions followed by group work that now forms the norm for some perpetrator programmes.

Table 4.12 contains one statement for which concord was found in Round 3 ("It is important to avoid collusion with perpetrators' justifications for their behaviour"), complete consensus had been present in Round 2. For a second statement ("It is important to work in ways which are meaningful to perpetrators from different cultures and backgrounds") complete consensus was found in Round 3 (Round 2 had displayed only a clear majority in agreement). In commenting on statement S9.12 (Table 4.12), some respondents considered that the word 'challenge' was not appropriate, others commented that this needed to be qualified as 'non-confrontational', or replaced by some other term like 'explored'.

Table 4.12 includes a summary of the views of respondents about the issue of qualifications and training. As can be seen, although the clear majority of respondents in Round 3 agreed that therapeutic interventions should be offered by professionals, by those with relevant training, by those with suitable qualification and by those with accredited training, in each case there were significant minorities who disagreed.

[11] This was one statement where the response set was different between all those who responded on this statement in Round 3 shown in the Table above, and the answers of those who declared expertise in this programme area in Round 1. Restricting the analysis to only declared experts in this area produces an even split between those in agreement and those in disagreement with the statement, whilst retaining a minority neutral response. The number of declared experts, at 9, is however relatively small.

Table 4.12 Therapeutic approaches for adult perpetrators of domestic violence and abuse, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S9.11 It is important to avoid collusion with perpetrators' justifications for their behaviour	**80**	**18**	3	0	0	40
S9.12 Workers should challenge perpetrator's use of physical violence, use of sexual violence, sexual abuse and coercion and expectations of power and control over (ex)partners	**64**	**26**	8	3	0	39
S9.13 It is important to work in ways which acknowledge and question the social and gendered context of domestic violence	**51**	**39**	7	2	0	41
S9.14 It is important to work in ways which are meaningful to perpetrators from different cultures and backgrounds	**63**	**37**	0	0	0	41
S9.15 Therapeutic interventions should only be led by those holding a suitable professional qualification	**25**	**40**	18	15	3	40
S9.16 Therapeutic interventions should only be led by those holding a suitable qualification	**23**	**46**	10	18	3	39
S9.17 Therapeutic interventions should only be led by those who have completed relevant training	**41**	**39**	10	10	0	39
S9.18 Therapeutic interventions should only be led by those who have completed accredited training [12]	**26**	**21**	24	21	8	38

As reported in chapter 3, the Delphi respondents emphasised the multi-agency, multi-sectoral service response required to domestic violence and abuse, a summary of key components in relation to responding to perpetrators is given in Figure 4.15.

Figure 4.15 The required multi-agency, multi-sectoral response to perpetrators of domestic violence and abuse

a) Education programmes for perpetrators should form part of a co-ordinated multi-agency response to domestic violence and abuse. These should be accessible through both voluntary and court mandated routes. Content should locate violence within patterns of coercive control which may entrap victims/survivors and limit their space for action. Perpetrators programmes should never be provided without linked support services for the abused partner.

b) Specific domestic abuse perpetrator programmes, delivered according to Respect guidelines for both adults and adolescent abusers should be available locally, backed by help lines, support services and associated drug and alcohol treatment programmes.

c) Linked support services for partners are essential, some add explicitly with feedback from victim into treatment of perpetrator.

d) Criminal justice system responding to apprehend, caution and to prosecute perpetuators.

e) Specialist, dedicated domestic violence and abuse courts and fast tracking through the criminal justice system.

[12] This was one statement where the response set was different between all those who responded on this statement in Round 3 shown in the Table above, and the answers of those who declared expertise in this programme area in Round 1. Restricting the analysis to only declared experts in this area produces an even split between those in agreement and responding neutrally to this statement, whilst retaining a minority disagreement response. The number of declared experts, at 8, is however relatively small.

4.4 Young people who perpetrate domestic violence and abuse

This programme area had a markedly smaller number of respondents than any other in Round 1 (11 responses, compared to all other areas having more than 30 respondents). There were greater number of responses in Round 2 (62) and Round 3 (40). Most respondents made reference to the need to use mixed approaches, tailored to the individual and age/developmentally appropriate, recognizing that the young person may well have been a victim of violence or abuse in their past. The importance of viewing the young person in the context of their family history and current circumstances was emphasized. Illustrative responses are shown in Figure 4.16.

Figure 4.16 Responding to young people who perpetrate domestic violence and abuse

'There are three broad impact factors leading to violence and aggression in a child/young person: Parental factors – child-rearing techniques, personal short-comings and personal problems; Child factors – temperament, fetal difficulties and psychopathy (mental illness); Environmental factors – stressful living conditions, violent home, poverty and other deprivation factors.'

'Eclectic mixture of different therapeutic approaches is needed for many clients to cope with the often traumatic needs'

'Long-term psychoanalytic psychotherapy and psychodynamic group work are effective; in conjunction with this consistent therapeutic support for parents/carers during treatment is essential to effective outcomes.'

'Giving the child confidentiality space. Offering the child a safe place to talk, explore their situation and the feelings about what is happening to them. A risk assessment should be made at the same time. Each child or young person should be dealt with on an individual case by case …. Complete confidentiality cannot always be offered owing to child protection issues. This is conveyed to the child or young person, wherever possible. No confidentiality is offered to abusers or in situations of life and death i.e. overdose. Confidentiality is not offered to children or young people who are abusers themselves.'

Except for relapse prevention, all of the specific therapeutic approaches named in the Round 1 Delphi questionnaire were reported as useful/helpful by at least one of the respondents. A summary of the positions put forward in responses to the questions on effective interventions, both in terms of what works best and what should not be used is shown in Table 4.13.

Table 4.13: Views on helpful/useful approaches and on approaches that should not be used: Young people who perpetrate domestic violence and abuse, Round 1

Helpful/useful approaches	Should not be used
• Feminist • Zero tolerance • Psychodynamic group work • Psychoanalytic psychotherapy • CBT • Gendered understanding of DV • Attachment theories • Parenting approaches • Personality disorder approaches • Developmental psychopathology • Treating both as victim and offender • Art therapies for those with limited verbal skills • Specific therapeutic needs for looked after children/young people and those in substitute care • Positive action	• Purely anger management • Anger management • Cultural explanations to allow for or explain DV • Psychological approaches that explain DV as an illness • Sociological approaches that explain DV as 'caused' by exogenous issues • Not just adult models

Tables 4.14 to 4.16 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation. For three statements, complete consensus was reached in Round 3:

- 'There is no single approach that works best for every individual in this group', see Table 4.14, in Round 2 this generated only a clear majority, with 3% of respondents disagreeing and 3% neutral.
- 'Interventions that work best are multifaceted, tailored to assessed psychosocial needs, intensive and, usually, long term', see Table 4.14, in Round 2 this generated only a clear majority, with 4% of respondents disagreeing and 7% neutral.
- 'The engagement of the young person in the management of his/her problems is crucial', see Table 4.15, in Round 2 this generated only a clear majority, with 2% of respondents disagreeing and 5% neutral.

Table 4.14: Therapeutic approaches for young people who perpetrate domestic violence and abuse, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S5.1 There is no single approach that works best for every individual in this group	**68**	**32**	0	0	0	38
S5.2 Interventions that work best are multifaceted, tailored to assessed psychosocial needs, intensive and, usually, long term	**74**	**26**	0	0	0	38
S5.3 It is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual	**56**	**33**	6	6	0	36
S5.4 Whether to treat young people who perpetrate domestic violence/abuse as victims or abusers needs to be considered on an individual basis	**51**	**32**	5	8	3	37
S5.5 Through specialist services, it is possible to work with this group both as offenders and as victims of domestic violence and abuse	**52**	**42**	6	0	0	33
S5.6 There is a need for the development of more specialist interventions for abusing children	**68**	**25**	8	0	0	40
S5.7 Behavioural and cognitive approaches on their own are insufficient to meet the needs of this group	**54**	**41**	3	3	0	37
S5.8 Anger management techniques are useful for this group	**11**	**56**	11	14	8	36
S5.15 Provision of residential settings for therapy are important for some young people in this group	**32**	**51**	16	0	0	37
S5.16 Secure accommodation in offender institutions does not provide a suitable therapeutic setting for this group	**36**	**31**	19	14	0	36

There were four statements on which concordance was reached in Round 3:

- 'Through specialist services, it is possible to work with this group both as offenders and as victims of domestic violence and abuse'; see Table 4.14, this statement was new in Round 3.
- 'There is a need for the development of more specialist interventions for abusing children', see Table 4.14, this statement generated only a clear majority in Round 2, with 2% strongly disagreeing and 7% neutral.
- 'Provision of residential settings for therapy are important for some young people in this group', see Table 4.13, this statement generated only a clear majority in Round 2, with 4% disagreeing and 11% neutral.
- 'Parents/carers should be assessed for their potential harm or support before being included in therapy for this group', see Table 4.15, this statement was new in Round 3.

In commenting on statement S5.3 (Table 4.14), some respondents preferred the term 'variety of approaches' or some other (unspecified) alternative to 'toolkit'. In relation to statement S5.4, some considered the use of the term 'victim' unhelpful for this group.

Table 4.15: Therapeutic approaches for young people who perpetrate domestic violence and abuse – engagement, use of touch and parent/carer involvement, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S5.9 The engagement of the young person in the management of his/her problems is crucial	**89**	**11**	0	0	0	36
S5.10 All interventions should include/involve the young person's parents and/or carers directly	11	23	9	**54**	**3**	35
S5.11 Working within appropriate guidelines, there is a place for touch within intervention	**6**	**64**	15	12	3	33
S5.12 The use of touch/holding within intervention is never appropriate	0	18	12	**61**	**9**	33
S5.13 Parents/carers should be assessed for their potential harm or support before being included in therapy for this group.	**49**	**49**	3	0	0	35
S5.14 Parents/carers do not need to be involved directly in the client's therapy in order to be supportive and aid recovery.	**17**	**49**	23	11	0	35

Table 4.16 summarises the views of respondents about the issue of qualifications and training. As can be seen, although the clear majority of respondents in each of Round 2 and 3 agreed that therapeutic interventions should be offered by professionals, by those with relevant training, by those with suitable qualification and by those with accredited training, in each case there were significant minorities who disagreed. The least disagreement is found with the requirement for 'relevant training'

Table 4.16: Therapeutic approaches for young people who perpetrate domestic violence and abuse – professionals and qualifications, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S5.17 Therapeutic interventions should only be led by those holding a suitable professional qualification	**29**	**34**	21	16	0	38
S5.18 Therapeutic interventions should only be led by those holding a suitable qualification	**33**	**44**	8	14	0	36
S5.19 Therapeutic interventions should only be led by those who have completed relevant training	**36**	**36**	17	11	0	36
S5.20 Therapeutic interventions should only be led by those who have completed accredited training	**27**	**27**	24	22	0	37

Chapter 5 Sexual violence and abuse

Chapter 5 reports the findings from the analysis of responses about therapeutic and treatment interventions for sexual violence and abuse. This category includes all interventions aimed at healing or ameliorating the effects of sexual violence or abuse on victims/survivors, or at directly modifying violent or abusive behaviour. This includes separate sections on:

- Adult victims/survivors of rape and sexual assault (chapter 5.1);
- Adult survivors of childhood sexual abuse (chapter 5.2);
- Children and young people who have been sexually abused (chapter 5.3);
- Child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking (chapter 5.4);
- Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults (chapter 5.5);
- Adult sex abusers and offenders (chapter 5.6).

5.1 Adult victims/survivors of rape and sexual assault

The strongest position emerging from responses for this programme area was on the value of intervention and service provision structured around a staged approach, drawing flexibly on a range of different approaches according to stage and circumstances/context, based on characteristics of victim/survivor-centredness, and stressing the importance of the quality of the therapeutic relationship, and of non-judgementality. Characteristics of this model are illustrated in Figure 5.1. There was a slight tension between this position and the view expressed by some other respondents that national standardization of interventions would be helpful. The importance of receiving an appropriate early response to first disclosure and of service integration was also emphasized, see for example Figure 5.2. Finally, a number of respondents emphasized that not all victim/survivors need long-term therapy or treatment.

Figure 5.1: Characteristics of a staged, integrative, client centred approach

'A thorough assessment and history taking of the client to determine if there is any previous trauma in their childhood or adult life, as this will inform treatment. ….The early stages of treatment should be on building rapport and creating a feeling of safety and trust for the client and building up their resources. The middle stage should be focussed trauma work, and then the final stage is re-integration into their life and work.'

'Work in a very integrative way. The therapy should fit the client, and not try and fit the client into a rigid theoretical approach. Certain stages of therapy require different approaches or orientations. It also depends on the client's history and level of functioning as to what approach may be used.'

'Offering core conditions, empathy, congruence and unconditional positive regard. Working at the service users own pace. Same counsellor/support worker for each session throughout the process. Being flexible with session content. Working in an appropriate way as per core conditions. Aiming to give choice rather than take away choice.'

'When working with women who have suffered trauma of this nature it is important to work at the client's pace and be supportive. The integrative approach allows models and theoretical perspectives to be adapted for the individual client. It is a respectful and non-judgmental process.'

'Approaches that are respectful of the client's view, and are respectful, human, relational and warm, whilst still being boundaried.'

Respondents emphasized that the context of social inequality and power dynamics must be understood as part of the therapy, and the victim/survivor's experience understood in a socio-cultural, political and human rights context. Differences in race, gender, class, sexuality, age

and ability must be respected and valued and therapy must be free from discrimination of any kind. Respondents also stressed the importance of recognising and acknowledging the methods by which survivors have managed the far-reaching effects of sexual violence.

Figure 5.2: The importance of initial response and service integration

'The response of the first person told of the assault can affect how a person recovers from an assault – a negative first reaction can be critically damaging. A good response is: believing; not blaming; not asking prying questions; offering choices; being clear what the person can offer, and keeping any promises made; being clear what time is available – if it is limited, offer time in the future, and give it; not controlling or prescribing "treatments"; giving, or finding and passing on, relevant information to enable informed choice; avoiding, or being very careful with, "why" questions; not making assumptions. If a recent assault, some practical, immediate help may be necessary – a place of safety, treatment for injuries, opportunity and support, but not coercion, to report to Police. Information on how, when, procedures of reporting can support people in this choice, but it has to be a choice. Because of the greatly enhanced chance of successful prosecution if an assault is reported immediately, the SARCS model of forensic evidence-gathering without commitment to report is helpful. An emotionally healthy person, with strong support networks, who receives the best possible treatment immediately after a single assault may go on to recover without much, or any, additional ongoing support. However, as people with a history of abuse in childhood are significantly more likely to become adult victims, what appears to be an isolated incident can trigger buried emotions; there will be many other situations when a survivor needs continued support. This support needs to be available when the person needs it and chooses to use it. A prolonged wait to use, for instance, counselling services, reinforces the feelings of lack of self esteem that so many victims of abuse experience.'

All of the specific therapeutic approaches named in the Delphi questionnaire were reported as useful/helpful by some of the respondents. A summary of the positions put forward in responses to the questions on effective interventions, both in terms of what works best and what should not be used is shown in Table 5.1.

Table 5.1 Views on helpful/useful approaches and on approaches that should not be used: adult victims/survivors of rape and sexual assault, Round 1

Helpful/useful approaches	Should not be used
• needs led, victim controlled, victim centred, person centred • holistic • integrative model • toolkit approach • psychodynamic • CBT • Gestalt • PICT (Parks Inner Child Therapy) • Empty chair therapy • Solution focussed, brief therapy • Debriefing • Narrative therapy • Attachment theory based therapies • Low arousal approaches • Affirmations and meditations • Contact with other survivors • Staged approaches • Distinction between Type 1 (PTSD, CBT, EDMR) and Type 2 trauma (dialectical behaviour therapy, schema focussed) • Creative therapies	• purely psychodynamic • purely drug therapies • purely CBT • PTSD unless assessed for it • Gender inappropriate staffing • Debriefing • Any visualisation techniques (as re-traumatising) • Regression • Hypnosis • Offering authentication for recovered memories • Forcing or promoting forgiveness • Challenging directly or contracting to control self harm • Brief or time limited (unless part of broader therapeutic process) • Use of touch or holding

For most of the specific therapeutic approaches listed in the questionnaire, at least one of the respondents raised some concerns in answer to the question (question 3) about what approaches should not be used and why. Most of the points raised related to the use of particular approaches being unhelpful at particular points/stages, or in particular

circumstances, rather than the approach being totally counter-indicated: For example, some respondents drew attention to the range of therapies recommended as suitable prior to a criminal trial in DH/HO/CPS guidance, which excludes hypnotherapy, drama therapy, regression techniques and groups in which disclosure of assault details takes place. Other respondents were concerned about the application of particular techniques owing to the danger of re-traumatisation (visualization, blank screen technique in psychoanalysis, EMDR, re-living exercises).

Ordering emerged as an important issue in many of the responses, both in reference to within the therapeutic process, and also in reference to the temporal distance between the assault and the intervention. On contact with services immediately after the assault, pregnancy and STI fears (and tests), as well as medical forensic and witness issues are prioritised, and need to be provided sensitively (these other services are addressed in section 4 of this report). Trauma-focussed therapies were regarded as generally unsuitable for use in early stages. Caution was also expressed about the use of psychodynamic approaches at an early stage. Some expressed the view that 'homework activities', undertaken between sessions may be too demanding or directive in early stages, but later may be considered empowering and engaging.

Tables 5.2 to 5.3 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation. Within these Tables, there were no statements that exhibited a complete consensus in Round 3. There were two statements where concordance was found in Round 3:

- 'There is no single therapeutic approach that works best for every victim/survivor in this group', where 3% of respondents expressed neutrality in Round 3, in Round 2, only a clear majority was found for this statement, with 1% each for neutral, disagree and strongly disagree.
- 'The approaches used should be needs-led and victim/survivor centred', where 1% of respondents expressed neutrality in Round 3, in Round 2, only a clear majority was found for this statement, with 3% respondents neutral, and 1% disagree.

There were a number of areas in which split positions were advanced:

- In relation to differences between service locations and therapeutic approaches for male and female rape victims/survivors, see Table 5.2 and comments made that illuminate the different views held in Figure 5.3.
- The need for accredited training, see Table 5.3.

