'It makes you feel a little less heavy'

Review of therapeutic services for young people in Rape Crisis services in Ireland

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Acknowledgements

The research team wishes to express our appreciation to all those who took considerable time out of their lives to assist us in conducting this research project.

We thank the service managers for the *many* ways in which you helped us to gather data from the centres and for the time you gave out of your unforgiving schedules to express your views and opinions on the services; it was all very much appreciated. To the equally busy frontline staff, for having your voices heard through focus groups or surveys, taking time to participate in our online survey, we thank you. We thank the stakeholders for providing an 'outsider's' view in attending focus groups and participating in telephone interviews. For the efforts of the advisory committee who met monthly throughout the duration of the project, provided ongoing advice and support, and whose dedication and commitment throughout the project was greatly admired by the team, we thank you. We also thank Tusla, the Child and Family Agency, for recognising the need for this research to take place and for funding the team to do so.

Finally, to the young people, thank you, not only for giving of yourself so generously and sharing your experiences so openly, but for demonstrating great strength, determination and resilience that gives others hope - those who continue to struggle to overcome the impact of sexual violence and those who share that journey and try to make that burden feel "a little less heavy". It was a privilege to work with you and to bear witness to your stories.

Disclaimer

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This report should be cited as follows: McElvaney, R., Monaghan, A., Treacy, C. & Delaney, N. (2019). *'It makes you feel a little less heavy': Review of therapeutic services for young people in rape crisis services in Ireland. Dublin: Dublin City University*

Glossary of terms

Rape crisis centre: Not all of the centres that provide sexual violence services to young people in this study go by the name of 'rape crisis centres'. This was discussed with the Advisory Committee and various terms were considered. For ease of communication, it was considered important that one term be used to describe all the centres. Thus, all centres are referred to in this report as 'rape crisis centres'.

Participant labels: Where quotes are used, participants are referred to using acronyms followed by a number to help the research team ensure representation across the participants groups; Service Managers (SM), Frontline staff (FS), Focus Group participants (FG; FGSH to represent focus group with stakeholders), Stakeholders who were interviewed (SH), and Young People (YP). The term 'young people' in this report refers to participants under 18 years.

Advisory Committee: The committee appointed by Tusla, the Child and Family Agency to liaise with the research team. This committee consisted of representatives from Tusla, and 3 rape crisis centres: Ann Ryan (chair), Natasha O'Keefe, Deirdre Roche, Mary Roche, Joan Sheridan, Ina Stanley and Aidan Waterstone.

The Research Team: The research team consisted of the following individuals based in Dublin City University: Rosaleen McElvaney, Phd, a clinical psychologist, psychotherapist and lecturer in psychotherapy; Andrina Monaghan, M.Sc. in psychotherapy, a psychotherapist and researcher; Christina Treacy, M.Sc. in psychotherapy, a psychotherapist and researcher; and Naoise Delaney, M.A. in psychology, a researcher.

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Executive Summary

The increase in referrals to rape crisis centres in Ireland of young people seeking therapeutic support following experiences of sexual violence has resulted in these centres extending their remit so as to respond to their needs. The international context (Convention on the Rights of the Child; United Nations General Assembly, 1989), and the national context provide some guidance on the special consideration needed when implementing care and support for young people.

This study reviewed current service provision to young people (<18yrs) in rape crisis centres in Ireland to identify recommendations and guidance for developments. A literature review was conducted on international best practice in relation to therapeutic interventions with children and young people who have experienced sexual abuse. Using a mixed methods design, online surveys, telephone interviews, focus groups and face to face interviews were conducted with a range of key stakeholders: service managers (n=15), frontline staff (n=40), external stakeholders (n=8), and young people under 18 years (n=16) who are currently or who have recently availed of these services.

Common themes evident in the mission statements of the centres are the provision of a supportive environment to those who have experienced sexual violence aligned with the aim to eradicate sexual violence from our society. Services provided include advocacy, court and Garda station accompaniment, individual and group therapy, and parent support. The therapists' qualifications range from diploma to masters level and they are accredited with a range of professional bodies, but primarily the Irish Association of Counselling and Psychotherapy and the Irish Association of Humanistic and Integrative Psychotherapy, the two largest professional bodies for counselling and psychotherapy in Ireland. It would appear that all therapists undergo additional training, specific to sexual violence, within the rape crisis centre networks and appear to be actively engaged in continuous professional development. The majority of therapists, where information was provided, had at least 10 years' experience working as a therapist with young people. Some therapists are undergoing training in child and adolescent psychotherapy at their own expense. Supervision is provided primarily within the centres. The dominant theoretical orientation appears to be a person-centred approach, drawing on CBT techniques, where appropriate.

Across 11 centres, where information was available, almost 300 children and young people were seen in the two year period 2017-2018, the vast majority of whom were over 14 years. Much of this proportion of children were seen in two centres, which provided a service to between 50 and 90 young people each. Referrals most typically came from parents, followed by SATU units and self-referrals. In most cases, parental consent was obtained in person from parents who were typically seen at the time of the first appointment. Where information was available (n=131), most children were seen for weekly appointments; the average number of sessions attended was 30 sessions, and the average attendance period was six months. Of the limited information available in

relation to attendance at mental health services (n=55), 30% of these were attending mental health services.

Key strengths of service provision to young people were seen as good interagency working relationships and effective communication, particularly with the Gardai and the SATU units; the Garda and court accompaniment service; the national 24 hour helpline based in the Dublin Rape Crisis Centre and helplines available locally, although these were restricted in some areas; and the volunteer network.

Young people's experiences of attending the centres is captured in the following themes: not wanting to attend, choice and not feeling pressurised, it helps to talk, relationship with counsellor, specialist help, explaining things to me, and coping skills. Many young people spoke of being reluctant to attend either in the beginning or on an ongoing basis, but this eased with time and the building up of the relationship with the counsellor. They spoke of how important it was to be given some choice in how the work unfolded and not feeling pressurised to talk about the abuse if they did not feel able to, or pressurised to come if they needed a break from work. They noted how helpful it was to talk – about the abuse, about how they felt about what had happened, but also about their everyday struggles. All young people described the value of the relationship with the therapist as one of feeling understood and cared about. Many referred to the therapist as a 'nice' person. The value of attending a specialist service was highlighted, where the therapists knew how to help them, understood their experiences and where they knew that other people attended for the same reason, so they did not feel alone in having experience of sexual violence. Psychoeducation was also seen as helpful. This included explanation by the therapists about the process of counselling, the legal process and how sexual violence impacts on young people. It also helped the young person understand their own feelings and behaviour and make sense of their experience in the wider context of their daily lives. Finally, many spoke of how helpful it was to learn to cope better – with their emotions, with going to and staying in school, and with managing important relationships in their lives.

Participants identified key issues that would enhance service provision including:

- better awareness of the services offered
- better awareness about sexual violence in general, which impacts on the accessibility of services
- more funding to support being able to respond to the growing need for the service
- avoidance of an overreliance on volunteers to provide services
- support for staff training
- clearer guidelines regarding mandatory reporting, in particular helping young people have a sense of what happens following a report
- more work to be done on building relationships with other agencies.

Recommendations

The implications of this study suggest several recommendations for policy and practice in service provision for young people who have experienced sexual violence.

1. It is recommended that the services provided by the Rape Crisis Centres to children and young people who have experienced sexual violence should be recognised as part of the overall response to sexual violence against children and young people in Ireland.

2. It is recommended that, given the positive feedback offered by the young people who participated in this study, therapeutic services for this cohort (primarily adolescents) continue to be provided by rape crisis centres and that the development of such services is informed by young people themselves, in line with Tusla's (2019) child and youth participation strategy.

3. It is recommended that collaborative initiatives are undertaken by all 16 rape crisis services, to agree a common set of standards or principles that inform their service delivery to young people.

4. It is recommended that rape crisis centres develop guidelines for practice that draw on international best practice in this field and the findings of this study, such as focusing on developing a trusting and supportive relationship, offering the young person choice where possible, facilitating young people to talk about their experiences, educating young people about sexual violence, emotional wellbeing and relationships; assisting young people in developing coping skills for managing emotional distress; and supporting parents to support their children.

5. It is recommended that the rape crisis centres conduct a needs analysis of therapists' training needs and, in collaboration with Tusla and the relevant counselling and professional accrediting bodies in Ireland, with particular reference to the recent Irish Association of Counselling and Psychotherapy (2019) standards, develop a training plan that addresses the optimum and most cost efficient manner of upskilling and training therapists to work with young people who have experienced sexual violence.

6. It is recommended that drawing on the experiences of several centres, protocols for interagency referral pathways and models of working be developed to ensure optimal and

consistent service experiences for young people. This should include initiatives that involve collaboration in multidisciplinary training.

7. It is recommended that rape crisis centres consider how their provision of services to young people could be made as inclusive as possible for those with disabilities or more 'hard to reach' members of our community.

8. It is recommended that Tusla consider the findings from this study and ascertain mechanisms for improving resources in rape crisis centres to facilitate service delivery (counselling, helpline, volunteer and administrative services), service promotion, and staff training.

9. It is recommended that the rape crisis centres and their funding agency, Tusla, give consideration to the importance of developing standard mechanisms and tools for recording data in relation to service provision across all rape crises centres in Ireland.

10. It is recommended that rape crisis centres develop service user friendly information resources, in a range of language and formats, that describe the range of services offered and emphasise the flexibility and inclusivity of services.

11. It is recommended that Tusla, in collaboration with other relevant stakeholders give consideration to calling for a public awareness campaign on sexual violence against children that aims to assist in the identification of sexual violence against children and provides information about youth service provision.