There were also a number of issues on which minority positions persisted throughout the consultation:

- Whether it is ever appropriate to have a therapist of the same gender as the perpetrator. A possible resolution of this would be through adoption of the position, also advanced, that victims/survivors should be offered choice in this area, this however did not command universal agreement in Round 3 (see Table 5.3). Comments included the importance of quality of relationship with therapist over gender, and the lack of feasibility/possibility of offering choice.
- Whether touch/holding has a place within therapeutic approaches or not (see Table 5.3). Comments made in relation to this programme area reiterated those noted in other areas earlier in this report.
- Whether mutual support/self help is appropriate at all stages, or only after the individual has received sufficient individual therapy (see Table 5.3).
- Whether survivor literature should be offered at all stages (see Table 5.3).

Table 5.2: Therapeutic approaches for adult victims/survivors of rape and sexual assault, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S6.1A 3 Stage model (Stage 1: Safety and symptom stabilisation; Stage 2: Dealing with the traumatic memories; Stage 3: Reconnection/Regaining a safe and fulfilling life) provides a suitable framework for responding to the needs of this group of victims/survivors	**14**	**56**	20	4	6	71
S6.2 There is no single therapeutic approach that works best for every victim/survivor in this group	**69**	**28**	3	0	0	71
S6.3 It is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual	**49**	**44**	4	1	1	70
S6.4 The approaches used should be needs-led and victim/survivor centred	**68**	**31**	1	0	0	71
S6.5 The approaches used should be victim/survivor directed	**44**	**37**	11	7	0	70
S6.6 Not all victim/survivors need long-term therapy or treatment	**31**	**60**	6	3	0	70
S6.7 Making a distinction between type 1 (one off or limited trauma) and type 2 trauma (long term abuse, usually originating in childhood) is important in selecting therapeutic approach(es) for use	**13**	**42**	13	25	7	71
S6.8 Behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs	**53**	**37**	7	3	0	70
S6.9 Male rape victims/survivors require therapies that are distinct and different from those offered to women	12	18	22	40	8	60
S6.10 Men who are raped need to be offered services that are separate from female rape victims/survivors	18	33	16	29	5	63

Figure 5.3.: Rape and sexual assault services for male victims

'Agree that some different approaches are helpful - but many may be similar too.'

'6.9 – therapeutic approaches need to take into account the different experiences, positionings and constructions of men as 'male' within our masculinist and heteronormative society

'S6.9 Male or female rape victims are people who are deeply hurt and distressed. Not necessary to have different therapies but requires separate services.'

'S6.9 and 10 The important issue here is that services are offered to men. Many services do not provide a service to men. If the therapist is working in a client led way then the needs/issues of the individual should be addressed.'

'Regarding S6.9: Male victims may not need different therapies, but they may need a separate forum/centre.'

'S6.9/10. There are a lot of similarities between male and female rape victims i.e. they often blame themselves. There are also a number of differences i.e. stranger rape is more common in men. We are dealing with the effects of rape and as long as the work is client focused and the therapist is well trained and experienced I don't feel that there is a need for separate services.'

'Ref S6.9 – not completely different but there are some differences and its important to recognise this.'

'Ref S6.10 – it is important to offer women a safe, secure environment to receive support and this inevitably has to be male free, this is why we strongly agree with this point.'

Table 5.3 includes a summary of the views of respondents about the issue of qualifications and training. As can be seen, although the clear majority of respondents Round 3 agreed that therapeutic interventions should be offered by professionals, by those with relevant training, and by those with suitable qualification, in each case there were significant minorities who disagreed. The least disagreement is found with the requirement for 'relevant training'. Views on the need for accredited training showed no clear majority.

Table 5.3: Therapeutic approaches for adult victims/survivors of rape and sexual assault – the use of touch, the gender of the therapist, survivor literature, mutual support/self-help, training and qualification, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S6.11 Working within appropriate guidelines, there is a place for touch within therapy	**7**	**65**	10	15	3	69
S6.12 The use of touch/holding within therapy is never appropriate	4	16	16	**52**	**12**	68
S6.13 It is never appropriate to use a therapist of the same gender as the perpetrator	4	0	13	**59**	**24**	70
S6.14 Choice of gender in therapist should always be offered	**36**	**47**	7	10	0	70
S6.15 Provision of survivor literature should be considered as a therapeutic option at all times	**25**	**45**	14	16	0	71
S6.16 Provision of survivor literature should only be considered after successful individual therapy/work	0	13	14	**61**	**11**	70
S6.17 Mutual support/self-help should be considered as a therapeutic option at all times	**18**	**53**	16	12	0	73
S6.18 Mutual support/self-help should only be considered after successful individual therapy/work	1	13	14	**57**	**14**	70
S6.19 Therapeutic interventions should only be led by those holding a suitable professional qualification	**21**	**34**	10	25	10	71
S6.20 Therapeutic interventions should only be led by those holding a suitable qualification	**21**	**39**	13	21	6	67
S6.21 Therapeutic interventions should only be led by those who have completed relevant training	**35**	**44**	7	13	0	68
S 6.22 Therapeutic interventions should only be led by those who have completed accredited training	18	25	21	34	3	68

As reported in chapter 3, the Delphi respondents emphasised the importance of a coordinated service response required for those who have experienced rape and sexual assault, a summary of key components is given in Figure 5.4.

Figure 5.4 Elements in the required coordinated service response to rape and sexual assault

a) Provision of sexual assault referral centres so that anyone who is raped or sexually assaulted in the UK has access to specialist coordinated early care

b) Standards for recruitment and training of staff working within SARCs, and others carrying out forensic examination of people who have been sexually assaulted, i.e. doctors and nurses

c) Consideration of medical aspects, e.g.
   - i) treatment of injuries
   - ii) forensic examination
   - iii) emergency contraception
   - iv) prevention and management of sexually transmitted infections including HIV post-exposure prophylaxis
   - v) follow up and aftercare

5.2 Adult survivors of childhood sexual abuse

Responses from this programme area emphasised the need for a “toolkit” approach (understood as the holistic use of a range of approaches), with a strong disregard for “one size fits all” interventions. Adult survivors of childhood sexual abuse were considered as presenting a range of issues; some as direct consequences of abuse, others as coping strategies developed during and after experiencing abuse and perhaps others still in response to the way in which their experiences had been dealt with previously in medical, family and therapeutic settings. In this way clients are characterised as being traumatised rather than sick, and are placed as the director and pace-setter of their own interventions.

Being believed is a particularly important, positive characteristic of any therapeutic interventions for this programme area; showing respect for the truth and validity of the emotions and recollections disclosed within therapy is essential for developing a healthy and productive relationship between the client and therapist. Given both the temporal lag between abuse and disclosure, and the temporal development of psychological trauma, memory recovery and authentication of memories is not encouraged, on the basis of being unhelpful, potentially harmful and possibly unethical (see Figure 5.5). Similarly approaches that “go looking for” memories, such as regression and hypnosis were either adamantly opposed or to be treated with extreme caution.

Figure 5.5: The role and limitations of memory work in a therapeutic setting

‘Recovered memories during therapy: Therapists working with survivors are often in a precarious position, especially if memories of abuse start surfacing during the course of therapy. Therapists should be aware of the possible contamination effects on memory, and unless there is definite, corroborating proof, should avoid informing their clients that they "know" the memories being recovered are authentic. A more productive and supportive approach is to acknowledge the client's distress, confusion, and agony of "not knowing" the concrete facts, and to maintain empathic connection. Within the framework of one's therapeutic work with abuse survivors the risk of being sued for "implanting false memories" is ever present. Therapists need to remain firmly within the boundaries of the treatment role to protect them from this likelihood.’

There was strong agreement that clients should be treated in a non-confrontational way, using low-arousal techniques to avoid re-traumatisation, and working at the client’s pace. Clients are expected to be fully informed of what the therapeutic setting can offer, for the combined aims of achieving genuine consent, understanding and adhering to clear boundaries, appropriate use of contracts between the client and therapist and ensuring that the client has both the internal resources and external support to cope with and experience benefits from the intervention.

The majority of the respondents acknowledged in some way that adult survivors of childhood sexual abuse often display symptoms of abuse through harmful coping strategies, and that part of the therapists role is to convey a sense of normalcy, that for example self-harm, eating disorders, phobias and dissociation are normal reactions to abnormal, traumatic experiences. In particular, patterns of dissociation and DID require both specialised understanding on the part of the therapist and also particular consideration when selecting and directing clients towards therapies. The role of dissociation in choosing approaches to therapy and the interaction and possible benefits and risks of specific therapies for DID clients, is less clearly agreed (see figure 5.6).

Figure 5.6: Clients with DID and Parks Inner Child Therapy

'An understanding of psychological and somatoform dissociation and the complex dissociative disorders (including complex-PTSD, Dissociative Identity Disorder and Dissociative Disorder Not Otherwise Specified) is often key to the successful care, support and treatment of adult survivors of repeated, extreme and/or prolonged sexual and other abuse in childhood.'

'[There have been] reports from survivors with complex dissociate distress who underwent Penny Parks Inner Child Therapy prior to their DID being correctly diagnosed and were very damaged by this model.'

'PICT was originally created to specifically help people recover from the trauma and damage of sexual, physical and emotional abuse during childhood, but it is equally effective for a wide range of emotional problems such as … DID'

All of the therapeutic approaches listed in the Delphi questionnaire were reported useful/helpful by some respondents. Table 5.4 shows a summary of the responses to questions on effective interventions, both in terms of what is helpful and what should not be used. With the exceptions of integrative theoretical model, zero tolerance, social learning theory and restorative justice, none of the approaches listed had unequivocal support. In particular, respondents raised concerns about the use of CBT, either in terms of its use at the exclusion of other techniques, or in terms of it placing an unnecessary and potentially negative emphasis on the client's 'wrong thinking'.

Table 5.4: Views on helpful/useful approaches and on approaches that should not be used: adult survivors of childhood sexual abuse, Round 1

Helpful/useful approaches	Should not be used
• Integrative model • Zero tolerance • CBT • Dialectical behaviour therapy • Psychodynamic • Gestalt • PICT (Parks Inner Child Therapy) • Solution focussed, brief therapy • Behaviour modification, panic and anxiety management • Debriefing • Narrative therapy • Attachment theory based therapies • Family systems therapy • Affirmations and meditations • Mutual support, survivor led therapeutic groups • Group therapy • EDMR and sensory-motor therapies • Art and creative therapies • Reality checking	• Memory recovery and authentication work • Regression • Hypnosis • Unstructured groups • Exclusively cognitive, behavioural or analytic approaches • Freudian psychoanalysis • Blank screen work

There was a broad range of suggested interventions and approaches that were considered as helpful, for different clients, at different stages of their therapy and for different aspects of their recovery. PTSD work, for example, was praised for being trauma specific but considered only relevant after assessment for both PTSD within a client's presentation and the client's readiness and suitability for trauma focussed work. Other respondents drew distinction between type 1 and type 2 traumas[13], and appropriate therapies for each.

[13] Type I trauma includes single, one-time events such as rape, accidents, natural disasters, or witnessing the death of a loved one (Terr, 1991).

These responses suggest that a certain level of disclosure and assessment are necessary before embarking on full therapeutic interventions. Other respondents suggested that for some clients this level of disclosure was unlikely or not appropriate to expect from the start of the contact with a client and that readiness to disclose and be assessed would be developed as a positive, intermediate outcome of developing a professional, therapeutic relationship between the client and therapist.

There is a slight tension between the strongly person-centred, client-paced position and at the same time the common rejection of unstructured groups and undirected and blank screen style individual therapies as too ungrounded and potentially harmful or traumatising. Whilst there is little disagreement that the client should drive the therapeutic process, it emerges that for some respondents a trained therapist is expected to retain responsibility for the parameters of that therapy. This is reflected too when respondents considered the role of survivor literature and survivor peer support groups. On the one hand hearing survivor stories can be inspirational, on the other they may be traumatic and triggering; one survivor may feel normalised by being engaged with a peer group of survivors whereas another may be left vulnerable working though their experiences with unqualified, non-professionals.

The role of touch within a therapeutic setting raised two diverging positions in Round 1; that all forms of touch are inappropriate and that some forms of touch may be appropriate. Responses in Rounds 2 and 3 included many comments on the difficulties of establishing appropriate guidelines in this area, but of the importance of doing so (see Figure 5.7). Table 5.8 later in this section shows responses to the position statements in this area.

The expectations of what the therapist's role entails, beyond the provision of psychological, talking or art therapies, varied somewhat between respondents and their descriptions of the scope of the contact between the therapist and client outside of the therapy room. Some respondents, for example, touched on the supporting role that service providers took in facilitating disclosure to family members about historical sexual abuse and also in facilitating confrontation or contact between the client and their abuser/s. Other respondents made it clear that it was not the therapist's role to engage in or encourage forgiveness of the abuser/s, as a means to "moving on" or "letting go".

For some respondents developing a long-term, trusting relationship with the client was supported by not having a fixed number of sessions or limiting the potential length of the client-therapist relationship. However, it was also suggested that having a clearly defined length and limit to the number of sessions or months that could be expected from the therapeutic intervention was important for meaningful contracting and also to avoid the client becoming dependent on the therapist or therapy.

Type II trauma involves multiple, prolonged, or chronic events, such as child abuse or captivity (Terr, 1991). There are several types of events that can be traumatic.

Figure 5.7: The role of touch between the therapist and client

'Touching/hugging survivors is fraught with dangers, I do not favour any touch however well intended. This might be a rigid approach but the repercussion of misunderstanding and confusion is great.'

'Any kind of physical contact within a therapeutic relationship also needs thought and care given the invasion of personal boundaries that survivors have experienced.'

'The use of safe touch can be crucial.'

'Important to establish safe boundaries for a client … [including] a No Touch policy.'

'Depends on the therapy, the therapist-client relationship and attunement to the needs of the survivor at a particular time. I doubt guidelines are sufficient to define the appropriate use, which requires great care, professional sensitivity and supervision – but I don't think touch should be completely banned from all work with survivors – to feel 'untouchable' can itself be painful, a manifestation of stigma.'

'Where a victim touches the counsellor for approval that they are aware of their issues or to say IM OK WITH THIS, I find to be ok. This kind of touch is victim led and can be thought of as reassurance for the victim that you as the therapist are not ashamed of the details that have been disclosed. Any approach of touch made by the therapist to the victim I am not in favour of, this can invade the victim's space and take away the control the victim has within the therapy.'

'A no touch contract with the victim is very useful at the start of therapy, the victim will understand why the therapist will not try to touch and gives the victim freedom to value the space they have within the therapy.'

'There are strong arguments surrounding the issue of touch within therapy, both for and against its use therapeutically. Guidelines would benefit from acknowledging this debate and should emphasise that professionals must consider the ramifications of employing its use, both on the vulnerable client and on the therapeutic relationship itself.'

'In talking of guidelines regarding touch, I feel that the best guideline is the client and touch should always be contracted and never assumed. The strength of the therapeutic relationship will be a guideline before the subject is broached with the client. The client should always be in control regarding touch and no matter how many sessions have occurred, touch should always be checked out.'

'Regarding touch. I feel it is important not to rule out the use of touch in therapy as long as there are very clear guidelines. As a general rule, I limit touch to holding a client's hand and I always offer this verbally before making any move to touch the client. I have held or hugged clients occasionally, at their request. Non-intrusive, respectful touch can be an important part of the healing process: it can provide 'grounding' in the present when a client is overwhelmed by memories, it also challenges the feeling of being 'dirty' or 'disgusting' and demonstrates that intimacy need not be sexual or abusive.'

'Touch from client to therapist within appropriate limits can have benefits but therapist-initiated touch could be threatening and get in the way of therapy. Potential for exploitation must be borne in mind at all times.'

'The use of touch needs to be negotiated with the client and may change over time. At the beginning the client may not want even a gentle touch on the arm when distressed.'

'non- intrusive, respectful touch can be very important part of healing process – can provide grounding and challenge 'disgust untouchability '. This again depends on a very safe, respectful relationship and agreed process re touch which is client lead . Gender of therapist clearly has big impact on this and women : woman touch may feel much safer and more possible than man: woman, except in woman:woman abuse.'

Tables 5.5 to 5.9 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation. There were two statements (Table 5.5) for which there was a complete consensus in Round 3: 'There is no single therapeutic approach that works best for every victim/survivor in this group' and 'The approaches used should be needs-led and victim/survivor centred', both of these showed only a clear majority in Round 2, with 2% disagreeing for the first of these statements, and for the second statement, 3% neutral, and 1%

each disagreement and strong disagreement. Expansionary comments in relation to needs-led and survivor centred are shown in Figure 5.8. There was one statement where concordance was found in Round 3, 'Behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs', with 3% respondents neutral; in Round 2 only a clear majority was found, with 7% neutral and 5% disagreeing.

There were a number of areas in which split positions were found, with no clear majority, persisting throughout the consultation:

- The use of hypnotherapy, regression and inner child techniques (see Tables 5.5 and 5.6).
- Whether therapy should always be offered on an open-ended basis (i.e. with no specified limit on length of therapy/number of sessions), see Table 5.7.
- The necessity for qualifications or accredited training on the part of the therapist (see Table 5.9).

For many other areas, although a clear majority position was found in Round 3, there were still sizable minority positions existing:

- Whether talking about abuse is a necessary part of the healing process (see Table 5.5).
- Whether all survivors of childhood sexual abuse should be offered assessment for Dissociation Identity Disorder (see Table 5.6).
- Whether the length of time, and/or number of sessions of a therapy, are appropriate commitments in a contract between client and therapist (see Table 5.7).
- The role of survivor literature has a role in the therapeutic setting (see Table 5.8).
- Whether therapeutic interventions can be led or facilitated by survivor peers without a professional qualification (see Table 5.9).

In each of these cases this lack of consensus was maintained throughout the three rounds of the consultation.

Table 5.5: Therapeutic approaches for adult survivors of childhood sexual abuse, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S7.1 There is no single therapeutic approach that works best for every victim/survivor in this group	**75**	**25**	0	0	0	69
S7.2 It is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual	**54**	**41**	2	3	0	68
S7.3 The approaches used should be needs-led and victim/survivor centred	**77**	**23**	0	0	0	69
S7.4 Talking about abuse is not necessarily part of the healing process	**12**	**61**	6	22	0	69
S7.5 Behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs	**63**	**34**	3	0	0	67
S7.6 There is a place for techniques that actively promote regression in the therapist's 'toolkit' but they need to be used with great caution	12	25	21	30	12	57
S7.7 There is a place for hypnotherapy in the therapist's 'toolkit' but they need to be used with great caution	5	37	21	28	9	57
S7.8 The use of techniques that actively promote regression is never appropriate	**21**	**30**	21	18	11	57
S7.9 The use of hypnotherapy is never appropriate	7	16	34	38	5	56
S7.10 The only appropriate role for hypnotherapy is for symptom management	2	21	42	28	8	53

Figure 5.8: Needs-led and survivor-centred

'Individuals seek help as they wish, from whom they wish and when they are ready and that's how it should be.'

'Apart from tailoring approaches to match need, I prefer not to be too dogmatic about what is best for the client i.e. touch or no-touch, literature or not, support groups or not. Everyone is different and to forget this takes away choices for the client – something that is so important for them to have. I normally offer a book list to clients at assessment, with a 'mental-health warning' – but may decide not to during the session. Generally I would never touch a client – but if the client wanted to work with touch I would be open to exploring this. A lot of clients will take a while before they are ready to meet other survivors, but for some it is just what they need straight away.'

'Mutual/peer support can be healing and empowering or it can be demanding and draining for different individuals. I do not believe there is a set pattern to follow. For some survivors this may be the most appropriate form of support with or without individual therapy; others will need the safety and boundaries provided by a facilitated therapy group or individual therapy. Survivors need the opportunity to discuss what form of support best meets their needs at the present time.'

'The therapeutic relationship must be build using empathy, unconditional +ve regard and congruence. Once trust has been established in the relationship, it may be possible to introduce various tools but techniques need to be discussed in advance with the client & the client needs to set the pace and the objectives. Self help groups can set the ground rules, aims and objectives but ideally need a trained facilitator – again with supervision and support.'

'Childhood sexual abuse is a life experiences not a disease or an illness so let's not prescribe a treatment/therapy. Although usually it is the long-term effects that we are dealing with we also need to help with the other areas of the survivor's life A totally holistic and individual approach is needed for each and every client.'

'A good debate emerging here. However, it doesn't seem too difficult. The establishment of an appropriate therapeutic relationship is clearly crucial – but then the use of appropriate interventions is also essential. I also like the view that what clients can do for themselves needs to be valued and nurtured – I think we forget that too often.'

Table 5.6: Therapeutic approaches for adult survivors of childhood sexual abuse – dissociation, DID and inner child approaches, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S7.11 All survivors of childhood sexual abuse should routinely be assessed for Dissociation Identity Disorder	3	16	15	**50**	**16**	62
S7.12 All survivors of childhood sexual abuse should be offered assessment for Dissociation Identity Disorder with an explanation of its relevance	7	23	18	**47**	**7**	62
S7.13 Dissociation is a common symptom and survival technique in this group and therapists should therefore be aware of the nature of dissociation, how to identify it and how to respond to it without further harming the client.	**61**	**30**	5	3	2	64
S7.14 'Inner child' approaches can be valuable for people with dissociation disorders	**12**	**51**	22	14	2	51
S7.15 'Inner child' approaches are not appropriate for people with dissociation disorders	0	10	28	**52**	**10**	50
S7.16 'Inner child' techniques are safe and useful techniques for this group	12	24	42	20	2	50

Table 5.7: Therapeutic approaches for adult survivors of childhood sexual abuse – contracting and fixed length therapy, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S7.17 It is useful for the contract between client and therapist to contain commitments about number of sessions/length of therapy	**21**	**52**	7	19	2	68
S7.18 It is important that therapy is offered on an open-ended basis (i.e. with no specified limit on length of therapy/number of sessions)	14	36	11	37	1	70
S7.19 The contract between client and therapist should be clear about any restrictions on length of therapy/number of sessions.	**37**	**53**	4	6	0	68
S7.20 The contract between client and therapist should describe how progress is reviewed and any scope for an open-ended arrangement	**43**	**49**	4	4	0	68

Table 5.8: Therapeutic approaches for adult survivors of childhood sexual abuse – the role of touch, the gender of the therapist and the use of survivor literature, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S7.21 Working within appropriate guidelines, there is a place for touch within therapy	**16**	**57**	12	15	1	69
S7.22 The use of touch/holding within therapy is never appropriate	2	7	13	**59**	**19**	68
S7.23 It is never appropriate to use a therapist of the same gender as the perpetrator	2	6	7	**63**	**22**	68
S7.24 Choice of gender in therapist should always be offered	**42**	**46**	6	6	0	69
S7.25 Survivor literature should only be used with extreme caution in the therapeutic setting	2	17	9	**59**	**13**	64
S7.26 Survivor literature plays a valuable role in the therapeutic setting	**17**	**64**	17	3	0	66
S7.27 The practitioner's involvement in the choice of whether or not survivor literature is used in the therapeutic setting should be sensitively passing on information about the availability of such literature, and communicating a willingness to allow discussion about anything the survivor has read	**32**	**60**	6	2	0	65
S7.28 The choice of the survivor should govern the use of survivor literature in the therapeutic setting**.**	**41**	**47**	8	5	0	66

Table 5.9: Therapeutic approaches for adult survivors of childhood sexual abuse – professionals and qualifications, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S7.29 Therapeutic interventions can be led by survivor peers working within suitable guidelines	**16**	**51**	16	17	2	65
S7.30 Therapeutic interventions should only be led by those holding a suitable professional qualification	**13**	**33**	9	39	6	69
S7.31 Therapeutic interventions should only be led by those holding a suitable qualification	**9**	**38**	18	29	6	66
S7.32 Therapeutic interventions should only be led by those who have completed relevant training	**16**	**58**	5	12	0	66
S7.33 Therapeutic interventions should only be led by those who have completed accredited training	14	21	23	35	8	66

Table 5.9 includes a summary of the views of respondents about the issue of qualifications and training. This demonstrates a lack of consensus, in particular on the importance of qualifications. Although a clear majority of respondents in each of Round 2 and 3 agreed that 'relevant training' was required; there was still a significant minority (12%) who disagreed. There was a clear majority in support of a role for survivor peers in leading therapeutic interventions (working within suitable guidelines). Comments in this area emphasised the difficulty of establishing what are appropriate professionals, training, qualification, and accreditation. Responses on the need for accredited training showed no clear majority.

Other areas discussed by the Delphi participants included:

- The need to address support for carers and families of survivors of sexual abuse, about which there was general agreement;
- Different positions about the most suitable location for services (voluntary versus statutory sector);
- Different positions about the relative suitability of specialist organizations versus specialist services within more generalist settings.

5.3 Children and young people who have been sexually abused

The strongest position emerging from responses for this programme area was on the value of interventions structured around a victim centred approach, using age, gender and developmentally appropriate techniques. Illustrations of positions on developmentally appropriate techniques are given in Figure 5.9, and views regarding the needs of this group and of disabled children are illustrated in Figure 5.10. The human qualities of the therapeutic relationship were emphasized as very important, as was the need to work with the non-abusing parents, carers, siblings and others in the child/young person's network. The importance of therapists understanding and being able to work with dissociation and dissociative disorders was emphasized. In providing therapeutic intervention, the importance of an understanding of lesbian, gay and bisexual development and affirmation for sexuality was stressed.

Figure 5.9: Developmentally appropriate intervention

'Different interventions work for different children. If very young, non-directive play therapy has proved beneficial if older a more holistic approach involving cognitive and other intervention approaches. Most of all young people and children need to make sense of what has happened to them, understand where the blame lies and be empowered.'

'Therapeutic groups for children (and parents/carers) which are for same gender and similar developmental stage, which are structured and time-limited, and which have a psycho-educational approach can be helpful in some ways. Children tend to associate these groups with school 'lessons' and this fact, along with meeting other children with similar experiences, can really help reduce stigmatisation, the sense of being different, and loneliness. Also, as a male working with female co-therapists, I have found these groups can also provide a different experience of a male and model an effective parental couple. In general, groups with children need to be conducted alongside parallel work with parents/carers to ensure that therapeutic benefits are supported and sustained. Although groups cannot reach some areas of distress, as a positive therapeutic experience, they can help some young people move on to individual therapy.'

'Narrative therapy can be used in play therapy as a way of helping children express and explore their experiences of life. Every story a child tells contributes to a self-portrait which he can look at, refer to, think about and change and this portrait can be used by others to develop an understanding of the storyteller. The stories we tell, whether they are about real or imagined events, convey our experience, our ideas, and a dimension of who we are. The therapist and child construct a space and a relationship together where the child can develop a personal and social identity by finding stories to tell about the self and the lived world of that self. The partnership agreement between child and therapist gives meaning to the play as it happens. The stories created in this playing space may not be 'true' but often will be genuine and powerfully felt and expressed.'

Figure 5.10: The needs of children and young people who have experienced sexual abuse

'Children and young people do not have the wherewithal to give informed consent to engage in sexually activity with adults. The responsibility for abuse always lies with its perpetrator. Sexually abusive behaviour in adults is not an illness but is chosen behaviour. The confidentiality and civil liberties of adults who abuse children must give way to the rights of children to be safeguarded from harm. Children and young people can recover from child sexual abuse. Recovery will be substantially assisted if at least one adult they know and trust believes them and sticks with them. Because of the enormity of the violation that child sexual abuse inflicts on a child – in that it distorts their sense of self and distorts or interrupts their development – most children will need some help from someone to recover from its impact. Building resilience in children and young people will assist them to recover and assist safeguard from being further targeted and abused. The needs of the criminal justice system (an adult arena where sanction is considered and meted out principally on behalf of society as a whole) should not take precedence over the needs of children to recover from their experiences and developing strategies for future safety. The vast majority of children who are abused will be targeted by someone they have some kind of emotional attachment to – therefore understanding how best to assist them will need to take account of and have understanding of their 'groomed environment' – what/who has stopped them speaking out. Children who tell will have made a decision at some level that it is better to tell than not tell – they will usually have weighed up that telling will feel 'least worst'. There are more subtle issue around communication when children tell through their behaviour/functioning.'

'Disabled children have specific needs in relation to child protection. They must be seen as a particularly vulnerable group of children. They must be regarded as an 'oppressed' group. They are routinely discriminated against. It has to be recognised that there is institutional disablism in all institutions, education, health and society. Disabled children are harmed by abuse. Quite alarming that this has to be stated. (There is a strong belief that disabled children are less likely to be affected by abuse because they are learning disabled or because they don't understand what happened. Some even believe disabled children have different feelings mechanisms; they don't feel things in the same way. Therefore cannot be harmed!) Disabled children are three times more likely to be abused when compared to non-disabled children. Disabled children have particular needs and requirements that are different to non-disabled children with regards to vulnerability, abuse and post abuse support. Disabled children are not 'children first', their impairment is a crucial element of their identity. The 'Children First' principle has allowed their specific needs to be ignored. This has been highly dangerous in child protection. This is not to deny they are children but they are different children. The political climate of termination of pregnancy (up to term in the case of disabled children) euthanasia and the sanctioning (almost) of so-called 'Mercy killing' have led to disabled children being seen as second class citizens and 'not worthy of life'. This impacts considerably on child protection issues. Disabled children have not been sufficiently researched (no UK research at all has been funded by government) in relation to child protection of disabled children. We don't KNOW how abuse impacts on disabled children (or how it impacts on adult disabled people's lives). However we do know (from research) that they are less likely to be case conferenced, less likely to be put on the child protection register, less likely to have a serious case review if they die or are injured, less likely to be interviewed by the police, less likely to be passed through CPS, less likely to give evidence in court, less likely to have a 'treatment' therapy package.'

All of the specific therapeutic approaches named in the Delphi questionnaire were reported as useful/helpful by some of the respondents. A summary of the positions put forward in responses to the questions on effective interventions, both in terms of what works best and what should not be used is shown in Table 5.10. For some of the specific therapeutic approaches listed in the questionnaire (CBT, feminist/pro-feminist, mediation/alternative dispute resolution, family systems, mutual support/self-help, restorative justice, relapse prevention), at least one of the respondents raised some concerns in answer to the question (question 3) about what approaches should not be used and why. Most of the points raised related to the use of particular approaches being unhelpful at particular points/stages, or in particular circumstances, rather than the approach being totally counter-indicated: For example, some respondents drew attention to the range of therapies recommended as suitable prior to a criminal trial in DH/HO/CPS guidance, which excludes hypnotherapy, drama therapy, regression techniques and groups in which disclosure of assault details takes place. Other respondents were concerned about the application of particular techniques owing to the danger of re-traumatisation (visualization, blank screen technique in psychoanalysis, re-living exercises). For some, behavioural and cognitive approaches can be characterised as too superficial without 'healing' type interventions, in other words were viewed as only being

able to be a part of the interventions required, and it was stressed that they must be implemented in a developmentally appropriate fashion.

Table 5.10: Views on helpful/useful approaches and on approaches that should not be used: Children and young people who have been sexually abused, Round 1

Helpful/useful approaches	Should not be used
• Integrative • Eclectic • Victim led, person centred • Feminist • Humanist • Holistic • Contracting • Social care model • Working with carers and families, therapy sessions with carers present • Child development models • Attachment theory approaches • Psychodynamic • Empty chair work • CBT • PTSD and trauma work • Counselling • PALM (psychotherapy and CBT) • Child psychotherapy • Gestalt • Very young = non-directive play • Older children = include cognitive elements • Group work, structured, age, gender and developmentally appropriate • Psycho educational approaches • Educational materials • Family systems • Residential, in- out- and day- patient settings • Trauma focussed work, EDMR • Narrative therapy • Creative and art therapies • Listening approaches • Play therapy • Writing and talking in the third person • Low arousal • Mediations and affirmations for older children • Female practitioners as "default"	• Limited number of sessions • Joint working with abusive parents/siblings, family therapy • Mediation • Restorative justice • Hypnosis, hypnotherapy • Blank screen psychoanalysis • Freudian psychoanalysis • Memory work • Emphasis on "justice" • Visualisation techniques • Single approaches • Disclosure of violent or traumatic incidents, descriptions of events in detail as re-living, and re-traumatising • Purely CBT • Purely psychodynamic • Purely behaviour modification

Tables 5.11 to 5.15 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation. There was one statement where complete consensus was found in Round 3, 'The ideal position is to be able to offer a choice of therapist gender' (see Table 5.12). For three further statements, concordance was found in Round 3 (see Table 5.14 for all of these):

- 'Children need access to therapies without their parents present', 5% respondents were neutral, in Round 2, concordance was found with 9% respondents neutral.
- 'Cognitive distortions which the child may possess can be explored either directly or through play', 12% respondents were neutral, the statement was new in Round 3.

- 'Cognitive distortions which the child may possess can be explored either directly or through the arts therapies/psychotherapies', 3% respondents were neutral, statement was new in Round 3.

Table 5.11: Therapeutic approaches for children and young people who have been sexually abused, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S1.1 Behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs	**66**	**26**	0	6	2	65
S1.2 There is no single therapeutic approach that works best for every victim/survivor in this group	**71**	**23**	2	0	2	66
S1.3 The approaches used should be needs-led and victim/survivor centred	**72**	**26**	0	2	0	65
S1.4 Talking about abuse is not necessarily part of the healing process	**19**	**57**	9	11	5	65
S1.5 It is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual	**56**	**38**	3	3	0	66
S1.6 A 3 Stage model (Stage 1: Safety and symptom stabilisation; Stage 2: Dealing with the traumatic memories; Stage 3: Reconnection/Regaining a safe and fulfilling life) provides a suitable framework for responding to the needs of this group of victims/survivors	**19**	**53**	13	14	2	64

In connection with the statements contained in Table 5.11, comments emphasised the importance of not viewing stage models as necessarily implying a single sequential process, the importance of working flexibly while using this and the importance of emphasising that alternative frameworks exist. The term 'toolkit' was criticised by some as implying a mechanistic approach.

Table 5.12: Therapeutic approaches for children and young people who have been sexually abused – the gender of the therapist and the use of touch, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S1.9 It is never appropriate to use a therapist of the same gender as the perpetrator	7	0	5	**51**	**37**	59
S1.10 Children/young people should have access to female practitioners as the default position	**17**	**28**	32	15	8	60
S1.11 The ideal position is to be able to offer a choice of therapist gender.	**72**	**28**	0	0	0	60
S1.7 Working within appropriate guidelines, there is a place for touch within therapy	**10**	**67**	10	10	2	57
S1.8 The use of touch/holding within therapy is never appropriate	4	11	18	**51**	**16**	55

In relation to the issue of choice of gender of therapist, a number of people commented that although this was ideal, it was not always, or even often or ever, possible to offer this; note that there was 100% agreement in Round 3 that choice was ideal. A number of respondents reiterated that the more important factor was the quality of the relationship created with the therapist rather than the therapist's gender. Respondents noted the importance of recognising that children may have experienced abuse by females or by both males and females.

Rounds 2 and 3 contained many comments on the use of touch in therapy, these illustrated the complexity of the issues to be considered, including the nature of the therapy (the difference between massage therapy and counselling for example), and the importance of a distinction between touch and holding. While survivor choice and wishes were seen by many as providing a governing principle, others identified the danger of clients consenting 'to keep a therapist happy'. There were also tensions around:

- The difficulty of establishing the appropriate point for therapeutic intervention to start (where the view is held that safety should be established first and ongoing abuse should not be occurring), see Figure 5.11 and Table 5.13.

These were maintained through the three rounds, with comments in Rounds 2 and 3 emphasising the dilemmas and contradictions involved in making appropriate choices to suit the particularities of each specific situation.

Figure 5.11: Views on the appropriate point for starting therapeutic intervention

'I take the view that therapeutic intervention is unlikely to be helpful (and may actually be harmful) if it is provided while a child is continuing to be sexually abused. When this is clear, protection is the only effective and ethical intervention. However, in 'real-life' circumstances where there is no direct evidence of ongoing abuse but it cannot be altogether ruled out, it is more difficult to be categorical about providing therapy. In such cases, I think general emotional support and specific educational input is perfectly valid and may even be ethically appropriate. However, I regularly see situations where children are clearly in need of therapeutic help but whose lives are so unstable (and possibly unsafe) that mental health services and therapists refuse to be involved until other agencies confirm stability or the child's safety. I am not convinced that the balancing of these priorities is always in the best interests of the child's emotional well-being.'

'The problem with all the above relates to the definition of therapeutic work/intervention/support and the distinction between this and assessment. Therapeutic work includes on-going assessment and also therapy-based assessment may help children and young people to talk more openly.'

'Whilst in principle one would want to ensure that children are safe and not being abused before trying to facilitate a healing process, the therapist can never be certain that everything has been disclosed and/or that they are not being abused currently by someone they know or with whom they live. Even if a child has been removed from the known abuser, an adult or another child or young person who they live with or know socially or through school may be abusing them. Perhaps the answer is that therapists should always bear in mind the possibility that a child may not be as safe as they would wish and be prepared to work with that uncertainty. I feel strongly that if a child in therapy discloses previous or current abuse, then therapeutic work must be allowed to continue. There may be a pause whilst the allegations are investigated, but this should be for a matter of days, not weeks. Therapeutic support should continue. If it is stopped it gives the child a message that it was wrong to tell.'