Background to this study

The past few decades have seen a significant increase in young people accessing services in Ireland as a result of experiences of sexual violence. This is in the context of an apparent worldwide reduction in reported prevalence rates of child sexual abuse (Finkelhor, Vanderminden, Turner, Hamby & Shattuck, 2013). Whether the observed increase in demand for services reflects an increase in prevalence of sexual abuse in Ireland is unknown and is unlikely to be known given the absence of a comparative reliable national dataset reflecting prevalence rates of child sexual abuse. This will hopefully change in the near future with Ireland's ratification in 2019 of the *Istanbul Convention* (Council of Europe, 2011), and the commitment to collect and maintain data in relation to all forms of violence. Statutory responses to child sexual abuse in Ireland over the past few decades can be summarised under two themes: the publication of child abuse guidelines and subsequent enactment of legislation in this area and the establishment of specialist services for children who have experienced sexual abuse. In parallel, the responses of the voluntary sector can be summarised under two themes: the establishment of services for children at risk of abuse (Children At Risk in Ireland; CARI) and the gradual development of services for children within adult rape crisis centres. This report is concerned with the latter and constitutes a review of youth therapeutic services within sexual violence services in Ireland.

Tusla, the Child and Family Agency (hereafter referred to as Tusla), established on 1 January 2014, has responsibility for commissioning and funding domestic, sexual & gender-based violence (DSGBV) services in Ireland. The *Istanbul Convention* (Council of Europe, 2011), to which Ireland is a signatory, places certain requirements on governments to address Domestic Sexual and Gender Based Violence (DSGBV). In Ireland, the *Second National Strategy on DSGBV 2016-2021*[1], sets out requirements on state agencies to meet these obligations and the Child and Family Agency Act 2013, identifies Tusla as the primary state agency with responsibility for services that respond to the needs of victims of DSGBV.

Therapeutic services for children and adolescents who have experienced sexual abuse/violence are provided in both generic and specialist services in Ireland in both statutory and non-statutory/voluntary sector. Specialist child sexual abuse assessment units were established in 1988 in four locations in Ireland: two in Dublin, one in Cork and one in Waterford. Three of these units (both units in Dublin and one unit in Waterford) now provide therapeutic services. Other Tusla specialist teams have operated across the country providing assessments. Generic therapeutic services include local HSE psychology

[1] Available at http://www.cosc.ie/en/COSC/Pages/WP08000096

services, child and adolescent mental health services, and family support services, funded by either the Health Service Executive (HSE) or Tusla. Children at Risk in Ireland (CARI), a voluntary organisation part funded by Tusla, provides specialist therapeutic services to children in Dublin and Limerick with some outreach services operating out of these two bases. Tusla is currently leading a national, multi-agency (Tusla, An Garda Síochána, the HSE, the Children's Hospital Group, the Probation Service and CARI) process to implement a national standardised service model for sexual abuse services for children and their families. It is proposed that this model will integrate and co-ordinate medical/forensic examination, child protection, garda investigation, evaluation, therapy and court processes in the form of regional centres that will support children who have experienced sexual abuse in a way that will facilitate accessibility to services and systems. An interdepartmental group, representing the Department of Children and Youth Affairs, the Department of Justice and Equality, the Department of Health, An Garda Síochána, the Health Service Executive and Tusla was established in January 2018 and tasked with producing an implementation plan for the development of dedicated child centred services to include recommendations for interagency working, identification of legal provisions required and cost estimates for a preferred model of service. A pilot service is due to be launched in the west of Ireland in late 2019, based on the work of the interdepartmental group and informed by the European funded PROMISE project, a collaboration of European countries endeavouring to develop best practice models that support children who have experienced sexual violence (See www.childcentre.info/promise). It is expected that this pilot will identify a blueprint for three regional centres (Cork, Galway and Dublin) as part of a national service for children and families.

Tusla commissions 16 rape crisis centres to deliver specialist sexual violence services nationally that provide a range of services to male and female victims and survivors of rape and sexual abuse. Service provision includes: helplines; counselling; advocacy; support; accompaniment when engaging with services such as An Garda Siochana, hospitals and Sexual Assault Treatment Units (SATUs) and court accompaniment services. SATUs are provided within seven regional hospitals across the country. In recent years, the rape crisis centres have responded to a growing demand from young people under 18 years of age and their parents for therapeutic services. While initially established to provide service to adults, many centres have responded to these demands by providing therapy to these young people.

The Tusla DSGBV programme and the 16 sexual violence service provider organisations have identified a need to examine their current service provision to young people aged under 18 years. The Dublin Rape Crisis Centre was established in 1979, followed by other centres across the country. By 1985, there were six rape crisis centres offering support, information and counselling to women who had experienced sexual violence

(www.rcni.ie) without any formal funding provided. In 1985, the Rape Crisis Network Ireland (RCNI) was established, bringing together the six centres to pool expertise, share information and work towards common goals. There are now 16 rape crisis centres and while initially these services provided support to women who were in crisis following sexual assault, over time, in response to increasing demand from local services and families, services were extended to adults who had experienced sexual abuse in childhood and young people under 18 years. These developments were not gender specific and over time the services have moved away from focusing exclusively on women. Each centre operates independently while supported by two networks – the Rape Crisis Network of Ireland and the Managers' Forum.

Limited research has been conducted in Ireland on services for victims of sexual violence. One such study, conducted by Kelleher and McGilloway (2009) identified barriers to services and gaps in service provision, from the perspectives of service providers. The barriers identified included feelings of shame and guilt on the part of survivors, issues in relation to naming and acknowledging the incident as sexual violence, and the persistence of societal myths about rape which compound self-blame in victims. The gaps in service provision identified in this study included a lack of awareness of sexual violence and services, limitations of the criminal justice system that deter women from proceeding with a complaint, and an insufficient geographical spread of sexual assault treatment units (forensic medical services).

The aim of the present study was to: identify best practice in service provision, particularly therapeutic provision for young people who have experienced or have been exposed to sexual abuse/violence; review service provision as is currently delivered in the 16 Rape Crisis Centres throughout Ireland, review the experiences of service users and other stakeholders and make recommendations as to what changes, if any, are needed to best meet the needs of such young people.

Literature Review

This section will provide an overview of research and policy with a view to identifying best practice in providing therapeutic services to young people who have experienced sexual violence. The research literature in psychotherapy can be seen as addressing two key questions: what works?, as in what factors contribute to successful outcomes, typically investigated through outcome research; and how it works?, how young people experience therapy, typically referred to as process research. While the latter research base tends to rely on studies with adolescents, many include younger children. Also, while outcome studies reflect the dominant focus in research, the overview of process research will be presented first to communicate what is involved in therapeutic work with young people who have experienced sexual violence. As far as possible, the language used to describe these studies is aligned with language used in the studies. For example, in the U.S. and many European countries, psychotherapy, counselling and psychosocial interventions are included in an umbrella term 'treatment'. The literature reviewed is largely confined to the period since 2000 in order to capture a more current picture of the landscape.

Overview of process research: young people's experiences of therapy

Process-focused research aims to investigate the processes that lead to change. Studies that focus on the process of therapy, as distinct from the outcomes, have explored young people's experiences of the therapeutic process, usually conducted on completion of counselling. Themes identified in these studies include the support of others talking about their feelings and about what had happened; being believed and feeling heard, learning about their self-worth, ways of thinking about sexual aggression, new coping skills, how to trust again and form healthy relationships (Nelson-Gardell, 2001; Mudaly & Goddard, 2006; Foster & Hagedorn, 2014; Beiza, Capella, Dussert, Rodrìguez, & Lama, 2015). Foster and Hagedorn (2014) noted the initial resistance to treatment experienced by young people, particularly when young people felt forced to attend, feared being judged and were uncertain that therapy would help them. These perceptions changed over the course of therapy, transforming to a sense of optimism and hope. They also saw therapy as a way to move forward so that they no longer believed the abuse was their fault. Young people (aged 9 to 18 years) in Mudaly and Goddard's study noted that although talking about the abuse was helpful it was also the most difficult part of the process. Several researchers have described the psychotherapy process as a 3-phased process involving building the therapeutic bond, talking about the CSA experience and a final phase related to the closure of the therapy (Beiza et al., 2015; Águila et al., 2016). Given that loss of trust is a central feature of sexual abuse (Finkelhor & Browne, 1985),

the establishment of a therapeutic relationship that provides a space for containment, respect and unconditional acceptance where the therapist can tolerate the young person's narratives of aggression and pain is valued. Once a relationship is established, the young person can progress to elaborating their experiences and giving new meanings to the life experiences. The third stage is linked with the closure of the process that involves a gradual disengagement and empowerment of the young person where they review their own process of change. Bury, Raval, and Lyon (2007), investigating adolescent experiences throughout a course of psychoanalytic psychotherapy, noted that engagement in therapy is more likely when the young person felt an affective relationship with the therapist, felt listened to and accepted. Talking and thinking in-depth facilitated the young person's understanding of the reasons behind their behaviour.

Adolescents in Beiza et al., (2015)'s study spoke of looking forward to the future where the abuse experience was not central to their life stories. They described therapy as a trusted and protective space where sexual abuse was explored alongside other issues. It was considered a space of learning, change and distraction that allowed the young person to transcend the CSA experiences, not just cope with it. The young people described finding new meaning in the experience of abuse and the ability to incorporate it into their life narrative through a dynamic process of change. Making sense of the abuse experience, finding new meaning in the experience and integrating the experience with other life experiences was also highlighted by young people in Capella et al.'s (2016) study. Their young participants reported enhanced psychological well-being: feeling empowered, better equipped to overcome future challenges and able to retake control of their lives. Psychotherapy facilitated these change processes through helping the young person change the meaning of the abuse experience and develop new capacities. Young people described their need to feel understood, heard and respected while also having a space where they could explore issues other than the abuse experience. An experience of connection, ease and trust with the therapist helped young people overcome their initial resistance to attending therapy.