'It is vital to move to a position where all policies, procedures and therapeutic approaches are based on the assumption that the majority of abused children are silenced and unable to disclose and their existence and their needs (e.g. for active, facilitative intervention) are taken into account routinely by all children's services, especially generic services where they are most likely to present with other problems. Although the Delphi exercise is making progress, I think it has not highlighted the existence and the plight of this group sufficiently as yet.'

'It is important to make a distinction between formal therapy and therapeutic support when considering the needs of children suffering on going abuse. Clearly, the priority is to take protective action to stop the abuse and prevent it happening again. Children do need help and support at this stage but they may not be in a position fully to engage with planned, longer term therapies because they are still having to survive in an abusive situation. Formal therapy may lead to the child feeling more vulnerable which then leaves them less able to defend themselves emotionally against further assaults. Children may need help to know who to talk to and how to report abuse but formal therapy aimed at achieving change is better done once the child is protected and safe. Doing nothing is not an option but the timing and nature of therapeutic work is important. There may be confusion when referrals for help are made. There is a big difference between a crisis response and planned therapy.'

Table 5.13: Therapeutic approaches for children and young people who have been sexually abused – therapeutic intervention and safety, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S1.12 Therapeutic intervention is unlikely to be helpful (and may actually be harmful) if it is provided while a child is continuing to be sexually abused [14]	10	40	6	31	13	52
S1.13 Therapeutic work should not start until the safety of the child/young person is established [15]	11	43	7	30	9	56
S1.14 Disclosure of ongoing sexual abuse should not exclude children/young people from receiving therapeutic support	**50**	**43**	3	3	0	58
S1.15 It is not appropriate for a child to engage in therapies that heal until after sexual abuse has ended. However, therapeutic assistance and the creation of a safe, supportive space may help a child to move on from the abusive situation.	**30**	**46**	13	9	2	54

Table 5.14: Therapeutic approaches for children and young people who have been sexually abused – involvement of parents/family, the use of play and arts therapies, and mutual support, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S1.16 Therapeutic work should include the supportive elements in the child/young person's network (parents, carers, siblings)	**35**	**51**	9	6	0	55
S1.17 Children need access to therapies without their parents present	**54**	**40**	5	0	0	57
S1.18 Cognitive distortions which the child may possess can be explored either directly or through imaginative play[16]	**26**	**65**	7	0	2	46
S1.19 Cognitive distortions which the child may possess can be explored either directly or through play	**32**	**56**	12	0	0	25
S1.20 Cognitive distortions which the child may possess can be explored either directly or through the arts therapies/psychotherapies	**31**	**66**	3	0	0	29
S1.21 Mutual support/self-help should only be considered after successful individual therapy/work	6	12	14	**52**	**16**	50

In commenting on the statements contained in Table 5.14 about the involvement of parents and family, respondents in Round 3 particularly emphasised that the two positions are not mutually exclusive and that opportunities for both are needed, with specific recognition that needs may shift over time (see Figure 5.12).

[14] This was one statement where the response set was different between all those who responded on this statement in Round 3 shown in the Table above, and the answers of those who declared expertise in this programme area in Round 1. Restricting the analysis to only declared experts in this area produces a majority disagreement with this statement, but does not remove all neutral or agree responses; the number of declared experts was 15.

[15] This was one statement where the response set was different between all those who responded on this statement in Round 3 shown in the Table above, and the answers of those who declared expertise in this programme area in Round 1. Restricting the analysis to only declared experts in this area produces a majority disagreement with this statement, but does not remove all neutral or agree responses; the number of declared experts was 15.

[16] A number of respondents comments that this could include arts therapies/psychotherapies (including all kinds of arts).

Figure 5.12: Views on the involvement of parents/family

'It is very beneficial to work with non abusing parents and carers but children and young people should be given confidential time to talk as they may not wish to disclose everything in front of adults Children may feel guilty and ashamed or may be worried about upsetting their parents. Careful planning and preparation are key to sensitive work. Children's accounts may trigger adults' own memories and issues with the risks that the adult needs get in the way of the child being free to talk. Also some parents may react with distress or in a punitive way towards a child who is trying to disclose abuse within the family.'

'There will be many times when it would be totally inappropriate to expect a child to attend counselling or psychotherapy sessions. When a child feels like talking about any abuse it many not be to a set timetable. It makes sense to offer guidelines/advice/support to MOTHERS – they are the ones most likely to be around when their child needs to talk. Coercing a child to talk when they are not ready compounds the abuse. A mother has the unique power to be listened to by their (especially younger) children. For older ones she needs to be warned that, however unfairly. they may feel great anger towards her for not being the all-seeing/all-rescuing person they expect and believe her to be. If their mother allows this anger without taking it personally - seeing it as a necessary process – the child/ren can then explore other feelings with her. Not once in twenty years of working with this charity has any father telephoned for help with his children.... For too long professionals have treated mothers with suspicion and lack of respect. Children need to see their mothers being treated with respect by professionals, not marginalised or dismissed as "mum". By considering and helping mothers we are able to help their children in the long-term.'

'Children have rights to private time with therapists for a number of reasons but most important not to assume that everything has been spoken about in the initial disclosure.'

'Some children take care of their parents and foster parents and try not to upset them by speaking about painful issues. They do need to know that they have the freedom to speak freely.'

'There are times when the therapeutic work should involve the supportive elements in the network and times when the child or young person should be seen alone. This can be made clear at the assessment and contracting sessions. This approach recognises the importance of the whole family system and the interactions within that.'

Table 5.15 summarises the views of respondents about the issue of qualifications and training. As can be seen, although a clear majority of respondents in each of Round 2 and 3 agreed that therapeutic interventions should be offered by professionals, by those with relevant training, and by those with suitable qualification, in each case there were significant minorities who disagreed. Responses on the need for accredited training showed no clear majority.

Table 5.15: Therapeutic approaches for children and young people who have been sexually abused – professionals and qualifications, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S1.22 Therapeutic interventions should only be led by those holding a suitable professional qualification	**35**	**27**	11	24	4	55
S1.23 Therapeutic interventions should only be led by those holding a suitable qualification	**23**	**37**	15	21	4	52
S1.24 Therapeutic interventions should only be led by those who have completed relevant training	**43**	**34**	8	15	0	53
S1.25 Therapeutic interventions should only be led by those who have completed accredited training	19	19	26	32	4	53

Comments made in Round 3 in relation to therapeutic approaches for children and young people who have been sexually abused reiterated those made in the first two rounds, emphasising particularly the complexity of the issues involved, the need for flexibility, and for facilitating control and choice by the individual client:

"The comments emphasising the undesirability of prescriptiveness and the need to assess each individual situation seem very important."
"I strongly agree with most of the statements. Healing is a very individual process and the methods used to support the process will vary. Acknowledgement of this is the key issue."
"In my own experience I believe in working alongside the survivor, I see them as the expert, in as much as they know their limitations and with help and support the worker and survivor can plan a suitable pathway to dealing with their issues. In my opinion it is vital the survivor stays in control of the therapeutic relationship. Survivors need a worker who will stay with them, be consistent, open and honest in their approach."

As reported in chapter 3, the Delphi respondents emphasised the importance of a coordinated, multi-agency service response required for children and young people who have been sexually abused. A summary of key elements is given in Figure 5.13.

Figure 5.13 Elements in the required coordinated service response for children and young people who have been sexually abused

1) For children and young people:
   a) The professional network needs to meet and have an agreed care plan which will need regularly to be reviewed
   b) Children and young people need to be able to access support services designed specifically for them i.e. not just for the adult survivors. Support should include peer-mentoring schemes, counselling, group support work, proactive support in schools (e.g. learning mentors, anti-bullying workers, school nurses), protective behaviours training, full education within schools relating to different forms of abuse. Services for children should build on known protective factors within families, school and the community.
   c) All professionals should/could help children with 3 simple consistent messages 1. It is wrong 2. It is not your fault 3. How to stay safe.
   d) It is important to ensure that children and young people are actively involved in designing and developing interventions.
2) For children who have been sexually abused:
   a) Work not only with the child but also carers and relevant family members. There is an important need for services for non-offending parents (both educational and therapeutic).
   b) Confidential help lines - These are useful for children (both victims and their friends), as well as for carers/parents, and professionals working with children. Although limited in formal therapeutic terms, many children and young people's preparation for, and experience of, calling a helpline has initiated their disclosure, or allowed them to disclose in a more effective way. There may be many other ways in which this sort of medium and perhaps related media (text, email etc) might be developed.

5.4 Child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking

The strongest position emerging from responses for this programme area was on the value of intervention and service provision structured around a victim centred and multi-agency staged approach. Responses stressed the importance of ensuring safety as the first stage in any intervention and the need to stop the abuse/exploitation, prior to moving on and healing through the application of any therapeutic intervention. Trauma symptomology needed to be alleviated before relational aspects were dealt with. One important issue was the need to build sufficient trust in order to facilitate sufficient disclosure in order to understand what problems need to be therapeutically addressed, and the quality of the human contact involved in any intervention was identified as important. The importance of including a focus on skills and personal development, and improvement in self-esteem were stressed. Characteristics of the overall approach are summarized in Figure 5.14. The importance of therapists

understanding and being able to work with dissociation and dissociative disorders was emphasized.

There are important differences between working with those "at risk" and those leaving or experiencing direct exploitation. There are also important differences in the methods of work that need to be used according to the age of the victims involved. For children and adolescents, child protection requirements obviously play a key part, and, for children, there is an emphasis on the difference between those who characterise the victims as children and therefore debate child protection and consent purely in terms of immaturity to be responsible for one's actions, and those who talk about adult coercion, grooming and vulnerability.

Figure 5.14: Characteristics of a staged, multi-agency, victim centred approach

- Respect for the child/adult victimised by prostitution, pornography, trafficking;
- An understanding of the methods of entrapment used by sexual exploiters during the grooming process and after entry into prostitution;
- Provision of opportunities for disclosure;
- Belief that they can have and are entitled to a better quality of life.
- Give girls/women/boys the time to speak of their experiences, what happened, how they felt and feel, what they would like to do to regain a better life;
- Give emotional support that conveys that they can have a better life and are worth it;
- Ensure the abuser(s) do not have access to her/him;
- Encourages girls/boys/women to undertake actions on their own behalf, offering assistance when it genuinely supports them towards independence;
- Provides information and support that empowers parents and other family members so that they can offer more effective support to their daughter/other relative as they are being groomed and sexually exploited prior to and after entry into prostitution;
- Adopt a multi-faceted approach to victims, i.e. responses to drug addiction, the need for safe housing, health services, social services involvement, employment/education.
- The importance of providing for easy access to services with flexible appointment times and, where possible, provision of access without appointments.

'Young people tell us that what is important is: accessibility, flexibility, honesty, confidentiality, safety, gendered provision, meeting others with shared experiences.'

Table 5.16: Views on helpful/useful approaches and on approaches that should not be used: Child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking, Round 1

Helpful/useful approaches	Should not be used
• Victim centred • Outreach work/multi-entry points • Psychotherapy • Psycho-educational • Attachment approaches • Humanist • Feminist • Skills and personal development, self-esteem work • Briere type approaches (inner experience, social context, 'symptoms' as logical responses to trauma) • Herman trauma framework • Trauma focussed/trauma specialists • Peer support • Zero tolerance • Gestalt • CBT for long term coping strategies • Regression	• Any approach that suggests blame of the victim • Punitive approaches to the victims or those 'nearly' in prostitution, pornography or trafficking • Anti-psychotic drugs, psychiatric prescriptions • Hypnotherapy • Regression • Unstructured group work • Group work before a trial • Boundary less • Time constrained • CBT too short term and not deep seated enough • Blank screen psychoanalysis • Kleinian psychoanalysis

All of the specific therapeutic approaches named in the Delphi questionnaire were reported as useful/helpful by some of the respondents. A summary of the positions put forward in responses to the questions on effective interventions, both in terms of what works best and what should not be used is shown in Table 5.16.

For some of the specific therapeutic approaches listed in the questionnaire (CBT, family systems, group therapy, drama therapy), at least one of the respondents raised some concerns in answer to the question (question 3) about what approaches should not be used and why. Most of the points raised related to the use of particular approaches being unhelpful at particular points/stages, or in particular circumstances, rather than the approach being totally counter-indicated: For example, some respondents drew attention to the range of therapies recommended as suitable prior to a criminal trial in DH/HO/CPS guidance, which excludes hypnotherapy, drama therapy, regression techniques and groups in which disclosure of assault details takes place. Other respondents were concerned about the application of particular techniques owing to the danger of re-traumatisation (visualization, blank screen technique in psychoanalysis, EMDR, re-living exercises).

The view that punitive approaches to the victims or those 'nearly' in prostitution, pornography or trafficking should not be used was particularly strongly expressed, see Figure 5.15. One part of this critique related to the use of secure accommodation/units, another to the use of child protection procedures, and yet another to approaches that encouraged prosecution.

Figure 5.15 Critique of punitive approaches

'Secure Accommodation should not be used as a principal and reactive measure to safeguard children and young people who continue to be sexually exploited.'

'The kind of advocacy which emphasises/encourages prosecution or other legal actions as a way of repair via obtaining 'justice' because it rarely provides repair, tends to re-traumatise and rarely results in justice.'

'Immediate movement into the child protection procedures and reporting to police and social services, such that enquiry will take place. This is likely to: put the victim in danger; put others in danger; stop the victim accessing appropriate health care; stop the victim accessing appropriate emotional care.'

'The use of secure units under civil orders do not help young people escape situations of risk in the longer term. This practice places young people in environments for offenders, sends the wrong message to them about their worth and are normally counter productive, leaving the young person too often rejecting the protective intention behind the order and placing themselves at increased risk on their release from secure accommodation.'

'Any intervention that treats children/young people subject to sexual exploitation as criminals. Children/young people up to the age of 18 are victims are legally victims. This also applies to trafficking of over-18s. Trafficked and smuggled children/young people should not be identified simply as illegal immigrants but as victims of exploitative migration.'

Tables 5.17 to 5.19 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation. In commenting on the statements contained within Table 5.17, respondents raised caution about the use of the term 'toolkit' as "too technique oriented"; suggestions were made that talking about a "range of therapeutic approaches" would be preferable. This table also shows clearly the greater level of agreement with approaches being 'needs led and victim/survivor centred' (100% agreement in Round 3) rather than 'victim/survivor controlled' or 'victim/survivor led'.

There was one statement on which complete consensus was found in Round 3 ('The approaches used should be needs-led and victim/survivor centred', Table 5.17); in Round 2, 1% were neutral.

Table 5.17: Therapeutic approaches for child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S3.1 A 3 Stage model (Stage 1: Safety and symptom stabilisation; Stage 2: Dealing with the traumatic memories; Stage 3: Reconnection/Regaining a safe and fulfilling life) provides a suitable framework for responding to the needs of this group of victims/survivors	**6**	**62**	13	17	2	47
S3.2 There is no single therapeutic approach that works best for every victim/survivor in this group	**78**	**20**	2	0	0	49
S3.3 The approaches used should be needs-led and victim/survivor centred	**81**	**19**	0	0	0	47
S3.4 The approaches used should be victim/survivor controlled	**38**	**27**	16	20	0	45
S3.5 The approaches used should be victim/survivor led	**46**	**37**	13	4	0	46
S3.6 It is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual	**58**	**38**	4	0	0	48

Table 5.18: Therapeutic approaches for child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking – value of different approaches and settings, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S3.7 Mutual support/self-help should be considered as a therapeutic option at all times	**31**	**53**	12	4	0	49
S3.8 Mutual support/self-help should only be considered after successful individual therapy/work	4	14	14	**57**	**10**	49
S3.9 Regression is a useful approach for child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking	5	17	21	**31**	**26**	42
S3.10 Behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs	**60**	**29**	8	2	0	48
S3.11 Provision of residential settings for therapy are important for some individuals in this group	**28**	**57**	13	2	0	46
S3.12 Secure accommodation in offender institutions does not provide a suitable therapeutic setting for those who have been harmed by prostitution, pornography and trafficking	**55**	**36**	9	0	0	47

There were three statements on which concordance was found in Round 3:

- 'There is no single therapeutic approach that works best for every victim/survivor in this group', see Table 5.17, 2% neutral in Round 3; in Round 2 there was a clear majority with 1% neutral and 3% disagree.
- 'It is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual', see Table 5.17, 4% neutral in Round 3; in Round 2 there was a clear majority with 7% neutral, 3% disagree, and 1% strongly disagree.

- 'Secure accommodation in offender institutions does not provide a suitable therapeutic setting for those who have been harmed by prostitution, pornography and trafficking', see Table 5.18, 9% neutral in Round 3; in Round 2 there was a clear majority with 11% neutral, 5% disagree, and 5% strongly disagree.

There were a number of areas in which, although there was a clear majority, considerable minority positions were advanced:

- The value of a three-stage approach, see Table 5.17;
- Whether regression is of value or not, see Table 5.18;
- The timing for mutual support/self help, see Table 5.18.

Table 5.19 summarises the views of respondents about the issue of qualifications and training. As can be seen, although a clear majority of respondents in each of Round 2 and 3 agreed that therapeutic interventions should be offered by professionals, by those with relevant training, and by those with suitable qualification, in each case there were significant minorities who disagreed; disagreement was least for 'relevant training'. Responses on accredited training showed no clear majority position.

Table 5.19: Therapeutic approaches for child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking – professional qualifications, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S3.13 Therapeutic interventions should only be led by those holding a suitable professional qualification	**27**	**27**	15	27	4	48
S3.14 Therapeutic interventions should only be led by those holding a suitable qualification	**22**	**40**	11	22	4	45
S3.15 Therapeutic interventions should only be led by those who have completed relevant training	**44**	**29**	7	18	2	45
S3.16 Therapeutic interventions should only be led by those who have completed accredited training[17]	20	15	35	28	2	46

5.5 Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults

The most common position here was that appropriate intervention required long-term engagement and a holistic approach to working with both the individual child/young person and their carers/family. An eclectic or multi-model approach was strongly supported. It was strongly emphasized that all work needs to be contextualised within the family/care system in which the child/young person lives, and careful preparation, (including extensive assessment and risk planning), is necessary before long term therapeutic interventions. Illustrative views are shown in Figure 5.16 and Figure 5.17. Attention was drawn to the need to recognize learning disability in formulating treatment strategies, and the importance of relating planned interventions to stage of development (see Figure 5.17).

[17] This was one statement where the response set was different between all those who responded on this statement in Round 3 shown in the Table above, and the answers of those who declared expertise in this programme area in Round 1. Restricting the analysis to only declared experts in this area produces a majority neutral response (88%) to this statement, removing all those who disagree, but retaining a minority agreement response. The number of declared experts, at 8, is relatively small.