Allnock et al.'s (2015) young participants in the UK identified negative responses to therapy to include inflexibility in sessions and pressure to talk, while positive responses included the need for the therapist to be caring, warm and having an interest in the child. Findings suggest that young people value a more flexible approach and that they express themselves in diverse ways. Engaging young people in therapy was accomplished by those therapists who were interested, caring, warm, friendly and open as well as those who listened to and validated the young person's experiences. Young people spoke of needing assurances that talking about the abuse was only necessary when they were ready. The right therapeutic environment was defined as "meaningful engagement, succeeding in supporting a child to develop positive coping skills or relieve themselves of self-blame and guilt" (p. 131). The therapeutic relationship was a key component in positive outcomes for young people. It was noted that a good experience of therapy at a

young age can positively impact on the survivor's views of practitioners and therapy and this, in turn, can reduce potential barriers for future support.

The development of the therapeutic relationship is a core aspect of all models of psychotherapy. Philips (2016) recommended that all agencies should emphasise the relational process when considering supportive interventions to young survivors. She suggested that practitioners should be flexible in their approach to assessments and interventions in order to adapt to the needs and pace of young survivors. Providing safe, trusting relational spaces for young people where communication about change can occur is facilitated through the collaboration of social workers and practitioners. Practitioners need to be knowledgeable in providing emotional support, hope, advice and trauma reduction. She noted active listening and reflective skills combined with genuineness and concern help practitioners attune to young people's moods and feelings. Therapist qualities described by young people in her study include "warmth, niceness, comfort, humour, respect and acceptance and professional skill in providing clear and honest explanations and choice about how to engage" (p.334). Young people valued appropriate physical environments that ensured privacy, comfort, confidentiality and suitable age-appropriate materials. Choosing how they communicated was valued by both young people and practitioners with young people's ability to engage and express themselves facilitated by their therapy setting and the accessibility to a variety of resources.

In the early stages of engagement for Phillips' (2016) participants, the therapeutic relationship was strengthened when therapists used fun and purposeful activities that focused on trust-building and as a way of getting to know each other. Phillips suggested that asking questions about the abuse particularly in the early stages of the relationship could undermine the development of a trusting and non-judgmental environment. She recommended that the pace of the therapy be adapted to the young person's needs so they do not feel pressured and are given time to develop a safe place where they can work collaboratively with the therapist. According to Phillips, clear communication about the issues that are beyond the control of the practitioner (e.g. timescales) is important so that children have information and choices. Formal support for non-abusing parents to cope with the impact that sexual victimisation had on their child and themselves was valued by both the young people and parents. She noted that parents are not only protective but are often traumatised by the consequences of having a child surviving sexual abuse.

Overview of outcome research: What works?

Outcome studies have dominated the research literature on psychotherapy with children and young people who have experienced child sexual abuse (CSA), focusing on changes in symptomatology in treatments that used manualized protocols (Hetzel-Riggin, Brausch & Montgomery, 2007; Capella & Gutiérrez, 2014). Notwithstanding the argument that the results of such studies may not be generalizable to community practice settings, these studies have demonstrated improvements in the form of a decrease in mental health symptoms (Clausen, Ruff, Von Wiederhold, & Heineman, 2012; Kjellgren, Svedin, & Nilsson, 2013), a decrease in trauma symptoms or PTSD (Dietz, Davis, & Pennings, 2012; Gospodarevskaya & Segal, 2012) and a decrease in externalising and internalising behaviours (Becker, Mathis, Mueller, Issari, & Atta, 2008; Graham-Bermann, Howell, Lilly, & DeVoe, 2011). Aside from a focus on reducing symptoms, other studies have identified therapy goals as those that focus on enhancing self-regulatory capacities (Kinniburgh, Blaustein, Spinazzola, & Van der Kolk, 2017), finding a new meaning for the abuse experience, incorporating CSA along with other experiences as part of the survivor's life narrative (Capella & Gutiérrez, 2014) and learning how to trust again (Foster & Hagedorn, 2014). Given that loss of trust is an important characteristic of sexual abuse (Horvarth & Bedi, 2002), the establishment of a bond with the therapist as well as re-establishing trust with others can have a positive impact on the young person's perception of healing (Nelson-Gardell, 2001).

The most recent comprehensive review of outcome studies in the field of CSA was conducted by MacDonald and colleagues (2016) who identified 198 effectiveness studies of psychosocial interventions for children and young people (up to age 25) who had experienced maltreatment, the highest number of which addressed sexual abuse. The range of interventions studies included: cognitive behavioural therapy, eye movement desensitization and reprocessing (EMDR), relationship-based interventions such as attachment oriented interventions, parent child interaction therapy (PCIT) parenting interventions, systemic interventions such as systemic family therapy, trans-theoretical interventions, multisystemic therapy (MST) and family-based programmes; intensive service models such as treatment foster care, therapeutic residential care/day care, co-ordinated care; activity-based therapies such as arts therapy, play/activity interventions, animal assisted therapy; psychoeducation, group work and psychotherapy/counselling.

Pooled data from CBT sexual abuse studies in the MacDonald et al. review suggested improvements in symptoms such as posttraumatic symptoms, depression and anxiety. According to their review, there was little or no evidence of the effectiveness of non-directive counselling, supportive therapy, music therapy, art therapy and other activity-based interventions, despite these being the most commonly offered therapies for children in the UK. These findings need to be considered in the light of the inclusion

criteria for MacDonald et al.'s review (that is studies that included a control group) and the imbalance between clinical literature and research studies, for example in the case of art therapy with sexually abused children (e.g. Malchiodi, 2012; 2015). Creative therapies are also widely used in school-based counselling provision in the UK (McElvaney, Judge, & Gordon, 2017), where recent studies have shown significant reductions in psychological distress following participation in school based counselling (Cooper, Steward, Sparks & Bunting, 2013) with improvements greatest for those children with the highest level of difficulty (Daniunaite, Cooper & Forster, 2015).

MacDonald's review found few studies that focused on the role of caregivers or the impact of the therapist-child relationship. According to MacDonald and colleagues, firm conclusions are difficult to draw in relation to which interventions are effective for which children, in relation to various maltreatment profiles (e.g. physical abuse, sexual abuse, etc) and in which circumstances. A range of difficulties with how studies have been conducted, in addition to the different policy and practice context of the study from that of most services in the UK makes it difficult to make conclusions as to whether positive outcomes recorded in research studies are likely to be observed in practice. (Rubin et al., 2016; MacDonald et al., 2012).

Studies that focus on treating symptoms of PTSD show Trauma Focused (TF-CBT) as the most effective, particularly where a non-offending parent is involved in the intervention. It was not possible to make any conclusions with regard to the comparative effects of interventions. While their review did not find robust evidence of interventions being of no benefit or that may result in harm, they did identify an absence of robust evidence for many interventions that are widely used in the UK. There are a range of therapies that are described as focusing on trauma and designed specifically for children and young people who have had traumatic experiences such as Trauma Focused CBT (TF-CBT; Cohen et al., 2012; Deblinger et al., 2016); and Trauma Systems Therapy (TST; Saxe et al., 2007). While drawing on a range of techniques, for example, play, skill-building, cognitive processing skills, the aims of these programmes typically are to improve emotion regulation, challenge maladaptive beliefs and addressing symptoms (behavioural, depressive, anxious, or posttraumatic), and help the young person develop coping skills. Many researchers have pointed out that when considering outcomes, it is important to include those outcomes that recognise the complexity of children's presentations and parents' concerns. Increasingly, authors are advocating for best practice in therapeutic intervention to focus on promoting resiliency processes, strengthen personal resources and build new competencies (Mac Donald et al., 2016; Beiza et al., 2015; Afifi & MacMillan, 2011).

Although the MacDonald's 2016 review was not able to identify a consensus as to what constitutes best practice in terms of effectiveness, they did highlight the common

features of those interventions that appeared to have some benefit. These included interventions that incorporated a) an educational component (helping children and parents to understand what happened and to allocate responsibility for the abuse to those that perpetrated it); b) believing and supporting children and helping children and their parents establish strategies for future safety; and c) where necessary, addressing the psychological impact of the abuse such as focusing on symptoms of post-traumatic stress or depression.

MacDonald and colleagues highlight the importance of a comprehensive assessment of the child's functioning and needs, which goes beyond establishing a mental health disorder, and includes physical, cognitive, speech and language, interpersonal and social development along with behaviour, self-esteem and educational attainment. They note that therapeutic intervention targeted at symptoms such as anxiety, PTSD and depression may be necessary but not sufficient to meet the child's needs. They also note that therapeutic intervention may not be sufficient if regarded as a single time-limited intervention but may be required at different times in the child's life. The involvement of parents or primary caregivers is essential, to support the child or young person's engagement in the therapy but interventions may also include the parent's participation or involve parallel work with the parent, addressing interaction patterns between the child and parent/caregiver or parenting support to help them address their child's behaviour difficulties. Children's own expressed needs and wishes need to be attended to, along with their parents/caregivers' views on where therapy is to be delivered. The authors noted that group work both for children and parents/caregivers can be helpful in reducing stigma and guilt, and allow for sharing of experiences. Trauma-focused cognitive-behavioural interventions were described as most effective for symptoms such as PTSD and anxiety.

Some attempts have been made to investigate interventions in community based services, as distinct from research-based therapeutic programmes in controlled settings. Carpenter et al.'s (2016) pragmatic randomised controlled trial evaluation study of the National Society for the Prevention of Cruelty to Children (NSPCC) therapeutic intervention, 'Letting the Future In' for sexually abused children and young people aged 4 to 17 years is a prime example. The study was conducted in response to Allnock and colleagues' studies (2009; Allnock & Hynes, 2011) that identified gaps in services in the UK as too little and often too late. Grounded in trauma, attachment and resilience theories, the NSPCC model is described as a psychodynamic approach that is delivered in a structured and phased method. Given that betrayal, shame, powerlessness, and traumatic sexualisation are typical characteristics of sexual abuse, it stresses the importance of the therapist attunement to the young person's emotional responses to abuse. Emphasising the development of the therapeutic relationship as core, it uses creative therapies to facilitate awareness and management of feelings. The model

provides young survivors up to four therapeutic assessment sessions and 20 intervention sessions that can be extended to 30 additional sessions if necessary. Acknowledging the importance of the carer support in the child's recovery, it offers up to eight sessions to the non-abusing carer.

Carpenter et al. (2016) noted that Trauma-focused CBT (e.g. scales, gradual exposure) was seldom used by the therapists in the study. They recommend that by using both creative therapies and CBT techniques a better balance would be provided and lead to improved outcomes. Both young people and their carers attributed the survivor's positive changes to the therapeutic relationship. The interventions reported by younger children included a strong element of play with the use of stories and books. While older children reported a host of interventions that included "creative arts and drawing/painting, written work, role-play and talking directly about their feelings and experiences" (Carpenter et al., p.87). Practitioners reported that they adapted to the needs of the child. Young people valued the creation of items such as a diary that helped remind them of their growth. Interventions that taught them to deal with overwhelming feelings of anxiety and/or anger were also valued. Children and young people reported positive outcomes including: improved confidence and sleep patterns, decreased guilt, blame, depression, and anxiety, better articulation of the abuse and ability to freely speak and deal with the experience of abuse openly and calmly with others. Other important factors that young people attributed to them being able to talk openly in sessions included therapist attributes (warm, friendly, cheerful caring, welcoming, and genuine), being listened to, trust and confidentiality.

A Norwegian study by Dittmann and Jensen (2014) interviewed 30 adolescents (aged 11-17 years) to explore their perceptions of TF-CBT. An important element of TF-CBT is the gradual exposure to trauma narrative where the young person is required to discuss details of their trauma experiences. Although many reported initially being uncomfortable discussing traumatic events with the therapist, they found doing so most helpful. Positive treatment outcomes such as resuming normal functioning were also attributed to factors such as the therapist's expertise, neutrality, empathy, and confidentiality as well as learning coping skills for reducing stress and trauma reminders.

In recent years there has been a trend towards developing treatment programmes that integrate well-researched interventions from different models, such as CBT programmes, with play and person-centred approaches along with a trend for CBT programmes to become more integrative, such as incorporating play techniques (Krueger & Glass, 2013). Fonagy and colleagues found that more than 50% of child therapists drew on a range of techniques in their work (Fonagy, Target, Cottrell, Phillips & Kurtz, 2002), rather than following one 'pure' model of therapy. A long standing critique of the efficacy research literature (that is, referring to research that is conducted under controlled conditions) is

that clinical practice with children bears little resemblance to those programmes evaluated in efficacy research (Chorpita Daleiden & Weisz, 2005; Fonagy et al., 2002; Krueger & Glass, 2013). Krueger and Glass (2013) conducted a systematic review of integrative child and adolescent psychotherapies and cite a number of approaches that allow therapists to select interventions that have an evidence base and integrate these into their work. They suggest that integrative treatments may in some cases be superior to evidence-based treatment protocols. Thus, an argument for individually tailored approaches, drawing on a range of interventions is attracting support. Kim, Noh & Kim's (2016) review of the literature on psychosocial interventions for sexually abused children found that using diverse treatments produced positive findings in psychological and social sequelae. Meta-analyses suggest that most treatments analysed in these studies are effective for symptom reduction – the inclusion criteria typically ensure that treatments included in these studies are manualised, short term treatments (Harvey and Taylor, 2010; Trasks, Walsh & DiLillo, 2011). Harvey and Taylor (2010) suggest that given that most treatments (e.g. Cognitive–behavioural, Insight-oriented and Eclectic) analysed in their meta-analysis are effective for symptom reduction; therapy needs to be targeted to individual needs because treatment outcomes varied across symptom domains. The largest effect sizes were noted in measures of PTSD/trauma and global outcomes. While moderate effect sizes were found in measures of internalizing symptoms, self-appraisal, externalizing symptoms and sexualized behaviour with small effect sizes found in measures of coping/functioning, caregiver outcomes, and social skills/competence.

Not included in McDonald and colleagues' (2016) list of interventions is what is sometimes referred to in the literature as 'treatment as usual' (TAU) or 'routine psychotherapy', often used to describe control groups when a specific model of therapy is being evaluated. The term though ill defined, typically refers to a generic form of counselling or psychotherapy and is more typically associated with community services, as distinct from services funded through research monies. It has been argued that randomized control trials (RCTs) may not represent the reality of psychotherapy applied in the real world where typically treatment offered is more varied and there are less clearly defined inclusion or exclusion criteria due to the responsiveness of real world services. McAleavey and colleagues (2019) explored the effectiveness of routine psychotherapy in a large sample of university counselling services (UCCs) in the U.S. (9,895 clients seen by 1.454 therapists in 108 UCCs). They compared client outcomes with data from RCTs and found equivalent improvement in symptom severity. A related debate is in relation to the importance of the therapeutic relationship as an agent of change rather than attributing progress in therapy to particular models such as CBT or psychodynamic psychotherapy. Caspi and colleagues (2014) have identified a 'p' factor, representing the relationship in psychotherapy as possibly the most predictive of successful outcomes. Patalay et al. (2015) have used this concept to distinguish between

those children who have had more successful outcomes in therapy. Fonagy and Allison (2017) have proposed that the p factor can be understood as a measure of resilience.

In summary, while most outcome studies have focused on manualised approaches such as CBT programmes, and there is evidence for the efficacy of these programmes in relation to a reduction of symptoms such as PTSD symptoms, anxiety and depression, there are concerns about the applicability of these findings to community based services. The core components which appear to be effective in therapeutic interventions with children and young people are psychoeducation, a supportive relationship, a focus on coping strategies, and a focus on symptoms where relevant.

Guidelines for best practice: Policy considerations

This section will draw on literature from international guidelines on working therapeutically with children and adolescents who have experienced sexual violence. The Convention of the Rights of the Child (CRC) 1989 (United Nations, 1989) imposes an obligation on member states to protect a child (under 18) from all forms of abuse and neglect (Article 19). Protective measures are defined as support for child and carers, identification, reporting, referral and investigation of abuse, treatment and follow-up, and involvement of justice services (Article 28).

In the US, the children's advocacy centres are a national network of services that bring together various disciplines involved in responding to child maltreatment – child protection, mental health, law enforcement, prosecution. Similar developments in Iceland and mainland Europe in the form of Barnahus or children's houses all emphasise the importance of delivering services to children from the one location. The Beijing Platform (1995) makes recommendations as to the provision of specialist trained health workers, integration of medical/health care services, referral systems that link the various sectors to include medical services, counselling, housing, law enforcement and offender programmes.

Practice guidelines for the **effective treatment of PTSD** were developed by Foa, Keane, Friedman & Cohen (2008) for the International Society of Traumatic Stress Studies targeted at clinicians working with adults. These guidelines have been updated and a third edition of the Internal Society for Traumatic Stress Studies PTSD Prevention and Treatment Guidelines are due to be published at the end of 2019 (www.istss.org). A position paper on complex PTSD in children and adolescents is available on the website. This paper concludes that at present, there is insufficient evidence to recommend a particular treatment for Complex PTSD (CPTSD) in children. The paper acknowledges that many treatments currently in use address difficulties such as negative self concept, emotion dysregulation, and difficulties with relationships.

A detailed outline of clinical practice guidelines, drawing on international best practice, incorporating investigation and therapeutic response has recently been published by Seshadri and Ramaswamy (2019) that identifies two levels of psychosocial response. The first level includes ensuring the child's safety, promoting rest and recreation, teaching relaxation exercises, and supporting the young person in resuming daily routine and developmental activities. Second level interventions, referred to as 'depth therapeutic interventions' include longer term therapy entailing regular sessions with a trained therapist or mental health professional. The objectives of these interventions, according to Seshadri and Ramaswamy, focus on helping the child provide a narrative in a gentle, non-threatening manner, helping the child recover from the experience through clarifying their experience and empowering the child to develop coping skills, and finally, helping the child develop ways to ensure their personal safety and life skills such as decision-making skills and assertiveness. The authors advocate the use of innovative therapeutic interventions, ranging from art and story-telling to drama and cognitive behaviour therapy focusing on containment and emotional regulations. The focus of work, according to these authors needs to address memory work, skills training, vision for the future as well as containment and emotional regulation.

As the Rape Crisis Centres developed out of a feminist tradition of developing services for women, it is worth referring here to international guidelines on service development to combat violence against women, notwithstanding the gendered nature of the recommendations. Kelly and Dubois (2008), in acknowledging the overlap between different forms of violence and the evidence that those who suffer the most harm are those who have suffered multiple forms of abuse, questioned the need for support services to target specific forms of violence, such as sexual violence. They noted that specialist women's Non-Governmental Organisations (NGOs), have proved to be the most responsive and effective in helping women and so should be the key providers of such services, drawing on skilled and knowledgeable staff, sufficient resources and the espousing of certain philosophical principles. They stressed the role of NGOs to innovate as well as to implement international good practice. Some service-specific standards for counselling are included in their recommendations, such as the importance of making individual action plans with service users that address safety, support and practice needs. They also outline a curriculum for counsellor training which they suggest should be a minimum of 30 hours and should include: a gendered analysis of violence against women, crisis intervention, a knowledge of trauma, coping skills, understandings of well-being and social inclusion, confidentiality, communication skills, an overview of local criminal and civil justice systems and relevant legislation, knowledge about statutory and non-statutory resources, knowledge of discrimination and diversity and empowerment.