Figure 5.16 Characteristics of effective intervention

'With children who sexually abuse other children, working both on their own victimisation if they have been abused but not shrinking from working on their abusing behaviour and ensuring that those around them (e.g. caregivers in substitute care or parents) do not minimise and deny this behaviour.'

'A multi-agency, systemic approach to case management; Rigorous, evidence based assessment; A range of measurable treatment interventions drawing on theoretical models including CBT, MST & psychodynamic principles; One size does not fit all with children showing sexually harmful behaviour since they have diverse needs. A diversity of evidence-based treatments will need to be designed to meet these needs.'

'Structured, re-educative approaches (e.g. CBT & MST) are needed with virtually all child sexual abusers at some stage in treatment'

'Long term individual dynamic work with selected children and adolescents who sexually abuse. Any psychological therapy intervention for children who sexually abuse must follow a rigorous assessment, must be evidence based and measurable, must be delivered by a trained and supervised practitioner and must be part of a co-ordinated, interagency care plan for the young person.'

'Interventions that work best are multifaceted, meeting assessed psychosocial needs, intensive and, usually, long term. Interventions should be tailored to the individual young person's needs. Drop-out is the single factor that most compromises the effectiveness of intervention. Thus, engagement of the young person in the management of his problems is crucial.'

'A multi-systemic framework is required, utilising cognitive-behavioural interventions with the young person, systemic family work and energetic liaison with education and social services. A tenacious and assertive outreach model should be adopted. Any intervention must be based on a comprehensive forensic mental health assessment of the young person's capacity, in order to keep the work tailored and realistically pitched regarding the young person's ability and environmental resources, that is their support. For some young people a structured groupwork programme based on cognitive-behavioural principles is very helpful.'

'Clinical approach requires eclectic thinking to addressing the complex interplay of aetiological factors and underlying issues. Hence need to combine family systems, behavioural, psychotherapeutic and expressive approaches.'

'Problematic sexual behaviours are multi-causal and require a range of interventions. Young people need to be able to understand the changes they need to make, be helped to develop new skills and rehearse new behaviours. Use of approach goal methods is more motivating for a young person than avoidance approaches and therefore usually more effective. Young people who are overwhelmed by feelings of shame, depression, hopelessness are unlikely to feel able to be honest or achieve change. Much support and encouragement to identify strengths and to develop trust is therefore essential. Attention to attachments, own victimisation and other traumatic experiences should form an important part of therapeutic plan.'

Figure 5.17 The importance of developmental appropriateness

'Interventions which are developmentally sensitive and take into consideration the whole of the young person's life and experiences including their strengths, resources and resilience factors. All interventions should include/involve the young person's parents and carers directly. Or where this is not possible their perspective should be included.'

'These children and young people have the capacity to change and that they should be worked with on the basis of their family context with a recognition of strengths as well as deficits.'

'Interventions with young people who sexually harm should: be individually tailored to meet the specific needs of the young person; be developmentally appropriate and the developmental needs of the young person; be informed by those factors seen to promote resilience and positive outcomes for young people; actively involve those in the young person's network including carers and parents.'

'Understand current symptoms and/or behaviours in context of developmental psychopathology, ecological perspective, social maps, trauma as a psychological wound and for perpetrators failed mentalisation.'

'The majority of children and adolescents who commit sexual offences are from a disadvantaged and frequently abusive family environment. A significant proportion will show some degree of learning disability and have a limited repertoire of positive coping strategies. It is important that the victimised aspects of these young people are acknowledged in any work undertaken but that this does not obscure the need for an adequate risk assessment. There are a number of developmental pathways described in the literature for juvenile sexual abusers but there has been a tendency to 'download' the knowledge base from adult sex offenders to a young age-group. In my view it is critical that a basic understanding of child and adolescent development informs work undertaken and that a strong emphasis is placed on prevention and management. A non-judgmental approach and an understanding of causes of anti-social behaviour and delinquency in young people should underpin work with young sexual abusers'

Except for zero tolerance, all of the specific therapeutic approaches named in the Delphi questionnaire were reported as useful/helpful by some of the respondents. None of the specific therapeutic approaches mentioned in question 4 of the questionnaire in Round 1 were viewed as unequivocally unhelpful for this group. A summary of the positions put forward in responses to the questions on effective interventions, both in terms of what works best and what should not be used is shown in Table 5.20. A strongly supported position was that provision of residential options was important for some children/young people (not however within the context of offender institutions).

Table 5.20: Views on helpful/useful approaches and on approaches that should not be used: Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults, Round 1

Helpful/useful approaches	Should not be used
• Long term engagement • Holistic • Developmentally sensitive • Three way work between the therapist, the client and their carer/family; active involvement of client's care network including their family • Residential stays, in-, out-, day- patient settings as appropriate • Risk management driven • Dual approach of client as being a potential risk and being at risk; case conferencing • Psycho educational approaches • CBT • MST (multi systemic therapy) • Family systems, family therapy • Group work • Child psychotherapy • Creative, art and play therapies	• Adult programmes • Confrontation • Minimising or denying the behaviour • Physical contact therapies, including holding therapies • Regression • Hypnotherapy • Polygraphy • Penile plethysmography • Medication • Non directive play work • CBT for purely behaviour modification or as sole intervention • Dynamic approaches which rely on insight-oriented techniques and complete reliance on talking therapy

Tables 5.21 to 5.23 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation. Comments on the statements drew attention to the diversity within the group of children and young people considered here, and how this mitigates against a global response to some of the statements (for example S4.1 in Table 5.21). In commenting on S4.2, a number of respondents were of the view that this was less appropriate or relevant for older children. Complete consensus was not found on any statement in Round 3. There were three statements on which there was concordance in Round 3:

- 'There is a need for the development of more specialist interventions for abusing children', see Table 5.21, with 5% neutral in Round 3; in Round 2 there was only a clear majority with 5% neutral and 3% disagree.
- 'The engagement of the young person in the management of his/her problems is crucial', see Table 5.22, with 3% neutral in Round 3; in Round 2 there was only a clear majority with 2% neutral and 3% disagree.
- 'Provision of residential settings for therapy are important for some children/young people in this group', see Table 5.23, with 10% neutral in Round 3; in Round 2 there was only a clear majority with 7% neutral and 2% strongly disagree.

There were a number of areas in which, although there was a clear majority, considerable minority positions were advanced:

- The value of a three-stage approach, see Table 5.21;
- That drop-out is the single factor that most compromises the effectiveness of intervention, see Table 5.21; comments in Round 3 drew attention to the multiple possible causes of drop out and the need to ensure that approaches used are developmentally appropriate and felt as relevant by the child/young person.
- Whether touch/holding has a place within therapeutic approaches or not, see Table 5.21. This tension was maintained through all 3 rounds.

In terms of the direct involvement of parents and/or carers in interventions, no clear majority position emerged, see Table 5.22; there was also no clear majority position in Round 2. There were a number of tensions in the responses about the extent to which a cycle of abuse should be regarded as inevitable or not and the extent to which early intervention in this is possible. This tension was particularly apparent in Round 1; comments in Round 3 were more dominated by those who considered that early intervention was effective.

Table 5.21: Therapeutic approaches for children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S4.1 Interventions that work best are multifaceted, tailored to assessed psychosocial needs, intensive and, usually, long term	**40**	**43**	9	6	3	35
S4.2 A 3 Stage model (Stage 1: Safety and symptom stabilisation; Stage 2: Dealing with the traumatic memories; Stage 3: Reconnection/Regaining a safe and fulfilling life) provides a suitable framework for responding to the needs of this group	**12**	**49**	15	21	3	33
S4.3 Behavioural and cognitive approaches on their own are insufficient to meet the needs of this group	**61**	**30**	6	3	0	33
S4.4 Drop-out is the single factor that most compromises the effectiveness of intervention	**17**	**43**	20	20	0	30
S4.5 There is a need for the development of more specialist interventions for abusing children	**57**	**38**	5	0	0	37

Table 5.22: Therapeutic approaches for children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults – engagement, use of touch and involvement of parents/carers, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S4.6 All interventions should include/involve the young person's parents and/or carers directly	6	26	26	34	9	35
S4.7 The engagement of the young person in the management of his/her problems is crucial	**63**	**34**	3	0	0	35
S4.8 Working within appropriate guidelines, there is a place for touch within therapy	**6**	**63**	13	16	3	32
S4.9 The use of touch/holding within therapy is never appropriate	6	13	16	**53**	**13**	32
S4.10 Parents/carers should be assessed for their potential harm or support before being included in the therapies of PPT victims/ survivors.	**47**	**44**	6	3	0	32
S4.11 Parents/carers do not need to be involved directly in the client's therapy in order to be supportive and aid recovery.	**9**	**66**	9	9	6	32

Table 5.23 summarises the views of respondents about the issue of qualifications and training. As can be seen, although the majority of respondents in each of Round 2 and 3 agreed that therapeutic interventions should be offered by professionals, by those with relevant training, and by those with suitable qualification, in each case there were significant minorities who disagreed. Responses on the need for accredited training showed no clear majority position.

Table 5.23 Therapeutic approaches for children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S4.12 Provision of residential settings for therapy are important for some children/young people in this group	**37**	**53**	10	0	0	30
S4.13 Secure accommodation in offender institutions does not provide a suitable therapeutic setting for this group	**44**	**38**	9	6	3	34
S4.14 Therapeutic interventions should only be led by those holding a suitable professional qualification	**26**	**34**	11	29	0	35
S4.15 Therapeutic interventions should only be led by those holding a suitable qualification	**15**	**55**	12	18	0	33
S4.16 Therapeutic interventions should only be led by those who have completed relevant training	**39**	**24**	18	18	0	33
S4.17 Therapeutic interventions should only be led by those who have completed accredited training	18	18	33	27	3	33

Finally, some key points of consensus about service delivery to children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults were:

a) It is important that they should not receive the label of sex offender and that their behaviour should be understood within a developmental and child protection framework. Importantly this should reflect the fact that the child will have strengths which need to be supported.
b) Importance of understanding that sexually inappropriate behaviour is an indication that a child may have been abused.
c) Specialist Residential treatment that links clinical work with day-to-day living is important for some of this group.
d) Need specific help for children and young people with certain disabilities, such as ADHD, ADD, autism, Aspergers, both at the general education and sex education level, and also if abusive behaviour comes to light. They may need a lot of help and support to enable them to think through their actions and understand the implications and consequences of their actions, also to understand the social and relational side of things. The help may well need to be tailored to actual circumstances, not delivered in a generalised way.
e) Those providing treatment, care and support need to be fully informed about a young person's history, risks and needs. They should be active members of any intervention programme and planning group. Close liaison between all those involved is essential.

5.6 Adult sex abusers and offenders

Responses in the programme area of adult sex abusers offenders largely assessed the usefulness of therapeutic interventions by whether they were assumed or 'proved' to influence recidivism and re-conviction. From this there is general support for the position that therapies for sex offenders are largely focussed on behaviour change, and sexual arousal management, CBT, medication and "home work" approaches were all advocated. For similar reasons, psychotherapy was less enthusiastically supported, as there is a perceived lack of evidence for its "success" in reducing offending. This is quite a different criterion to that used in other programme areas, and this shift towards outcome as more important than client sensitivity is further reflected in the advocacy of medication, hormone treatments and chemical castration; highly invasive, medicalised and controlled by the service provider rather than the client.

There was a concurrent position suggested, that many offenders were previously victims themselves, and that this underlying victimisation needs to be addressed in order to heal or change their deviancy. To clarify, accepting and challenging prior victimisations comes in the form of empathy and understanding of the client, rather than collusion or discounting of the seriousness of the offender's actions. The need to not minimise or justify sex offending as caused by, or the inevitable product of, an abused or victimised background was strongly stated. Psychotherapy and PTSD type work were suggested as relevant for addressing underlying problems, alongside approaches that directly tackle deviant and inappropriate sexual behaviour.

Offenders in therapy are considered a risk to others, themselves, and potentially to the therapist. The therapist is 'at risk' both in terms of the professional burden assumed when working with sex offenders as also in terms of the potential for malicious "grooming' of therapists by calculating clients, when the reward for successfully completing therapy can be sufficient motivation for offender clients to "fake" improvements within the therapeutic setting, particularly as much of the therapeutic interventions for sex offenders are provided with criminal justice or prison settings. There is a strongly stated need for rigorous clinical supervision, 'sophisticated understanding' and risk assessment of the client as part of the therapeutic relationship.

Confidentiality, a cornerstone in most other programme areas, is less exclusively considered here: breaking confidence may be both a necessity for child, adult and community protection as well as a therapeutic aid for group work and involvement of families in their therapy.

Group work, particularly when referred to in criminal justice or prison settings, was largely supported as effective. Peers challenging each other within the group may have therapeutic and safety benefits over predominantly individual approaches. Public admissions can help to develop empathy for others in the group, and in line with social learning approaches, offenders can 'model' and learn from others going through the same process. A note of caution about collusion was provided within this position, and good monitoring and supervision of group work was viewed as essential.

By involving the offenders' families as part of their intervention the client may benefit from having their confidentiality and privacy compromised. There is agreement that perpetrators and victims should be kept apart, but there is also some assertion that including the offender's family within the therapy is productive. The family can act as an informal monitoring of the offenders behaviour and can provide a social situation in which the offender can live after leaving the criminal justice system, encouraging and facilitating change (see Figure 5.18).

Figure 5.18 The role of the family in sex offender therapeutic interventions

'Where possible and practicable, it is best if the offender's learning is shared with a close family member or friend for ongoing, long-term support. The tangible product of intervention programmes needs sharing with family and professionals to allow ongoing support and effective supervision into the future. All need to recognise the potential for lapse/relapse, (rather than ignore this potential).'

'Offenders in any category of offending will feel less vulnerable and be more supported if they have family links. The presence of knowledge within the family group can also provide a policing system amongst them who are closest to the offender.'

'For some individuals sexual offending is the offender's means of meeting fundamental needs. Those for whom abusive thoughts and behaviours have become a key part of life need to have something positive to put in its place. The fear of a vacuum of unmet need does not encourage a positive approach to change. For change to be maintained, offenders need ways of meeting their needs in non-abusive ways. Plans for an abuse-free New Life need to be built into treatment programmes and supported thereafter.'

'Family work (provided that power differentials are addressed) helps to provide a context in some cases.'

'[I do not support] family centred interventions (speculation for this would include the central role in which perpetrators have in manipulating family dynamics and the danger of victim blaming effects)'

All of the therapeutic approaches listed in the Delphi questionnaire were reported useful/helpful by some respondents. Table 5.24 shows a summary of the responses to questions on effective interventions, both in terms of what is helpful and what should not be used. Overly confrontational or judgemental approaches, such as "scared straight" style programmes and overtly religious programmes were adamantly rejected as being unhelpful and ignoring underlying 'root' causes of offending. Respondents indicated some concerns that CBT style work does not address the underlying causes to sufficiently affect sexual predatory deviancies. Respondents were also wary that person-centred approaches were open to, or even prone to, minimising the offences or collusion with the offender.

Figure 5.19 Interventions for potential sex offenders

'Need to have facilities available for those who have no criminal record but who are concerned about their behaviour/desires. '

'An increase in the availability of advice to those who know they have a sexual interest in children, such as confidential freephone numbers.'

'Services for those who fear they may abuse but have not yet done so.'

'More provision of treatment for unconvicted abusers.'

There was a general acceptance across the respondents that sex offending and sexual predatory deviancy are, and should be, stigmatised and socially unacceptable. However this also means that within society there are not enough pathways to getting help prior to offending, that people at risk of sex offending or at the early stages of predatory deviancy do not have access to support and therapy (see Figure 5.19).

Table 5.24 Views on helpful/useful approaches and on approaches that should not be used: adult sex offenders, Round 1

Helpful/useful approaches	Should not be used
• Integrative model • CBT • Social learning approaches • Group work • Medication (non-sexual) • Chemical castration and hormone medication • Sexual arousal management • Low arousal techniques • Verbal satiation techniques • Relapse prevention • Psychodrama • Psychoanalysis, to address perpetrators own issues • Functional analytic psychotherapy • PTSD type work	• Predominantly or purely psychoanalysis • Non-directive counselling • Purely CBT • Family centred interventions • Religious and born again approaches • Scared straight programmes • Hypnotherapy

Tables 5.25 to 5.27 summarise the responses to specific statements assessed in Round 3 of the Delphi consultation. Within Table 5.25 there was one statement on which complete consensus was reached in Round 3 ('there is no single therapeutic approach that works best for every member of this group'), this amounted to 100% agreeing or strongly agreeing; in Round 2 there was a clear majority for this, with 4% neutral and 7% disagree. In relation to statement S10.6 in Table 5.25, one respondent in Round 3 suggested a re-phrasing as: "those leading therapeutic interventions should be aware of the possibility that clients may have been abused".

Table 5.25: Therapeutic approaches for adult sex offenders, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S10.1 It is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual	**40**	**54**	3	3	0	35
S10.2 There is no single approach that works best for every member of this group	**65**	**35**	0	0	0	34
S10.3 Behavioural and cognitive approaches on their own are insufficient to meet offenders' needs	**47**	**32**	6	15	0	34
S10.4 All adult sex offenders should be assessed for personality disorders	**18**	**44**	12	27	0	34
S10.5 Therapists working with this group should be aware of the nature of personality disorders, how to identify them and where to refer clients with such disorders.	**41**	**56**	0	3	0	34
S10.6 It should be assumed that adult sex offenders were previously victims themselves, unless otherwise indicated by the client	9	15	9	**41**	**27**	34

There were three statements for this programme area where no clear majority position emerged:

- 'Interventions for adult sex offenders are best delivered in group situations', see Table 5.26;
- 'Medication can be a valuable adjunct to the psychological treatment of adult sex offenders', see Table 5.26 and Figure 5.20;

- 'It is important to involve family members within the therapy/treatment for sex offenders', see Table 5.27 and Figure 5.17.

Figure 5.20 The inappropriateness of notions of client centredness for adult sex offenders

'Interventions should be victim centred. This is one area where client centred work is not advisable. Attitudes and behaviours have to be challenged to have any success.'

'Certainly, the intervention should be needs led, but rather than being purely client centred, it must take account of the needs and safety of those at risk from and/or who have been abused by a particular abuser'

'Client-centred seems to imply that the victim is forgotten. This is not the case with sex offender work; however, the start of a therapeutic intervention has to be with the perpetrator. Needs may well include a need to reduce his own risk by raising anxiety about his propensity to offend, and developing victim empathy is one of many ways to increase anxiety about offending behaviour within the perpetrator.