Astbury (2006) in reviewing service provision for victims/survivors of sexual assault in Australia concluded that psychological support should include believing the client,

acknowledgement and validation of feelings, support of decision making as well as the provision of information and contacts to other services. An initial assessment of the sexual victimisation should ascertain information about the type, duration, and severity of the violence. An evaluation is needed of the survivor's psychological needs, symptoms, and concerns, as well as identifying any changes to these issues (e.g. depression, anxiety, sleep difficulties, traumatic stress) over time. Up-to-date information to give to survivors on referrals to sexual assault, legal and other relevant community-based services should be available in a user-friendly format.

The Daphne III European Commission funded the Safeguarding Teenage Intimate Relationships (STIR) project, based on the first study of interpersonal violence (IPVA) in young people's relationships in the general population (aged 14 to 17) across five European countries (Bulgaria; Cyprus; England; Italy and Norway; Barter et al., 2015a; 2015b; 2015c). The study highlighted the importance of addressing gender attitudes to prevent sexual violence in addition to sex and relationship education to address young men's use of pornography, in particular promoting the development of more critical attitudes regarding the differences in values and behaviour conveyed by pornography and positive intimate relationships. Awareness of sexual violence was highlighted (Barter et al., 2015d) to facilitate disclosure and encourage young people not to take full responsibility for addressing issues related to IPVA. The interviews with young men and women suggested that pressure to engage in sexual activities was extensive for some young women across all countries and normalised to such an extent that it made it difficult for young people to recognise rape as rape (Barter et al., 2015b).Sending sexual visual images was considered normal behaviour, using social networks as a platform to perpetrate abuse exacerbated the impact, and the impact was experienced differently for young men and for young women with young women reporting more negative impacts. The STIR briefing papers concluded that service and intervention programmes must provide a holistic approach to supporting young people in order to address the interconnection of risk, incidence and impact of different forms of childhood violence.

The need for young people's voices to be heard is a recurrent theme in studies that aim to capture children and young people's perspectives on services they receive (Mudaly & Goddard, 2006). Consultations with young people in the context of developing strategies for addressing sexual violence highlight their views that governments are not doing enough to address issues such as their wish to be heard and consulted on decisions made regarding their rights, discrimination based on race, religion, disability or gender and training for professionals in listening to children (European Network of Ombudspersons for Children (ENOC, 2015; see consultation process with the European Network of Young Advisors (ENYA; www.enoc.eu); Council of Europe, 2016). One area where professionals arguably rely on children and young people to educate them about challenges in the area of sexual violence is that of online risks. The EU Kids Online study (Livingstone & Haddon, 2009), drawing on

25,000 9-16 year old internet users and their parents across 25 countries highlighted how parents' knowledge of internet usage lagged behind children's knowledge, leaving children vulnerable to online risks. Children and young people are increasingly presenting to services, having experienced abuse either exclusively online (e.g. being coerced into posting sexual images that are then circulated), or as a precursor to offline abuse (e.g. being targeted and lured into an abusive relationship). The perceptions of young people that 'sexting' is a normal part of romantic relationships or a means of exploring sexuality and sexual identity (see Cooper, Quayle, Jonsson, & Svedin, 2016 for review) raises issues about the need for awareness training in the general population of both children and adults. In addition to the challenge of responding to online risks and abuse facilitated by new technologies, the unprecedented numbers of children migrating to Europe in recent years, with its associated risks of sexual exploitation and sexually transmitted infections in addition to prior experiences of sexual violence such as female genital mutilation, require skilled professionals to respond to these children and young people's needs in culturally sensitive ways (Lalor & McElvaney, 2010).

The World Health Organisation (2017) guidelines on responding to children and adolescents who have been sexually abused recommends that young people should be offered child centred and gender sensitive support. They suggest that both young people and their non-abusing carers need both first-line support and psychosocial support to promote "well-being and functioning, involving psycho-education, support for managing and coping with stress, and promoting daily functioning as they recover from their traumatic experience over time" (p.34). Other support for non-abusing carers should include information about possible signs or symptoms of post-traumatic stress disorder (PTSD) and/or behaviours or emotions that the child may show in the coming days or months and when to seek further help (p.34). Age appropriate information should be provided to young people about "likely signs or symptoms or emotions that they are likely to experience and when to seek further help. Explain to the child or adolescent (as appropriate), and/or their non-offending caregivers, that they are likely to improve over time" (p.34). Since the young person's safety is paramount, those offering psychological interventions need to assess the potential implications of the treatment/care they are providing so they can respond in ways to lessen the risk of harms. A thorough training and ongoing supportive supervision of personnel is needed for those delivering psychological interventions. Stress management interventions should be considered for those deemed to have PTSD or symptoms of PTSD. Adaption of all interventions should be considered for diverse approaches to the different cognitive development and levels of maturity of young people. Extra effort may be required to improve access to services for hard to reach groups, for example, those from rural areas, those with disabilities, minority groups and carers who may have to take time off from work to attend or take their children to sessions. They emphasise the importance of a comprehensive assessment of needs prior to

interventions and ongoing support and supervision for all healthcare workers involved in responding to young people's needs.

Summary

In summary, while extensive research exists to support the effectiveness of psychosocial interventions with young people who have experienced sexual abuse, there is limited support for favouring any particular model of practice over another. Many authors have called on practitioners to draw on the range of evidence based interventions available while others have highlighted the importance of developing innovative therapeutic interventions that are individually tailored to meet young people's needs. Studies that have involved young people directly and asked them about what they find helpful reveal the importance of the therapeutic relationship as a holding and containing space for young people to talk about their experiences, explore, express and learn to manage their feelings; learn new ways of reflecting on and making sense of their experiences; developing coping skills to deal with their distress; and receive support to deal with their everyday life challenges as they navigate their way through the healing process and get on with their lives. A holistic approach to responding to young people's needs was highlighted, taking account of the diverse range of needs that children may present with following an experience of abuse. There is an acknowledgement within the field of a move towards a more child-centred, integrative and holistic approach that takes into account the age, gender, and developmentally appropriate techniques when delivering therapeutic services to sexually abused young people (Itzen et al., 2010).

This literature suggests a number of key factors that are important in considering best practice in this field. Those characteristics of therapy that have either been found to lead to better outcomes for young people, are recommended as best practice in the field, or which young people and their carers have highlighted has helped them in the recovery process include: a comprehensive needs assessment, including consideration of the implications of intervention so as to minimise further harm; specialist expertise that is child centered and gender sensitive; a flexible approach that facilitates young people being able to express themselves in diverse ways and adapts to the needs and pace of young people; a caring, warm therapist; psychoeducation; the opportunity to talk about their experiences and their feelings in a non-pressurised way; being heard and believed; learning new coping skills; making sense of their experiences; being able to put their experiences in context and look to the future; learning how to trust again and form/maintain healthy relationships; and support for carers. In terms of specific therapeutic models, Trauma Focused CBT has been found to be the most effective when treating symptoms of PTSD while it has been noted that in community based practices, an integrative approach to therapy that incorporates many features from the efficacy and effectiveness studies is becoming more common. It is clear

from this review that the perspectives of adolescents and their parents/carers is underrepresented in the literature.

The perspectives of adolescents and parents/carers is underrepresented in the literature (Carpenter et al., 2016) despite recent developments in acknowledging the autonomy and rights of young people to have their voices heard in matters impacting on their lives. Children and young people are increasingly being recognised as experts on their own experiences (Bergström et al., 2010) and study designs are beginning to take account of the importance of true participation of young people in research studies. While this is evident to some extent in the literature on child sexual exploitation, it remains limited in research on child sexual abuse (Matthews, 2019). Much of the literature refers to guidelines for practice with children and adolescents, neglecting to differentiate between these quite distinctive phases of development. Starrs (2019), who advocates a relational approach based on Gestalt therapy, emphasises the importance of meaningful therapeutic alliances with both adolescents and their parents but also the need to consider the young person's difficulties in the context of their wider developmental processes.

The trend noted above towards integrating evidence based techniques and interventions appears fitting with Tusla's commissioning strategy (Tusla, 2017) and the recent project, Outcomes for Children, National Information & Data Hub Project which commits to providing an interactive information source to inform policy makers, service providers, Tusla managers, practitioners, information managers and local communities in planning and delivering services that are evidence informed and/or evidence based.

Method

This research study, incorporating a concurrent mixed methods design (Creswell, 2013; Teddlie Tashakkori, & Johnson, 2012), reviews the current provision of services for young people (under 18's) in Ireland by rape crisis centres. The research methods used included two online surveys (service managers and frontline staff), telephone/face to face interviews (service managers and young people), four focus groups (3 frontline staff and 1 stakeholder) and three stakeholder telephone interviews. The study had four aims.

Aim 1: (identify best practice) was accomplished through a desk-based literature review and consultation with experts in the field (through telephone or email consultation) and with expert organisations.

Aim 2: (review current service provision) was conducted through online surveys, with service managers and frontline staff, structured telephone interviews with service managers, focus groups with frontline staff, telephone interviews and focus group with stakeholders and individual face to face interviews with service users.

Aim 3: (review experiences) was conducted through online surveys and telephone interviews with service managers and online surveys with frontline staff, focus groups with frontline staff and stakeholders, telephone interviews with stakeholders and individual face to face interviews with service users.

Aim 4 (make recommendations) was addressed through the synthesis of data gathered throughout the study and presented in this report.

Data Collection

An online questionnaire was circulated to all service managers in Rape Crisis Centres/Sexual Violence services in Ireland (n=16). Service Managers were contacted via email and telephone and a convenient time was arranged to conduct the online survey in the format of a structured interview. As some of the data sought involved extracting information from client files, this method of data collection was considered most appropriate. The intention was to provide managers with an opportunity to collect required data in advance of the telephone interview or to complete the online survey following the interview. The process of data collection, in particular ensuring full coverage of questions asked, was challenging. On occasion, the data was not ready for input into the survey at the allocated time of the structured interview and service managers committed to submitting the survey following the interview. This resulted in a number of missing responses. The design of the Service Managers online questionnaire (See Appendix A) was informed by consultation with the advisory group and with

reference to data gathering tools already in operation in some of the centres. A participant information sheet was embedded into the invitation email, outlining the details of the study and providing a link to the online questionnaire.

The questionnaire consisted of seven sections. Section One introduced the questionnaire and asked for consent. Section Two elicited information about the centre and the services offered. Section Three covered referrals and allocation procedures in the centre. Section Four asked about each of the therapists that were working with young people under 18. Section Five and Section Six explored data on young people who had attended the service in 2017 and 2018. Section Seven asked about views on current service provision. A total of 15 service managers responded to this online survey and 14 of these participated in a telephone interview.

A frontline staff online questionnaire was also circulated to service managers through email to service managers, requesting that this be forwarded to all frontline staff. The design of this questionnaire was aligned to the open question schedule used in the frontline staff focus groups. Questions included asking about the participant's role in the centre, their views on young people's access to services, what was helpful or challenging in providing a service to young people, what services they considered essential in providing a response to young people, how such services should be structured, what qualifications should be required for therapists working in such services and what support needs staff have in such services. 19 frontline staff from RCCs responded to an online survey and 21 attended focus groups in Dublin, Kilkenny and Galway, representing therapists, volunteers, helpline staff and administration. A stakeholder focus group was conducted. Due to difficulties with attendance at this group, an additional three telephone interviews were conducted with stakeholders, bringing the total to eight, representing gardai, SATU staff, specialist sexual abuse service, school completion and a community agency. The schedule of questions for both the stakeholder focus group and the stakeholder telephone interviews followed the same format as the focus groups for frontline staff.

Finally, semi-structured interviews with young people who had attended a centre in the past two years were conducted. These young people (14 self-identified as girls and two as boys) were all recruited through centre staff. Information sheets about the study were made available to parents and young people and permission sought to pass on contact details to enable the researcher to make direct contact with parents and young people to arrange a mutually convenient time to meet. They were given seven days to consider their decision to participate or not, with assurances that this would have no impact on their service. Written consent was obtained from parents and written assent from young people. The young person's choice of venue for the interview was respected, 15 choosing to participate in the interview in the service centre and one choosing to participate in the

interview at home with a guardian present by pre-arrangement. A protocol was in place in the event that a young person became distressed during the interview. The young people and their parent/guardians were offered time to ask questions throughout the interview and it was made clear to the young person that they could stop the interview at any time and/or withdraw from the research project entirely. The young people were asked open ended questions about their experiences of accessing the RCC service, what they found helpful, what could have been better and what advice they would offer professionals providing services to young people who have had an experience of rape and/or sexual violence. Interviews were audiotaped and transcribed as soon as possible following the interview. The transcripts of these interviews were anonymised by the researchers following transcription of the recordings. Thus, 16 young people participated in interviews, ranging in age from 15 to 18 years, recruited from 7 centres. The type of abuse experienced ranged from sexual fondling to vaginal penetration with perpetrators ranging from peers, family members and parent's partner. The duration of abuse ranged from once off rape incidents (n=6) to sexual abuse that that took place over a period of time.

Data Analysis

Completed questionnaires from the Qualtrics platform and interview transcripts were uploaded to and stored securely on a University secure google drive site in a qualitative analysis software database, nVIVO (QSR International, 2011). An excel spreadsheet was generated from within the Qualtrics database and uploaded to facilitate descriptive analysis. Interviews and text responses from questionnaires were analysed drawing on Braun and Clarke's (2006) thematic analysis procedures. While the data from surveys, interviews and focus groups were at first analysed separately, a further analysis was conducted to integrate all data sets. This involved comparing findings, identifying similarities between the datasets and identifying how the quantitative and qualitative data complemented each other and added richness to the overall findings.

This study obtained ethical approval from the Tusla Child and Family Agency Research Ethics Committee. Procedures were informed by best practice in conducting research with vulnerable populations on sensitive topics (Draucker, Martsolf, & Poole, 2009; Hunleth, 2011; McClinton Appollis, Lund, de Vries, & Mathews, 2015). All procedures for storing data were GDPR compliant. The following members of the research team contributed to the various stages of the project:

- Design of the project: Rosaleen McElvaney, Christina Treacy and Andrina Monaghan;
- Literature Review: Christina Treacy, Rosaleen McElvaney and Naoise Delaney;
- Recruitment of participants: Christina Treacy and Andrina Monaghan;

- Service managers' interviews: Andrina Monaghan and Christina Treacy;
- Focus Groups: Andrina Monaghan, Christina Treacy and Rosaleen McElvaney;
- Analysis of Service Managers' Interviews and Surveys (both Service Managers' and Frontline Staff): Rosaleen McElvaney, Naoise Delaney, Christina Treacy and Andrina Monaghan;
- Analysis of young people's interviews: Rosaleen McElvaney and Andrina Monaghan;
- Execution of report: Rosaleen McElvaney with assistance from Naoise Delaney, Andrina Monaghan and Christina Treacy.

In summary, this study consisted of a concurrent mixed methods design that reviewed the current level of provision for young people in rape crisis centres in Ireland. Data was collected through online surveys, telephone/face to face interviews and focus groups with service mangers, frontline staff, stakeholders and young service users. Ethical approval for the study was obtained from the Tusla Child and Family Agency Ethics Committee. All procedures for storing data were GDPR compliant. Descriptive summary analysis was developed using Excel; thematic analysis procedures were used to analyse the data.

Findings

The primary aim of this study was to investigate the provision of therapeutic services to young people by the 16 Tusla-funded rape crisis services in Ireland.

The findings drawn from the online surveys with service managers (SM) and frontline staff (FS), interviews with service managers and stakeholders, focus groups with frontline staff (FG) and stakeholders (SHFG), and interviews with young people (YP) are presented below under the following headings: *the centres*, *the young people, young people's experiences of attending the centres,* and *what needs improvement.* Sources for quotes are denoted by initials (SM, FS, FG, SHFG or YP) and the relevant number associated with this source.

The Centres

Mission statements

The mission statements of the rape crisis centres are individualised to each centre and have both common and diversified themes. The common themes refer to 'creating a safe place' for those affected by sexual violence, providing support and working to prevent sexual violence through awareness raising and advocacy. Some centres aspire to the "*elimination of sexual violence at both a community and national level*" (SM04). Additional themes are empowerment, helping people reach their potential and providing sensitive responsive services, "*Our mission is to provide a counselling service sensitive to the needs of survivors of Sexual Violence, Rape, Childhood Sexual Abuse and Sexual Harassment, that is empowering, non-judgmental and consistent in approach that promotes the safety, privacy and dignity of the survivor*" (SM13).

Range of services provided

Information on service provision was provided by 15 centres. This relates to service provision in general, not specifically to service provision for young people. All 15 centres reported that they do not charge a fee for the services offered for young people. The services offered include advocacy, court accompaniment, individual and group therapy, parent support in the form of face to face engagement and helplines. The nature and range of services differs according to the size and resources of the centres. For example, twelve centres noted that they provide advocacy. In some centres the counsellor acts as the young person's advocate throughout the process, "*Counsellor is often the advocate for young person throughout process"* (SM12). Psychoeducation was seen as a crucial element of providing advocacy to young people. A common theme was the need for

more resources and funding to extend advocacy services, "*Having people there and available so therefore funding and resources are crucial to providing same"* (SM05). A national free helpline is available through the Dublin rape crisis centre that provides 24-hour access. It was unclear how many RCCs provide a local helpline; where these were available, there was more restricted access, "*Our helpline operates between the hours of 9-5 Monday-Friday (when we are onsite). The helpline when not manned refers people to the national helpline*" (FG01). Calls to the national helpline are directed to local services or information is passed on so that local centres can follow up with the caller. Twelve service managers noted that they offer court accompaniment.

Fifteen service managers reported that they offer individual therapy; five reported offering group therapy, although none had been provided in 2017 & 2018. Qualitative data suggested that group work varied from "*group counselling*" (FS11) to "*group work with a psycho-education role for teenagers to normalise some of their symptoms and use peer support. Similar group support for parents*" (SM06). All centres noted they offer family support. All centres require parent/guardian participation at the time of the assessment. Five centres recorded having joint sessions with both the young person and parent present for one or more sessions. "*Family support is provided although it is in an ad hoc manner and tailored specifically to the needs of the individual young person's family*" (SM06). Two centres offer counselling sessions for the parent while a third offers a 30-minute session "*time constraints prevent them for doing anything more*" (SM 03).

A range of therapeutic interventions are offered (n=15 centres). All but one adapted their model of working with young people from the RCC Trauma approach that was used in their work with adults. All centres were described as primarily using a client centred approach, with 6 stating that they use CBT. Other models mentioned include Gestalt, Radical Relationship, Integrative and Narrative therapy. The importance of the therapeutic relationship as fundamental to working with young people who have experienced sexual violence was one issue that was highlighted by respondents across all centres represented in this study. Nine centres referred to creative therapies and these included art therapy (6), play therapy (4), sand therapy (2), use of masks (1), clay (1) and writing poetry (1).

Profile of therapists

There is considerable variability with regard to staff qualifications and training across the rape crisis centres represented in 14 responses. Figure 1 provides information on training levels of therapists across these 14 centres for a total of 63 therapists. A distinction was not made here between therapists who work with young people and therapists who work with adults in the centres. Most staff are trained up to degree level.