'I agree that the approaches should be led by the treatment needs of the abuser, but as written the statement does not take account of the needs and safety of those at risk from and/or who have been abused by a particular abuser. The term 'client centred' is unhelpful in this area. I would have preferred an option to choose a different form of words, e.g. 'led by the treatment needs of the abuser and taking into account issues for those abused by him or her'.

'Risk must be defining characteristic not need.'

'I think that totally client-centred work is likely to miss important criminogenic needs such as deviant sexual arousal – as many sexual offenders are unlikely to volunteer information about these issues unless asked. On the other hand, I think it is also possible to present treatment as something that will benefit the offender in terms of increasing his contentment with life, rather than as something that is being done "to" him solely in order to prevent him victimising again. In my experience, and with some research evidence, offenders are more interested in interventions that they feel area t least somewhat designed to benefit them, than those they feel are designed solely for crime prevention. It is possible to do this without compromising the need to effectively target criminogenic risk factors.'

Table 5.26: Therapeutic approaches for adult sex offenders – needs led, group work, medication, recidivism and confidentiality, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S10.7 The approaches used should be needs-led and client centred	**20**	**49**	6	20	6	35
S10.8 Interventions for adult sex offenders are best delivered in group situations	3	38	18	35	6	34
S10.9 Group work should only be considered after successful individual therapy/work	6	18	27	**39**	**9**	33
S10.10 Medication can be a valuable adjunct to the psychological treatment of adult sex offenders.	15	37	33	7	7	27
S10.11 Sexual arousal disruption is an important part of interventions with sex offenders	**0**	**81**	12	8	0	26
S10.12 Reducing recidivism is only possible when offenders are taught new skills and ways of dealing with sexual arousal	**13**	**67**	17	3	0	30
S10.13 Adult sex offenders should not be offered any form of confidentiality during the course of their treatment	6	8	11	**67**	**8**	36
S10.14 Offering sex offenders [limited] confidentiality encourages disclosure and openness to interventions	**14**	**65**	11	8	3	37

Comments were made by a number of respondents in relation to some of the statements in Table 5.26:

- in relation to statement S10.7 on client-centredness, see Figure 5.20;

- in relation to statement S10.11 on sexual arousal disruption, see Figure 5.21;
- in relation to the statements on confidentiality see Figure 5.22.

Figure 5.21 Sexual arousal disruption

'Where this is a problem, it is vital to address it as it is one of the most significant risk factors for reconviction. However, this statement presupposes that all sexual offenders have problems in this area, which is not the case.'

'Many sex offenders are not thought to exhibit persistent deviant sexual arousal, and therefore sexual arousal disruption is only important for the minority (large minority) who do. More important interventions are indicated for those who don't have deviant arousal, including the identification of key emotional triggers.'

'Medication can have a very useful role especially with offenders who are hypersexual or have deviant arousal patterns. I agree with the comments that not all offenders have deviant sexual interests to offer such an intervention to all offenders would not be necessary. But if present – I think it must be properly and carefully assessed and receive special intervention.'

Figure 5.22 Confidentiality

'A complete lack of confidentiality is likely seriously to reduce any motivation to attend treatment. It also pushes offenders into a situation where they feel completely out of control which is likely to increase risk of reoffending. It is important though that this work is done by people who know about the behaviour of sex offenders and who will not be groomed by the offender or collude with the offender's attempts to keep confidences.'

'It rather depends on what you mean by' any confidentiality' if pertaining to abuse committed by them, then no, but if abuse metered out to them that may be okay, and various other factors may need to be kept confidential.'

'The boundaries of confidentiality should be spelt out clearly at the outset. These should include clarification that any information the offender gives about historical or current offending will be shared with clearly designated authorities/individuals. The therapist should make it clear that child protection will always take precedence. However, information given by the offender regarding his personal life history should not be shared without his consent. Many sexual offenders have personal histories which include emotional, physical and/or sexual abuse, the detail of which it is inappropriate to reveal outside the therapeutic setting. I agree if 'limited' is boundaried. If it means more than that, I disagree.'

'Offenders in groupwork should give each other a commitment that they will not talk about each other's offending outside the group. If they do so, this can harm not only each other but also their families and victims.'

'There can never be confidentiality if this puts a child at risk'

Table 5.27 summarises the views of respondents about the issue of qualifications and training. As can be seen, although the majority of respondents in each of Round 2 and 3 agreed that therapeutic interventions should be offered by professionals, by those with relevant training, by those with suitable qualification and by those with accredited training, in each case there were significant minorities who disagreed. The least amount of disagreement was found for 'relevant training'.

Table 5.27: Therapeutic approaches for adult sex offenders – involvement of family, qualifications and training, Round 3

	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree	Number of responses
S10.15 It is important to involve family members within the therapy/treatment for sex offenders [18]	0	25	33	39	3	36
S10.16 Some family sessions may be beneficial after therapeutic work, provided that child protection concerns have been fully addressed	**8**	**64**	14	11	3	36
S10.17 Therapeutic interventions should only be led by those holding a suitable professional qualification	**28**	**39**	14	17	3	36
S10.18 Therapeutic interventions should only be led by those holding a suitable qualification	**20**	**51**	11	14	3	35
S10.19 Therapeutic interventions should only be led by those who have completed relevant training	**33**	**42**	14	11	0	36
S10.20 Therapeutic interventions should only be led by those who have completed accredited training	**25**	**28**	25	19	3	36

[18] This was one statement where the response set was different between all those who responded on this statement in Round 3 shown in the Table above, and the answers of those who declared expertise in this programme area in Round 1. Restricting the analysis to only declared experts in this area produces a majority neutral response to this statement, but does not remove all those who agree or disagree.

Chapter 6 Conclusions

In this final chapter we present a summary of the main findings and explore some implications, as well as the limitations of the study.

Principles, values and core beliefs and issues across all programme areas

In each round respondents were asked to comment on principles, values and core beliefs. Analysis in Round 1 identified five clusters of themes: power and responsibility; protection, safety and risk management; interventions; criminal justice; working together, providing and sharing information. A fair amount of commonality was identified across all 10 programme areas. Diversity, inclusion, equal treatment and basic human rights principles were strongly suggested as fundamentally important, suggesting that a human rights/equalities framework was a required basis for policy and practice, with explicit attention to gender, sexuality, ethnicity, and disability within this. A second over-arching theme was the notion of the importance of a victim/survivor centred approach (associated with characteristics such as empowerment, giving control and choice to victims/survivors); this was suggested, by some, to include choice for victims/survivors in terms of the gender, sexuality and age of the person they work with. Differences were identified in the way victims/survivors were viewed compared to abusers/perpetrators.

The use of a wide variety of therapeutic approaches was also something common across all programme areas. This was reinforced in the responses to the list of therapeutic approaches provided in Round 1 (see question 4 in Appendix 3), where in each of the programme areas each of the approaches was reported as useful/helpful by some respondents.

Respondents were asked to comment on two existing sets of guidelines that were mentioned frequently in the responses to Round 1. The respondents were generally supportive of both the BACP Ethical Framework and the Respect Guidelines, with high percentages agreeing that they are the most appropriate guidelines presently available (Round 2; 72% and 81% of respondents respectively).

Findings within programme areas

Within each programme area, respondents were asked to comment on which therapeutic approaches might be considered helpful, and analysis of these responses identified the most frequently chosen approaches for each programme area. Respondents were also asked to indicate their position of agreement or disagreement in response to a variety of statements about interventions, approaches, training and treatment of clients. For many items there was a clear majority position (of agreement, neutral or disagreement), which is defined as where the most frequently held of these positions was held by at least 20% more respondents than the next most frequently held position. For some items the majority position was less clear (i.e. there was less difference in the percentage of respondents holding the majority view and the next largest group), and in a minority of items, there was a unanimous response. Each of the ten programme areas identified at least one item on which all the respondents could agree or be netural. As well as developing potential consensus, the method of re-assessing items in Round 3 also allowed respondents to re-position their views in light of previous findings and

discussion. This did not occur in all programme areas, but where a clear majority position changed between Rounds 2 and 3, this is highlighted.

Respondents in Rounds 2 and 3 were asked to comment only in areas in which they had experience and expertise. By identifying which areas respondents had declared that they had experience in as a part of Round 1, it was possible to examine whether there were differences in response between those who declared expertise in the area in Round 1, and those who had answered in the particular programme area in a later Round. For the majority of items, the declared-expert position did not vary from the overall respondent position. However, for a small number of items (8 out of 209 in Round 3) there was a difference between declared-experts and others. These points of contention have implication for developing policies that are both informed by experts in the area and acceptable to the broader expert group.

Adult victims/survivors of domestic violence and abuse

One item drew unanimous agreement/complete consensus in Round 3: ‘there is no single therapeutic approach that works best for every victim/survivor in this group’.

Two further items received no disagreement in Round 3: ‘the approaches used should be needs-led and victim/survivor centred’ ; and, ‘behavioural and cognitive approaches on their own are insufficient to meet victim/survivors’ needs’. This may indicate that general principles are emerging about how to respond and conceptualise services provided for adult victim/survivors of domestic violence and abuse.

Diverse positions emerged, and were maintained throughout, in relation to: the role of medication in treatment; the use of conflict management techniques; the value and place of mediation; and the value of routine enquiry.

Children and adolescent victims of domestic violence and abuse

Three items generated no disagreement from the respondents in Round 3: ‘choice of therapeutic intervention should be needs led, guided by the age and maturation of the child and their individual experiences and degree of victimisation’; ‘children need access to therapies without their parents present, abusive or non-abusive’; and, ‘the child’s therapeutic intervention (including its pace) should be considered independently from any therapy for the non-abusing parent’.

There was disagreement about engaging children in interventions prior to the end of the threat, or presence, of abuse. Declared experts indicated a clear majority position of disagreement with the statement that safety and separation are pre-requisites to therapeutic intervention, however for all respondents there was more discordance in positions with 56% in agreement and 40% in disagreement, with 4% neutral.

Adult perpetrators of domestic violence and abuse

Two almost completely polarized positions arose within the responses on this programme area, based on the use of two different definitions of domestic violence. The first of these positions was held by those who saw (or defined) domestic violence as being about the use of coercive control within an intimate relationship, and the second by those who saw (or defined) the term domestic violence as covering a much wider field of difficulties within an intimate relationship. Both positions recognized the existence of female perpetrators of domestic

violence and abuse, and the existence of domestic violence and abuse in homosexual relationships (both male and female). Within the responses in all three rounds of the consultation, the first position was more common than the second.

Two items drew unanimous agreement from the respondents in Round 3: 'there is no single approach that works best for every member of this group'; and, 'it is important to work in ways which are meaningful to perpetrators from different cultures and backgrounds'. For one further item, 'it is important to avoid collusion with perpetrators' justifications for their behaviour', there was unanimous agreement in Round 2, and no disagreement, but one neutral respondent, in Round 3.

There was some lack of consensus about the timing of group work. In response to the statement that 'group work should only be considered after successful individual therapy/ work' declared experts were split between agreement and disagreement, compared with a clear majority position of disagreement in all respondents.

Young people who perpetrate domestic violence and abuse

On three items, there was unanimous agreement from the respondents: 'there is no single approach that works best for every individual in this group'; 'interventions that work best are multifaceted, tailored to assessed psychosocial needs, intensive and, usually, long term'; 'the engagement of the young person in the management of his/her problems is crucial'.

There was indication of moving towards agreement about where best to place young people who abuse others, with no disagreement (but some neutral respondents remained) in Round 3 with the statement that 'provision of residential settings for therapy are important for <u>some</u> young people in this group'.

For three further items, there was no disagreement: 'there is a need for the development of more specialist interventions for abusing children'; 'through specialist services, it is possible to work with this group both as offenders and as victims of domestic violence and abuse'; 'parents/carers should be assessed for their potential harm or support before being included in therapy for this group'.

For one further item, 'behavioural and cognitive approaches on their own are insufficient to meet the needs of this group', there was no disagreement with the position in Round 2, however there was one respondent in Round 3 who disagreed (out of 37 respondents).

More than any of the other programme areas, there is a strong agreed message here about how to respond to young people who perpetrate domestic violence or abuse through flexible engagement in specialist services, and striking a balance between perpetrator and victim approaches.

Adult victims/survivors of rape and sexual assault

Two items about approaches within interventions produced no disagreement in Round 3: 'there is no single therapeutic approach that works best for every victim/survivor in this group'; and 'the approaches used should be needs-led and victim/survivor centred'.

There was one area where a notable divergent position was maintained about whether men who are raped need to be offered services that are separate from female rape victims/ survivors, and whether therapies for men are distinct and different than those required for women. In Round 3, 51% of respondents agreed or strongly agreed that male services should be separate from female services, with 34% disagreeing and 16% neutral. In terms of whether distinct and different therapies are required for men and women, in Round 3, 30% of respondents agreed or strongly agreed while 48% disagreed and 22% were neutral. These are key issues for service providers in terms of accessibility and acceptability and may require further elaboration.

Adult survivors of childhood sexual abuse

Two items drew unanimous agreement in Round 3: 'there is no single therapeutic approach that works best for every victim/survivor in this group'; and, 'the approaches used should be needs-led and victim/survivor centred'. For one further item, there was no disagreement in Round 3, and two respondents who espoused a neutral position: 'behavioural and cognitive approaches on their own are insufficient to meet victim/survivors' needs'.

There were a number of areas where no clear majority position existed, and divergent views remained in all rounds. The first of these was in relation to the use of three specific forms of therapy, namely: regression, hypnotherapy, and inner child techniques. The second area was in terms of whether therapy should always be offered on an open-ended basis. The third area was in relation to the necessity for qualifications and accredited training.

There was broad endorsement of person-centred approaches that are tailored to the individual client, though there remains debate about the role and appropriateness of some approaches for some clients.

Children and young people who have been sexually abused

One item generated complete unanimity in Round 3, namely that the ideal position is to be able to offer a choice of therapist gender.

Three items generated no disagreement from respondents: 'children need access to therapies without their parents present'; 'cognitive distortions which the child may possess can be explored either directly or through play'; 'cognitive distortions which the child may possess can be explored either directly or through the arts therapies/psychotherapies'.

For one further item, 'the approaches used should be needs led and victim/survivor centred', there was no disagreement in Round 2, but this consensus was not present in Round 3 (1 respondent out of 65 disagreed).

Two statements indicated disagreement between the declared expert and overall respondent majority positions. Declared experts indicated a clear majority position of disagreement with the statement that 'therapeutic intervention is unlikely to be helpful (and may actually be harmful) if it is provided while a child is continuing to be sexually abused', whereas the overall group of respondents showed no clear majority position, 50% agreed, 44% disagreed and 6% were neutral. Declared experts indicated a clear majority position of disagreement

with the statement that 'therapeutic work should not start until the safety of the child/young person is established', whereas the overall group of respondents showed no clear majority position, 54% agreed, 39% disagreed and 7% were neutral. These two points have serious implications for setting working practices that engage with children whilst abuse is ongoing, and may need further attention to address the diverging views within the overall respondent group.

Additional comments indicated that there is a need for therapeutic and educational services for non-abusing parents, and for work to be carried out with carers and family members as well as the children.

Child, adolescent, and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking

There was unanimous agreement in Round 3 that 'the approaches used should be needs led and victim/survivor centred'. There were three items where no disagreement from the respondents in Round 3 was expressed: 'there is no single therapeutic approach that works best for every victim/survivor in this group'; 'it is most helpful to think in terms of a 'toolkit' of approaches, each of which may be useful at a particular stage for a particular individual'; 'secure accommodation in offender institutions does not provide a suitable therapeutic setting for those who have been harmed by prostitution, pornography and trafficking'.

Although there was less agreement about the specifics of interventions, there was a general agreement that clients need flexible and adaptable interventions. Additional comments suggest that it is important that services are provided with flexible access routes.

Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults

Three items received no disagreement from respondents in Round 3: 'there is a need for the development of more specialist interventions for abusing children'; 'the engagement of the young person in the management of his/her problems is crucial'; and, 'provision of residential settings for therapy are important for some children/young people in this group'.

There was no clear majority opinion from respondents about the statement that 'all interventions should include/involve the young person's parents and/or carers directly', diverging positions were maintained throughout the consultation. In Round 3, 32% agreed, 43 % disagreed and 26% were neutral.

In both Rounds 2 and 3 there was a clear majority agreement with the statement that 'secure accommodation in offender institutions does not provide a suitable therapeutic setting for this group'.

Additional comments advanced that the label of sex offender is not suitable for children. In conjunction with the above positions on the role of family, secure accommodation, and residential settings, it is apparent that there is room for further debate about where in the system to place young people who display sexually inappropriate behaviour.

Adult sex offenders

Only one item drew unanimous agreement for this client group: there is no single approach that works best for every member of this group.

There was no clear majority opinion from respondents about the value of group work for offenders, the value of medication as an adjunct to psychological treatment, or about the involvement of family members in therapy/treatment for sex offenders. The split of views in these areas therefore merit careful examination.

Additional comments also suggested that there is a need for sexual dysfunction clinics and services for people who have no criminal record but are concerned about their behaviour or desire to act, and potential for confidential telephone lines for those who have sexual interest in children.

Conclusions

The Delphi consultation has produced a detailed synthesis of views, with a high level of consensus in relation to the topics of: principles, values and core beliefs; prevention; managing safety and risk; training; improving outcomes and addressing obstacles.

Within the topic of effective interventions in terms of therapeutic and treatment approaches, although areas of consensus exist (as detailed above), there is much more complexity within each of the ten programme areas. Across the ten programme areas there remained minority positions for most of the statements presented, indicating the breadth and nuances of the expertise explored within the consultation. However, for many of the statements, a clear majority position could be identified, and there were broadly coherent themes emerging from the responses, endorsing person-centred approaches, which are flexible and responsive to the individual needs, readiness and experience of the client. The experts have offered a broad range of knowledge and experience, and from this, in each programme area, some clear messages about best practice and broadly acceptable approaches to service provision do emerge. There are a number of areas however, detailed above in the body of the report, in which divergent positions are held, and were maintained throughout the rounds in the consultation.

Areas of movement and difference between declared experts and the broader expert group are particularly important to reflect on in developing guidelines, as well as in discussions on developing services and working practices. Emerging support for engaging with abusing partners may be controversial for some experts; there remains strong opposition to this and where there is strong conflict of opinion it is important for policy to offer the flexibility that was so widely endorsed throughout the programme areas. Additionally, there may not be space for coming to a consensus opinion about where in the system to place children and young people who perpetrate violence and abuse simply because there is no ideal place at present; reflected in the strong endorsement for developing more specific services. By looking closely at the areas of non-consensus and movement, and informed by the findings from systematic literature reviews, it is possible to identify the details that require further development, against the backdrop of broad consensus about good working practices and service provision. This is however beyond the scope of this report.