There are staff who have completed either degree or masters level training in counselling or psychotherapy without formal training in child and adolescent work; many of these have pursued CPD courses in working with children. Information was not provided on qualifications for 17 therapists and on accreditation relating to 14 therapists. For four of the therapists where qualifications were not listed, these were described as accredited. It would appear from the focus group data that there are some therapists working with children and adolescents that do not have qualifications for this specific work although they do have significant experience working with young people. "*While we don't have specific qualifications, we do have a lot of experience*" (FG01). A majority of therapists where information was available were described as having at least 10 years' experience working as a therapist and a similar period working with children.

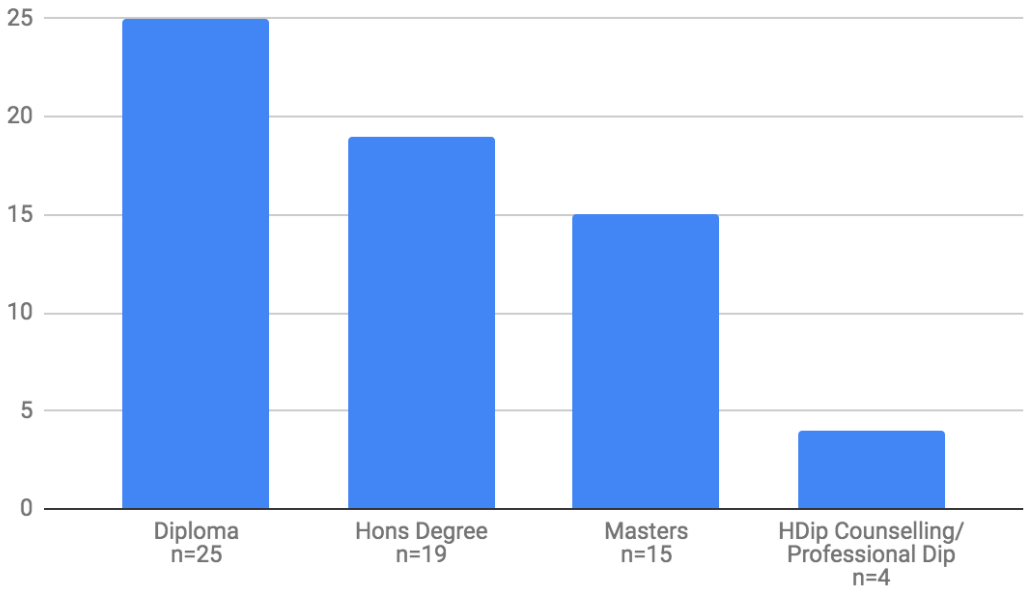

Figure 1. Training level of therapists (n= 63) (n= 14 centres)

New staff go through an induction and training process before they commence therapeutic roles. "*All RCC staff attend a period of induction (40hrs) some have previous experience and qualifications although all staff and volunteers undergo RCC training*"(SM12); "*We provide 100 hours Specialist Sexual Violence Training as developed by our National Body (Rape Crisis Network Ireland) to all staff and volunteers before they can work in the centre*"(SM11). Training in trauma and in working with young people was considered important to meet the needs of those who have experienced sexual violence "*All therapists need at least degree level with extensive clinical hours dealing with sexual violence and trauma along with training on working with young people who have experienced sexual violence*" (FS08).

Gaps in training appear to be addressed through continuous professional development. "*The staff also get extra training in relation to working with young people and trauma*" (SM05). The type of trainings in working therapeutically with young people varies: "*recently did a workshop on sand play, she works a lot with Art therapy and they have done Bronagh Starrs workshops* (adolescent psychotherapy trainer). *Another therapist did a workshop on suicidal ideation for young people*" (SM04). Funding for training in youth counselling differs across centres with some sponsoring staff to complete a masters degree "*currently are paying for fees for those who wish to pursue a masters degree. They pay because it is a benefit to the centre"* (SM08). Others appear to struggle to meet the requirements for training "*Some continuing education is done through the centre when relevant but not as much now because the funding was cut. Funding barely covers the staff costs*" (SM02). This variation is likely related to the variability in size and resources of various rape crisis centres across the country. Staff support needs primarily consisted of supervision (clinical supervision and peer supervision), having an open-door policy in the centre whereby staff could seek support from the service manager, having an opportunity to debrief in relation to the impact of the work and team building activities. A participant in a focus group referred to having a child and adolescent counsellor to which all under 18's are referred. This post had to be lobbied hard for and while they feel this initiative is working very well, supply is unable to keep up with demand. Most of the therapists for which information was available (see Table 1) were described as humanistic and or integrative in their theoretical orientation and were accredited members of the Irish Association of Counselling and Psychotherapy.

Table 1.

Theoretical Orientation (n=65) and Accreditation of Therapists (n=69)

Theoretical Orientation[2]	Therapists (n)
Humanistic/Person Centred	16
Gestalt	1
CBT	6
Integrative	15
Humanistic + Integrative	25
Psychodynamic	2

Accreditation Body	Therapists
Irish Association of Counselling and Psychotherapy	45
Irish Association of Humanistic and Integrative Psychotherapy	15
Other (PCI[3], British Association of Counselling and Psychotherapy, Association of Professional Counsellors and Psychotherapists in Ireland)	9

Service managers were asked about supervision support for therapists in each centre. Information was provided on 69 therapists who are provided with supervision by the centre. See Figure 2 for the breakdown of type of supervision, most of which is individual.

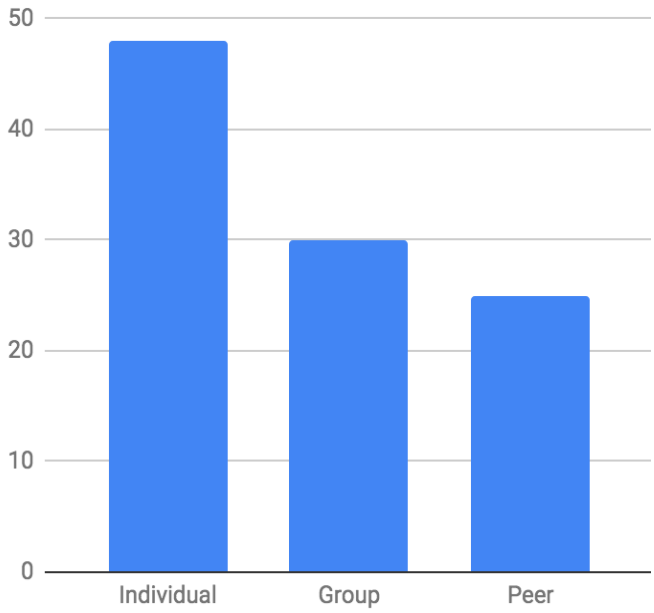

Figure 2. Supervision provided by centre.

[2] A description of theoretical orientations is available on www.psychotherapycouncil.ie
[3] This appears to refer to PCI College, a training institute rather than an accreditation body

The young people

Service managers were asked to detail the **number of young people under 18 who had attended in 2017 & 2018,** who had made the referral, how parental/guardian consent was obtained, and details of their attendance. Information on young people's attendance was provided by 11 service managers. Across these 11 centres, service managers reported that a total of 299 young people under 18 attended between January 2017 and December 2018. A small number of young people under 13 attended (n=8) with the majority being over 14.

There was considerable variability in attendance across centres, given the size of the centres. This ranged from 3 centres where less than five young people were seen in 2017-2018 to 5 centres where between 15 and 30 young people were seen, to 2 centres where between 50 and 90 young people were seen.

The main **referral agent** was the parent, in 33.3% of cases, followed by SATU (15.8%) and self-referral (11.5%) (see Figure 3).

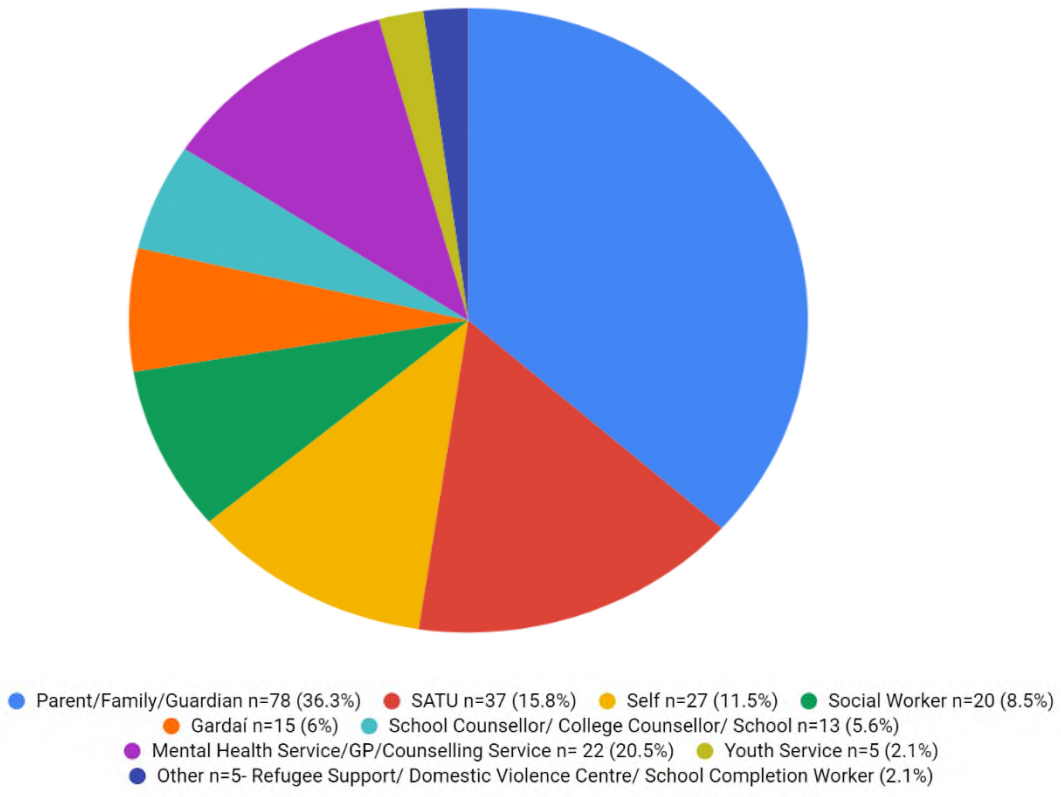

Figure 3. Sources of referral

Parental consent was obtained for the most part in person (94.6%) with a small number being obtained by post (n=9), email (n=1) or through Tusla (n=1).