Limitations of consultation

The consultation was carried out to a very tight timetable, within a strictly limited budget. This probably adversely affected the response rates, although the rates reported above can be considered good in the circumstances and adequate for the analysis presented here. It also meant that it was not possible to consider more than three rounds. Given the complexity of the issues addressed (and the breadth of the consultation), it is perhaps not surprising that many areas remained where consensus was not reached. This may in part have been due to the limitation to three rounds. Limitations of time and resource also constrained the analysis that it was possible to carry out. In addition, in relation to some of the ten programme areas, the number of respondents on particular points was small (under 5). Care is therefore needed in interpreting percentages where the number of respondents is small.

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Appendix 1: List of acronyms

ACPC: Area Child Protection Committee
ACPO: Association of Chief Police Officers
ACT: Acceptance & Commitment Therapy
ADHD: Attention Deficit Hyperactivity Disorder
BACP: British Association for Counselling and Psychotherapy
BCU: Basic Command Unit (police)
CAADA: Co-ordinated Action Against Domestic Abuse
CAFCASS: Children and Family Court Advisory and Support Service
CAIU: Child Abuse Investigation Units (police)
CAT: Cognitive Analytic Therapy
CICA: Criminal Injuries Compensation Authority
CDRPs: Crime and Disorder Reduction Partnerships
CPS: Crown Prosecution Service
CRARG: Coordinated Response and Advocacy Resource Group from April 3rd known as CAADA
CROP: Coalition for the Removal of Pimping
CSAP: Correctional Services Accreditation Panel
CSOTP: Community sex offenders treatment programme
DAC: Design Against Crime
DBT: Dialectical Behaviour Therapy
DID: Dissociative Identity Disorder (previously known as Multiple Personality Disorder-MPD)
DV: domestic violence and abuse
DVIP: Domestic Violence Intervention Programme
EMDR: Eye Movement Desensitization and Reprocessing
IDAP: Integrated Domestic Abuse Programme
ISSD International Society for Dissociative Disorders
KPIs: key performance indicators
LAAs: Local Area Agreements
LAC: Looked after children
LSCB: Local Safeguarding Children Board
MAPPA: Multi-Agency Public Protection Arrangements
MARAC: Multi-Agency Risk Assessment Process
MST: Multisystemic Therapy
N6: a qualitative data analysis package
NAPAC: The National Association for People Abused in Childhood
NIMHE: National Institute for Mental Health in England
NOMS: National Offender Management System
NPD: National Probation Directorate
NPS: National Probation Service
NSF: National service framework
OBPU: Offending Behaviour Programmes Unit
OCD: Obsessive Compulsive Disorder
PALM: therapy which integrates Psychodynamics initially and CBT
PSA: Public Service Agreement
PTSD: Post-Traumatic Stress Disorder
RM2000: Risk matrix
SAGE: Sexual abuse groups Exeter

SARA: Spousal Assault Risk Assessment Guide
SARC: Sexual Assessment Referral Centre
SOLO: sexual offence liaison officer
SOPO: Sexual Offences Prevention Order (new measure in 2003 Sexual Offences Bill, replacing Sex Offender Orders and Sex Offender Restraining Orders)
SMTs: Senior management teams
SPECSS: Metropolitan Police Domestic Violence Risk Assessment Model
SPSS: Statistical Package for the Social Sciences
STI: sexually transmitted infections
TA: transactional analysis
TCG: Tasking and Co-ordination Group – within police force at various levels
UKCP: United Kingdom Council for Psychotherapy
YOI: Young Offender Institution

Appendix 2: Invitation email sent to VVAPP expert groups

Dear Colleague

We have now held meetings of each of the 6 Expert Groups advising on the implementation of the VVAPP programme of research, i.e.:

i. Adult domestic violence victims, survivors and perpetrators (13 June 2005)
ii. Child victims of domestic violence and child sexual abuse (14 July 2005)
iii. Adolescent and adult sexual abusers and offenders (29 April 2005)
iv. Adult victims of rape and sexual assault (10 June 2005)
v. Adults sexually victimised in childhood (28 June 2005)
vi. Prostitution, pornography and trafficking (all ages) (23 September2005)

These meetings have been extremely helpful in developing the research methodologies for the Delphi and Service Mapping exercises in particular, and with the feedback we have had from individual experts we are ready to begin the implementation of both.

We would like to conduct the Delphi expert consultation using you - the VVAPP specialist advisers and Expert Group members - as an important part of our Delphi Expert Panel.

This is a new development, and very different from the original proposals discussed at the Expert Group meetings. Participating in the Delphi would involve you in taking part in three rounds of consultation over a period of about a year from October 2005.

The questions in the first round are open ended and will require some time and effort from each contributor to provide detailed and structured information in response to each question. I am attaching the list of questions to be covered to give you an idea of what you are being asked to respond to.

Round two will require you to rank your level of agreement with issues identified in round one using a rating scale, and round three will involve identifying areas of consensus. Rounds two and three will require much less time and effort. Your contribution throughout will be anonymised.

Participating as a Delphi expert panel member will require a significant commitment from you in the first round - to provide, probably quite a lot of information: to include everything you regard as important to inform policy and practice through the National Service Guidelines that will be published based on the information provided by the Delphi consultation.

However, this provides a unique opportunity for all those with an academic, professional or personal interest in these issues to influence policy and practice at national and local levels. We hope this will act as an incentive for individual experts to make time to answer the Delphi questions in their area - or areas - of expertise.

We also propose to extend the Delphi panel to include additional experts, based on your advice on other individuals and organisations you think should be included. We would expect to achieve a panel in the region of 250 - 300 experts recruited in this way.

The Delphi round one questionnaire will be sent out in the week beginning 10 October, with a closing date of 5 December for responses to the first round. This will give you a two month

period in which to complete your contribution. This time is intended to allow organisations, in particular, an opportunity to consult with their members. However, where possible we would want panel members to complete their questionnaires as early as possible, as data entry will begin as soon as questionnaires are returned.

We propose to collect information from victims, survivors and service users (including abusers) through the organisations which represent their interests: e.g. Women's Aid, The Survivors Trust, Respect, the Children's Charities, etc. I will be writing more about this separately, directly to those organisations.

The findings of the Delphi Round One will be presented to the Expert Groups in April 2006, with the second and third rounds taking place between May and October 2006, a report published by December 2006, and guidelines drafted for publication by April 2007.

The success of the Delphi will be entirely dependent upon the breadth and completeness of coverage of the experts involved, and the quality of answers provided in round one.

I would be grateful if you could:

- let me know if you are prepared to act as a Delphi panel expert as outlined here (I hope you will and if you are please complete and return the Consent Form attached below);
- let us have names and contact information for other individuals and organisations you feel should be involved in the Delphi exercise (a full list of EG members and specialist advisers is attached).

If you have any comments or questions please feel free to contact me. Many thanks from

Professor Catherine Itzin
<<contact details>>

Appendix 3: Questions in Round One Delphi Consultation

Principles and Core Beliefs

1. What do you see as the most important principles and core beliefs to inform work with victims/survivors and/or perpetrators of sexual and domestic violence and abuse?

Effective Interventions

2. If you are an academic or practitioner, what interventions work best in the support, care and treatment of victims/survivors and/or perpetrators?
   If you have expertise from personal experience, what treatments and interventions have worked best to help you live with and recover from your experience of sexual and domestic violence and abuse?

3. What practices or approaches should NOT be used and why?

4. If you are an academic or practitioner, which theoretical models and therapeutic approaches inform your work? If you have expertise from personal experience, what has helped you and why?

Please mark relevant boxes. Please note you may mark more than one of these.

[ ]	**PTSD/trauma therapy**	**[ ]**	**humanist**
[ ]	**cognitive behavioural**	**[ ]**	**psycho-dynamic/psycho-analysis**
[ ]	**feminist/pro-feminist**	**[ ]**	**recovery**
[ ]	**mediation/alternative dispute resolution**	**[ ]**	**integrative theoretical model**
		[ ]	**social learning theory**
[ ]	**family systems**	**[ ]**	**restorative justice**
[ ]	**mutual support/self help**	**[ ]**	**zero tolerance**
[ ]	**ecological/holistic**	**[ ]**	**relapse prevention**
[ ]	**art/drama therapy**	**[ ]**	**group therapy**
[ ]	**person centred**		

[ ] other, please specify

Please explain below the rationale for your preferred approach(es) and recommended psychological therapy(ies)

Managing Safety and Risk

5. What do those providing treatment, care and support need to know and do to ensure interventions are safe and effective for victims, survivors and abusers/perpetrators?

Training

6. What training and/or experience is required to provide effective interventions? What should this training involve and how should it be delivered?

Prevention

7. What needs to be done to prevent sexual and domestic violence and abuse?

Improving Outcomes

8. What recommendations would you like to make to develop policy and practice to improve outcomes for individuals affected by sexual and domestic violence and abuse?

Addressing Obstacles

9. What obstacles prevent these improvements and how can they be addressed?

The following options were offered for all questions:

DO NOT WISH TO ANSWER [ ] DO NOT KNOW THE ANSWER [ ] NOT APPLICABLE TO MY EXPERIENCE [ ]

Appendix 4: Protocol for the Delphi Expert Consultation

Department of Health/NIMHE
Victims of Violence and Abuse Prevention Programme

Delphi Protocol

This Delphi consultation is part of the work within the Victims of Violence and Abuse Prevention Programme, funded by the Department of Health, NIMHE and the Home Office. The programme aims to develop an evidence base that will inform practice and help to improve the mental and physical health of adults, children and young people affected by domestic and sexual violence and abuse. The Delphi will involve a wide-ranging consensus-building exercise with experts, academics and practitioners, working across all areas of domestic and sexual violence and abuse. Focusing especially on mental health and abuse we are consulting with key stakeholders about what works in the treatment and care of victims, survivors and perpetrators, covering adults, young people and children.

Aims
The aim of the Delphi consultation is to identify areas where there is and is not consensus among experts about what is known and what works in the treatment and care of people affected by child sexual abuse, domestic violence and rape and sexual assault. While helping us to identify areas of agreement and disagreement about effective mental health service responses, this Delphi consultation will also support the evidence base derived from the systematic literature review that we are proposing to undertake as part of the wider programme of work.

Method
Delphi is a robust research methodology with a substantial literature to support it. The Delphi approach involves identifying experts and obtaining their views anonymously. The responses are analysed, summarised and then fed back to the experts to obtain their views again, and using a rating scale, to rank these in order of importance. This provides both qualitative and quantitative information that is synthesised again and circulated as the consensus views of all stakeholders. Our Delphi consultation exercise will involve three rounds of consultation with experts.

We will consult with academic experts, voluntary and independent sector organisations providing treatment for victims and perpetrators, and from mental health services provided within the statutory NHS and social care sectors and the criminal justice system. We aim to recruit participants who have expertise working in one or more of the following areas:

i. domestic violence (adult victims and perpetrators),
ii. sexual assault and rape (adult victims)
iii. adult survivors of childhood sexual abuse
iv. children and young people who are victims of domestic violence and sexual abuse
v. adolescent and adult sexual abusers and offenders.
vi. child, adolescent and adult victims of commercial sexual exploitation

Participants will be recruited following recommendations made by the Royal Colleges and professional bodies, and by the Expert Groups and Specialist Advisers supporting the work of the VVAPP. Specialist participants will be selected to cover A&E, acute psychiatric services, community mental health services and work at the level of PCTs.

The selection criteria for panel membership (apart from academic members) will take into account:

- Geographical Spread (by Strategic Health Authority areas)
- Rural/urban balance
- Range of services offered
- Specific groups of people for whom the service is provided e.g. BME groups, religious groups, sexualities
- Specialist support offered e.g. for people with disabilities, drug or alcohol problems
- These who are known to offer a particularly good or innovative service, or are known to be interested/active in the issues

Participation

Participation in this Delphi study will involve:
In Round 1 - filling out a questionnaire asking you about your expert knowledge and experiences. This will have open ended questions. This stage of the consultation is likely to be the most time consuming as we want to encourage you to give detailed answers if possible. The questionnaire could take you about 40 minutes to complete.
In Round 2 – the research team will report on findings from the questionnaire and draft a second questionnaire for circulation. This questionnaire will consist of statements with which you will be asked to rate your level of agreement or disagreement. This questionnaire should take about 15 minutes to complete.
In Round 3 – the research team will provide you with a summary of your answers to the second questionnaire and the overall (anonymous) answers and ratings provided by the entire Delphi expert panel. You will in this stage be asked to review your answers in light of the group responses to see if a consensus or agreement can be reached. This stage of the consultation should take about 15 minutes to complete.

Results

A final report on the Delphi findings will be produced. The report will be used to inform further policy and practice development. The findings from the Delphi will be used to develop National Service Guidelines. The findings will also be published in relevant academic and practitioner journals. A summary of the findings will be sent to all Delphi participants at the end of the project.

National Institute for Mental Health in England

Department of Health/NIMHE
Victims of Violence and Abuse Prevention Programme

Statement of Ethical Practice

People who work with individuals affected by domestic violence or sexual abuse may understandably be concerned that taking part in this Delphi consultation might compromise their confidentiality and the safety of their services. This document has been prepared to give you some reassurance by explaining to you how we intend to deal with these important issues. Every practical effort will be taken to ensure that information collected from you will be kept confidentially and securely within the programme team. The information we take from your questionnaires will be analysed by us to produce the interim and final reports. Contributions will be anonymised and no one involved in the consultation will be mentioned by name in any of the reports, or be identifiable for other reasons.

How will this work in practice?

1. Securing informed consent from participants.

Information about the Delphi consultation will be given to each participant to enable them to give, or withhold consent, on an informed basis.

A Delphi consultation protocol has been drafted. This summarises the Delphi consultation, what it will involve and what we expect to produce.

Each potential participant will be sent a letter telling them about the Delphi and what would be expected from them if they agreed to participate. The letter will advise potential participants they can contact members of the research team if they have any concerns or questions about what the Delphi involves. The VVAPP team email addresses and telephone numbers will be given in the letter.

A consent form will be attached to the letter. Participants will be asked to sign and return the consent form. The consent form will clearly explain the level of commitment, especially the time, we expect participants would have to provide.

The consent form will tell participants they have the right to withdraw their consent and to stop participating at any stage.

Participants who are sent questionnaires will be told that they can give partial or qualified consent. They may prefer to skip over and not answer a particular question.

2. Protecting the privacy and confidentiality of participants;

The names, addresses and identifying details of participants in the Delphi consultation will remain confidential to members of the programme team. No other person will be allowed access to this information without securing first written consent from each participant.

3. Minimising any risks of harm to participants that may result from their involvement in the Delphi consultation

The Delphi consultation is all about the mental and physical health of people affected by sexual and domestic violence and abuse. Some participants in the Delphi may find their involvement raises issues for them personally that they experience as emotionally challenging or upsetting. The consent form will alert participants to this possibility and inform them of helpline information that will be available on the web.

4. Providing information on the outcomes of the Delphi consultation

Delphi participants will be given anonymised feedback on the findings at rounds 2 and 3 of the consultation. All participants will also be given a summary of the final report. The expert groups working with the Programme will advise the VVAPP team on how best to provide further information and feedback to participants.

The expert groups will also advise the VVAPP team on how best to disseminate results.

Delphi - Consent Form

NHS

National Institute for
Mental Health in England

Name:	
Job title:	
Institution/Organisation:	
Email:	
Telephone:	
Address:	

I have read the protocol and attached documents outlining the aim, scope and method of this Delphi consultation. I understand that my views as a participant will be treated confidentially and fed back to the Delphi panels anonymously.

Participation will involve filling out a questionnaire in Round 1, commenting on the summary of findings in Round 2, and reviewing and feeding back on the revised report of findings in Round 3. It is estimated that completing the questionnaires and giving feedback may require approximately 3 hours of my time given over a period of one year. By consenting to being involved in this Delphi study, I agree to commit my time and resources in order to complete all three rounds of the consultation.

I understand that I have the right to withdraw my consent and to stop participating at any stage although I will notify the VVAPP team if I take this decision.

I wish to participate in this Delphi consultation.

☐ **YES** ☐ **NO**

Signature:_ Date: _ _ _ _ _ _ _ _ _ _ _ _

National Institute for Mental Health in England

Victims of Violence and Abuse Prevention Programme
Round One Delphi Consultation

Notes for Participants

This Delphi consultation is part of the work within the Victims of Violence and Abuse Programme, funded Department of Health, NIMHE and the Home Office. The programme aims to develop an evidence base that will inform practice and help to improve the mental and physical health of adults, children and young people affected by domestic and sexual violence. The Delphi will involve a wide-ranging consensus-building exercise with experts, academics and practitioners, working across all areas of domestic and sexual violence and abuse. Focusing especially on mental health and abuse we are consulting with key stakeholders about what works in the treatment and care of victims and perpetrators, adults and children.

You have been approached as a person with expert academic or practice based knowledge which is relevant to informing the development of best practice. We are approaching identified experts with knowledge and experience of relevant to services for:

- Adult victims of: childhood sexual abuse
  domestic violence
  rape and sexual assault
  commercial sexual exploitation
- Child and adolescent victims of:
  child sexual abuse
  domestic violence (including witnessing)
  rape or sexual assault
  commercial sexual exploitation
- Children and young people who display sexually inappropriate behaviour
- Child and adolescent perpetrators of:
  sexual abuse
  domestic violence
- Adult perpetrators of :
  child sexual abuse
  domestic violence
  rape and sexual assault
- Families and non-abusive parents of:
  victims or perpetrators of child sexual abuse (current or historic),
  domestic violence, rape and sexual assault

'Services' here include the broad range of self help, voluntary, independent and statutory agencies providing services to people affected by domestic and sexual violence and abuse. 'Services' include victim support and perpetrator services provided within or in partnership

with the criminal justice system, as well as support, welfare, preventive and therapeutic services provided across a broad range of agencies or independently by professionals.

The questions in this first round of the Delphi consultation are open ended and have been designed to be appropriate for people working across a wide range of services and academic disciplines. The questions will ask you to give us your personal opinions and to tell us about what you have learnt from your experience and study in your particular area of work. It is important that you consider the questions from your own perspective and tell us what we need to know about the state of the academic evidence, the challenges and what works in your area of work. Please answer the questions as fully as possible.

You are invited to comment on eight areas of policy and practice regarding people affected by violence and abuse:

i. Adult victims of domestic violence
ii. Adult perpetrators of domestic violence
iii. Adult victims of rape and sexual assault
iv. Adult victims of childhood sexual abuse
v. Children and adolescents who are victims of domestic violence and sexual abuse
vi. Young people who engage in sexually inappropriate and abusive behaviour
vii. Adult sexual abusers and offenders
viii. Child, adolescent and adult victims of commercial sexual exploitation

If you have experience relevant to more than one or possibly all of these areas of work please do comment on these as fully as possible. Your answers can be as long as you want. If you are completing this questionnaire in paper copy, please continue on separate sheets and attach these to the questionnaire if necessary. Please can you clearly number your answers so that we can be sure which of the above eight areas of policy and practice your answers relate to. (E.g. if you choose to answer Qn1 with reference to adult sex offenders and children who display sexually inappropriate behaviour please number your answers as 1vi and 1vii).

This round of the Delphi will be the most time consuming for you. Not all of the questions will be relevant to your area of expertise. It would help us if you could indicate on the questionnaire which questions you cannot complete because they are not relevant to your work. You will find that the questions that are relevant to your work require fairly extensive answers and will consequently be time consuming. The success of the Delphi will be very dependent upon the quality of answers people provide for this first round of the consultation. We would like you to support your answers with examples and evidence where relevant and possible. We thank you in advance for your commitment and willingness to contribute your time and expertise. Subsequent consultations in Rounds two and three of the Delphi will be less time consuming and less demanding.

Although you will have already signed a consent form indicating your willingness to participate in the Delphi consultation, you may withdraw your consent wholly or partially at any time. If you are unable to answer or would prefer not to answer certain questions in this questionnaire please could you indicate your reasons by including a brief statement under any uncompleted question. (E.g. ‘do not want to answer’, ‘do not know the answer’, ‘not applicable to my work’) This will help us considerably in our analysis of results and feeding back to participants in the next round.

If you have any questions about the Delphi or need advice on completing this questionnaire please contact the research team by telephoning: <<numbers removed here>>

If you want support as result of your own experiences:

Experiences of domestic violence, childhood sexual abuse, rape and sexual assault are common amongst the general population. You may yourself be currently living with domestic or sexual violence and abuse or have perpetrated, experienced or lived with the consequences of abuse at some time in your life. Taking part in this Delphi consultation may affect you and raise issues personally for you. You may find it helpful to approach the free and confidential helplines for advice and support.

The National Domestic Violence Helpline 0808 200 247 is available on a 24 hour basis (domestic violence Victims, adults and children)

The Respect Phoneline 0845 122 8609 (textphone 020 8748 9093) is available Monday, Wednesday, Friday 10 am to 12, Tuesday 2 to 5pm (domestic violence adult perpetrators)

The Rape and Abuse Line 0808 800 0123 is available every evening from 7pm to 10pm (for female and male victims of rape and sexual assault)

The RASAC helpline is available Monday to Friday 12 noon – 2.30 pm and 7 pm to 9.30 pm and Sat & Sun 2.30 to 5pm (for women and girls who have been raped or sexually abused, however long ago)

The Careline is available Monday to Friday 9am to 1pm and 7 to 10 pm (providing national crisis telephone counselling for children, young people and adults.)

Stop It Now Freephone helpline 0808 1000 900 is available Monday to Thursday 9am to 9pm and Friday 9 am to 7pm (a child sexual abuse prevention service providing help for anyone concerned about child sexual abuse, including perpetrators)

Appendix 5: Differences on key topics across the 10 programme areas.

The tables in this Appendix show the differences on key topics across the 10 VVAPP programme areas identified in the responses on values, principles and core beliefs in Round 1 and subsequent feedback on these in rounds 2 and 3. In each table rows are defined by the programme areas (key to abbreviations below), the columns define the topics. Topics have been clustered into groups as follows:

Table A5.1: Sector issues
Table A5.2: Safety, risk and assessment
Table A5.3: Criminal Justice - police, prosecution, punishment and rehabilitation
Table A5.4a and A5.4b: Maintaining links, creating distance between perpetrators and victims
Table A5.5: Approaches to perpetrators/abusers – responsibility, offending and mandated responses to offences
Table A5.6: Societal and victim responsibility
Table A5.7: Other issues: deviance, medicating and suicide

Key to programme area abbreviations

SRSA	Adult victims/survivors of rape and sexual assault
SCSA	Adult survivors of childhood sexual abuse
SPPT	Child, adolescent and adult victims/survivors of sexual exploitation in prostitution, pornography and trafficking
CASA	Children and young people who have been sexually abused
CYPIB	Children and young people who display sexually inappropriate behaviour or who sexually abuse other young people, children or adults
ASO	Adult sex offenders
SDV	Adult victims/survivors of domestic violence and abuse
CADV	Child and adolescent victims of domestic violence and abuse
YPDV	Young people who perpetrate domestic violence and abuse
APDV	Adult perpetrators of domestic violence and abuse

NOTES

Some cells in the table are shaded grey. The statement(s) provided in these cells represents the position of *least disagreement,* but do not represent a complete *consensus*.

Where different positions are evident within a programme area on a particular topic, these are identified in the table.

Where neighbouring rows within a column are merged (no lines between them) the position(s) shown are shared by the programme areas concerned.

Where a cell is shown blank, this indicates that no particular position was advanced for this topic in the programme area concerned.

Table A5.1: Sector issues – working together for the benefit of others in the sector

	Multi-agency approaches	Sharing information	Public protection	Child protection
SRSA	Multi-agency approaches are necessary for responding to and providing interventions for domestic and sexual violence.	Sharing information between agencies is important for multi-agency work, but issues of confidentiality and data protection define and limit the sorts of information that may be shared and with whom.	Public protection is an important consideration when defining the roles and responsibilities of individuals, organisations and the law.	
SCSA				As adult survivors disclose historical abuse, child protection is only important consideration if the next generation is at risk from the abuser.
SPPT				The protection of the victims of PPT is paramount; if the victims are children at the time of exploitation then their protection is subsumed under the umbrella of child protection.
CASA				As victims are children at the time of the abuse and disclosure, then child protection is the most important concern of professionals dealing with them.
CYPIB				Child protection is essential but complicated by the child being both vulnerable and a potential risk to others.
ASO				Child protection is the most important consideration if offenders disclose that their victims are children or young people.
SDV				If a client discloses that they have children living with them, then child protection is the most important consideration.
CADV				As victims are children at the time of the abuse and disclosure, then child protection is the most important concern of professionals dealing with them.
YPPDV				
APDV				Child protection is at least of equal importance to adult victim protection.

Table A5.2: Safety, risk and assessment

	Safeguard	Health, needs and skills assessment	Risk assessment	Risk of abuse/risk to others
SRSA			Risk assessments, both of risk to self and risk to others, are important parts of any intervention. They should be conducted by professionals, based on ethical and informed understandings of risk and potential for harm. Where appropriate risk assessments should be carried out over time, rather than a static, single events.	The emphasis is on the risk from others, with supplementary self-risks.
SCSA				The emphasis is on the risk from others, with supplementary self-risks.
SPPT	Professionals have a responsibility to safeguard child/ren from abuse and/or exploitation.	In response to the significant risks posed by PT, victims/survivors require health assessments including STI and HIV testing.		The emphasis is on the risk from others, with supplementary self-risks.
CASA	Professionals have a responsibility to safeguard the child and other children in the household from abuse.			The emphasis is on the risk from others, with supplementary self-risks.
CYPIB	Professionals have a responsibility to safeguard other children/victims, as well as to safeguard the vulnerable perpetrating child.			The emphasis is split between the risk to others and the potential for being at risk from others, as sexually inappropriate behaviour can make a young person vulnerable.
ASO	Professionals have a responsibility to safeguard children – both disclosed victims and potential, future victims	Clients may require their mental health assessed and where appropriate have non-abusing life skills developed.		The emphasis on the risk to others. There are additional self-risks associated with being in a remand or custodial setting.
SDV	Professionals have a responsibility to safeguard the non-abusing parent and child/ren from abuse and trauma.	Clients may require assessment of their skills to live and cope independently, including housing and finance as well as emotional dimensions; where appropriate survivors may need support to develop these skills.		The emphasis is on the risk from others. There are also supplementary self-risks and risks for children in the household if the victim/survivor is a parent.
CADV	Professionals have a responsibility to safeguard the child against violence and trauma.			The emphasis is on the risk from others.
YPPDV		Clients may require their inter-personal skills to be assessed and where appropriate have these skills developed.		The emphasis is on the immediate risk to others and the potential for escalated risk to others in the future.
APDV	Professionals have a responsibility to safeguard the non-abusing parent and child from abuse and trauma			The emphasis is on the risk to others.

Table A5.3: Criminal Justice - police, prosecution, punishment and rehabilitation

	Criminal Justice – police	Criminal Justice – prosecution and trials	Criminal Justice – punishment & deterrence	Criminal Justice – rehabilitation (vs. punishment)
SRSA	The police require more training, to show victims greater sympathy and to provide better facilities for interviews and forensic examinations.	There is a need for more successful trials, to this end there is need to make changes to evidence and witness examinations.	Punishment and penalties act as deterrents against offending and re-offending. Punishment has no effect without rehabilitation; harder penalties may deter victims from coming forward or others voicing concerns.	Rehabilitation is essential for prevention in of future offending. Rehabilitation has not been proven to work; rehabilitation of the offender not the central concern.
SCSA		There are problems with historical abuse victims being believed and being able to provide proof and credible evidence.		
SPPT	The police require more training about exploitation, specifically trafficking, and to understand coerced victimisation better.	Victims make poor witnesses; their credibility is limited by perceptions of their own criminality and role in being coerced. There is also a need for greater emphasis of pimps and johns.		
CASA	The police require more training, for indicators of abuse, and how to sensitively deal without and collect evidence, without re-traumatising the victim.	Providing evidence can re-traumatise children. When providing evidence there are concerns about their credibility and maturation/ability to understand the courts proceedings.		
CYPIB		Criminal justice routes may not be appropriate or necessary.		
ASO	The police require specific training to support better evidence collecting for criminal cases.	Recent legislation needs to be fully applied, to improve convictions.		
SDV	The police require more training, to take DV more seriously and to have a more appropriate view of victims/survivors.	There is a tension between what is or isn't realistic from prosecution, with problems in producing evidence and securing convictions		
CADV	The police require more training about how to approach and respond to young people as victims and secondary victims.	Wherever possible, children should be kept out of criminal justice proceedings.		
YPPDV	The police need to take DV, even when perpetrated by a young person or child, more seriously and intervene with discretion.	Where appropriate perpetrators should experience the full weight of the police and their powers of arrest. However, family centred solutions are preferred over prosecution.		
APDV	The police need to take DV more seriously, and respond to perpetrators in stronger terms.	Sentencing and penalties should reflect the seriousness of the crime, with a potential for a DV register.		

Table A5.4a: Maintaining links, creating distance between perpetrators and victims

	Removal and relocation	Forgiveness/reconciliation
SRSA		
SCSA		Historical abuse raises many questions about forgiveness and "letting go" but these are neither aims nor measures of interventions and recovery.
SPPT	Victims need to withdraw from the social environment of exploitation. Geographical distance and relocation may be necessary to provide safety.	
CASA	Abuser and child need to be separated, either by removal of the abuser or the child.	
CYPIB	There is tension between retaining or separation from family unit , which requires a case by case decision.	Mediation and family work are essential.
ASO	Removal of adult, plus removal of adult from society to prison	There may be potential for some reconciliation, through family reconstruction.
SDV	Non-abusing parents and children may need to relocate to safe houses and refuges. However, there is disagreement whether the abuser should go or whether the victim has to leave.	Mediation in any form increases risk and exposure for the victim survivors. Forgiveness and reconciliation are not encouraged.
CADV	Where possible the non-abusing parent and child should safely separate from the perpetrator. Removal of the perpetrator may be necessary to provide safety.	Children who remain loving towards their abusive/violent parents are not exceptional and should not be discouraged from seeking reconciliation in adulthood.
YPPDV	There is tension between retaining or separation from family unit , which requires a case by case decision.	Mediation and family work are essential.
APDV	Where possible the non-abusing parent and child should safely separate from the perpetrator. Removal of the perpetrator may be necessary to provide safety.	There is no provision for mediation, but reconciliation is not excluded if the partner maintains contact during therapy.

Table A5.4b: Maintaining links, creating distance between perpetrators and victims

	Abusers/perpetrators role in/ access to family	Involvement of partner/parents in therapy or recovery
SRSA	There is neither need, nor benefit from any contact with abusers/perpetrators.	
SCSA	There is neither need, nor benefit from any contact with abusers/perpetrators but need to consider disadvantage if this means lack of contact with entire extended family, loss of entire family, family connections.	
SPPT	There is neither need, nor benefit from any contact with abusers/perpetrators, and the wider group of abuse supporting adults.	If a PPT victim is a child or young adult it may be appropriate and helpful to involve their family in recovery process
CASA	There is neither need, nor benefit from any contact with abusers/perpetrators.	The non-abusing parent should be involved in an intervention.
CYPIB	Ideally the abuse/violence is addressed and the family is preserved, even if the young person is removed for a short time.	Family centred approaches and involving other family members are important.
ASO	There is a need for offenders to have real lives outside of abusing, including family support. Family reconstruction is not ruled out in every case.	Perpetrators should not have contact with their abused or potential victims, but there may be grounds for maintaining family links.
SDV	Ideally there should be no contact between the abuser and victim. Safety outweighs family preservation.	Therapy and recovery are for the individual and therefore do not include anyone else, particularly the abuser/perpetrator.
CADV	Ideally there should be no domestic contact but where child safety can be maintained, contact may be possible.	The non-abusing parent should be involved in an intervention.
YPPDV	Ideally the abuse/violence is addressed and the family is preserved, even if the young person is removed for a short time.	Family centred approaches and involving other family members are important.
APDV	Although separation may be necessary in the short term, perpetrators may maintain some contact and the victims may be involved in the intervention provided.	Victims who remain to some degree in a relationship with the perpetrator should be involved, indirectly, in the intervention; for example with information sharing.

Table A5.5: Approaches to perpetrators/abusers – responsibility, offending and mandated responses to offences

	Abusers/perpetrators as offenders	Perpetrator responsibility	Mandatory reporting, mandatory prosecution
SRSA	All abusers are offenders.	Sexual and domestic violence and abuse are the personal choice and responsibility of the perpetrator. Other factors may play a part but do not remove this responsibility.	
SCSA	All abusers are offenders.		
SPPT	All abusers are offenders. Victims should not be classed as offenders, even if they were coerced and participated in perpetrating abuse, violence or criminal sexual activity.		Mandatory reporting of underage sex doesn't help because fewer vulnerable people will come forward for help. There is a need for improvement in reporting, rather than making is mandatory.
CASA	All abusers are offenders.		
CYPIB	Children and young people who abuse others are not offenders, but *inappropriate* (and they are also seen as victims themselves).		Reporting of and notifying criminal authorities of the abuse/violence should be discretional.
ASO	All abusers are offenders.	Sexual and domestic violence and abuse are the personal choice and responsibility of the perpetrator. Other factors may play a part but do not remove this responsibility.	There are arguments for mandatory prosecution, mandatory imprisonment and mandatory therapy.
SDV	All abusers are offenders.	Sexual and domestic violence and abuse are the personal choice and responsibility of the perpetrator. Other factors may play a part but do not remove this responsibility.	
CADV	All abusers are offenders.		
YPPDV	Young people who perpetrate DV are offenders. However, rather than criminalising them for life, they may be seen as *troubled* rather than pathologised.		Reporting of and notifying criminal authorities of the abuse/violence should be discretional.
APDV	All abusers are offenders.	Sexual and domestic violence and abuse are the personal choice and responsibility of the perpetrator. Other factors may play a part but do not remove this responsibility.	

Table A5.6: Societal and victim responsibility

	Societal responsibility	Victim blaming/co-responsibility
SDV	Society is responsible for maintaining gender and power inequalities, and the financial dependency of women (particularly mothers) on men.	There is no responsibility attributed to the victims/survivors.
SRSA	Society is responsible for tolerating certain forms of rape as permissible (for example, date rape, marital rape).	There is no responsibility attributed to the victims/survivors.
SCSA	Society is responsible for turning a blind eye or not listening at the time of historical abuse.	There is no responsibility attributed to the victims/survivors.
SPPT	Society is responsible for seeing PPT as inevitable. Non-harming males are responsible for PPT through using prostitutes/pornography, and therefore making it permissible and creating "the market".	There is a degree of responsibility attributed to the victims, where vulnerability in seen in terms of limited choices there is an inference that the victim colluded with or acquiesced to the coercer.
CASA	Society is responsible for not doing enough to identify and stop it	There is no responsibility attributed to the victims/survivors.
CADV	Society is responsible for not doing enough to identify and stop it	There is no responsibility attributed to the victims/survivors.
CYPIB	The family and parents of the child are more responsible than society in general.	There is no responsibility attributed to the victims/survivors. In addition, the perpetrators are often seen as victims themselves.
YPPDV	Society and the family are responsible for fostering violence in the home.	Some – role of parents in raising violent children
APDV	Society is responsible for tolerating violence and supporting gender and power inequalities.	There is no responsibility attributed to the victims/survivors, there is no "women-blaming".
ASO	Society is responsible for making it harder for abusing men/women to get help without exclusion from society, keeping abuse "underground".	There is no responsibility attributed to the victims/survivors.

Table A5.7: Other issues: deviance, medicating and suicide

	Medicalising/deviance	Suicide and Self-harm
SDV	Practical and developmental interventions are preferred over medication.	Self harm is a coping mechanism, not a symptom of an under-lying pathology. Clients present a suicide risk.
SRSA		Where no contact remains with the perpetrator/abuser, risk for rape and sexual abuse victims is characterised almost completely in terms of self harm.
SCSA		Self harm is a coping mechanism, not a symptom of an under-lying pathology. Clients present a suicide risk.
SPPT	Medicating victims/survivors is inappropriate if they had a prior drug dependency or drugs were used to reinforce exploitation.	Self harm is one dimension of multiple self-perpetuated problems, which may include addictions, psychological disorders.
CASA		Self harm is a coping mechanism and may also be an indicator of abuse.
CADV		Self harm is a coping mechanism and may also be an indicator of abuse.
CYPIB		Self harm is one dimension of multiple or underlying problems.
YPPDV		
APDV		
ASO	Medication may be beneficial. Use of deviance as an approach to treating clients may be appropriate.	Clients present a suicide risk whilst in prison or custody.