Information on whether a report was made to Tusla/An Garda Siochana was available for 221 children, reports were made in the case of 203 children.[4]

Information about number of sessions attended was available for 131 young people. The average number of sessions attended was 30, with a range of 1 – 87 sessions. The period during which young people attended ranged from 1 session to 39 months, with 11 clients still attending. The average attendance period was 6 months. In addition, 54 calls were taken from young people during this period over 13 centres; the average number of calls per client was 2.8 (range 0 to 25). This data did not include calls taken in relation to young people not attending the centre. Many centres do not keep records of helpline calls.

Many young people were also attending **mental health services** concurrently with attending an RCC. Information was available for 55 out of 243 clients, with 18 attending mental health services and 37 not attending. Figure 6 below illustrates the frequency of appointments. Most young people attended weekly.

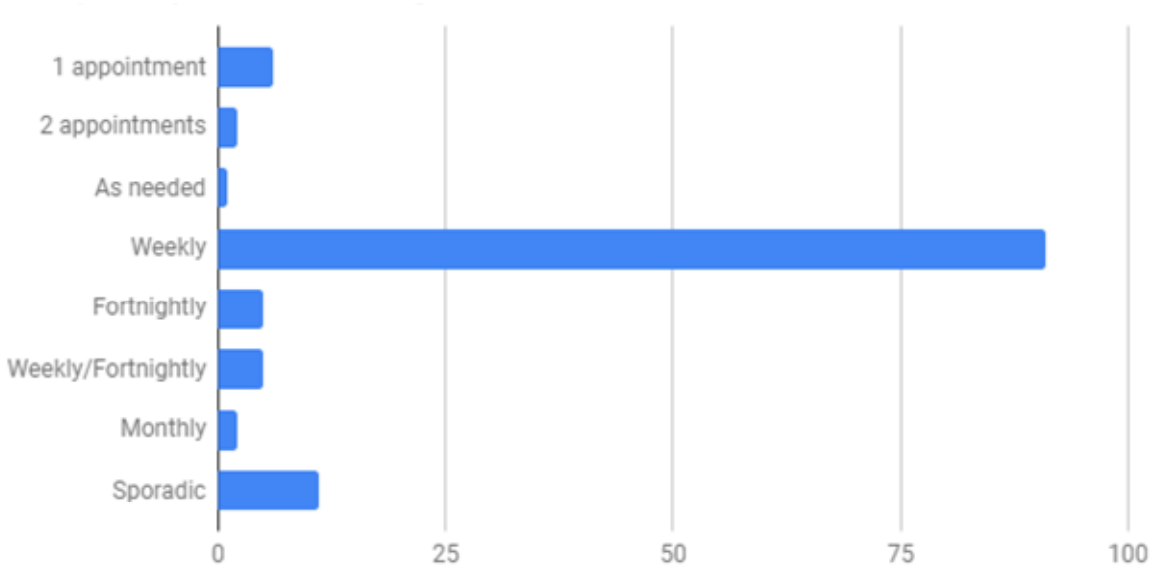

Figure 4. Frequency of young people's attendance (n=114)

[4] Child protection policy guidelines in Ireland since 1987 have placed an obligation on professionals to report concerns about child abuse to statutory authorities. This policy has been embedded in legislation with the Children First Act 2015 that places a legal obligation on designated professionals, including counsellors to report such concerns to both child welfare services (Tusla) and An Garda Siochana.

What works well?

Participants identified the strengths of the services from their perspectives as being a good working relationship and good communication with other agencies, the garda and court accompaniment service, and the helpline.

A **good working relationship and good communication with other agencies** were identified as one of the key strengths of the services and what works well at present. The key agencies referred to in this regard were Gardai and SATU units and to a lesser extent, social workers, guidance counsellors, courts services, GPs and schools "*agencies are getting together more to find out what is required for the child*" (FG02). Many professionals ring the helpline for "*advice on what to do as often the young person is begging them not to tell anyone. They want to know what has to happen next"* (FG01). On occasion this was in relation to mandatory reporting *"these professionals are terrified and afraid of getting into trouble, mandatory reporting presents major challenges*" (FS12). "*A garda might phone the RCC where they sense the young person wants to come but finds it daunting to do it themselves; the garda might accompany the young person to the centre to make an appointment*… "*they all work together to help the young person to get to the service*" (SM08). Good working relationships were seen as key for staff not to feel isolated, "*I'm not on my own, there is a multi-disciplinary team, that gives me and the client confidence"* (FG01).

According to one service manager, the forensic/medical examination can be an ordeal and the young person and their families are usually in a state of shock to find themselves in this situation. "*It helps that there is a very good relationship between the SATU unit and the local rape crisis centre, with trained SATU volunteers on call 24 hours, 7 days a week to attend with a young person as needed… They can be a support to both the young person and family members before the examination, and usually wait to see them again afterwards"* (SM03).

One service manager described how the Garda, the social worker and the school all work together to facilitate the RCC in making direct contact with the family to offer the young person an appointment (SM02). It was noted as particularly helpful when a Garda was prepared to come to the centre and interview the young person onsite which was experienced as comforting by the young person, "*this particular professional is very sensitive and manages traumatic situations well which is invaluable to the service*" (SM06).

Some centres use a key worker system whereby one key individual in the centre is the link person with outside agencies, "*The key workers system is very useful, as in links with Garda, guidance teachers, social workers and teachers. When we have a key person, it makes the continuity of care easier. Like a lot of the young people change their numbers regularly and it can be hard to keep in touch. So, if there is a link person it really helps*" (FG01). In some areas, an identified link person is also available in the Garda, "*having that*

key person in the garda, that's what's made the difference" (FG02). One service manager noted the importance of the Gardai having a named contact in the RCC, "*This increases the likelihood that the garda will contact this named person directly and this applies to other agencies as well…The garda appreciate if the young person goes to RCC, then more likely to take the case forward because the young person is getting support… the garda know by encouraging the young person to attend, it helps them in the long run"* (SM08).

Multidisciplinary and multiagency training, either that provided by RCCs or by others was seen as a way of enhancing interagency working. RCCs provide training to SATU staff and Garda which was seen as assisting with ongoing liaison. The RCCs provide input into the Garda training programme in Templemore training college and many centres keep open communication channels with their local Gardai, both offering and receiving feedback as to what is helpful or unhelpful for clients. One manager described "*inter-training between agencies*" (SM03) whereby RCC staff participate in training in SATU and SATU staff participate in training in RCC, "*It's good because this creates a personal contact between the service*" (SM03). "*We work with new Protective Services Unit a lot. We go in and talk to them and give workshops offering guidance on how to manage working with a victim following an attack. That helps build relationships and also, they can use our building to get statements from the young people. Good communication is key"* (SM10).

Several service managers referred to regular meetings with other agencies, either informally or formally. Informal meetings consisted of inviting various agencies to the centre to discuss the services offered. Formal meetings involved regular meetings between key agencies (Garda, SATU, GPs, forensic teams, state prosecutor) which may meet up to four times a year, "*It's a multi-disciplinary team…we have already put it into place that the Garda team are available to us and us to them at all times. The entire MDT* (multidisciplinary team) *come in every November for a social gathering and relationship building…these types of relationships work well for bringing in professionals to talk to the clients about reporting off the record*" (SM09). These meetings foster a sense of interagency co-operation and help to smooth out any problems that may arise in the smooth running of the various services.

The Garda and court accompaniment service was identified as a strength by a small number of services where this is available, "*Having to go to a Garda station to provide a statement can be daunting even for adults, so it can be a great support for a young person if the therapist can offer them accompaniment on the day by someone experienced and trained…Parents also feel the benefits of these services"* (SM03).

Finally, one service manager spoke of how involvement in different committees (e.g. Children and Young Persons Service Committee; CYPSC) relating to young people helped with building relationships with other agencies (SM06).

However, the data shows that some feel time was a constraint in relation to building interagency relations, "*having time to build the relationship with agencies is a challenge*"

(FG02). Others felt that if the agencies worked more closely together that they would be able to create a feedback loop which they feel would be helpful, "*More co-ordination and communication between the various services and the creation of feedback loops between the services*" (SM06). Again, others felt that the limited resources they receive can impact negatively on these interagency relationships and more resources in this area would improve these relationships, "*More awareness of our service needed. Resourced to talk/train Gardai Community involvement to raise awareness, lack of time/money to do so"* (SM12). The data indicates that staff feel that if the agencies communicated more regularly that they would become more aware of issues coming from both agencies, "*Perhaps regular meetings with Garda/legal profession to highlight issues from both sides"* (SM08).

The helpline was another aspect of the service that emerged as one of the key services that work well. The helpline was described as providing advice and support to professionals, parents and young people (often friends of those needing services). It was also described as an adjunct to counselling in terms of an additional support, particularly for clients who may have suicidal issues, "*it offers the young person support in between sessions* (FG01). Most of the initial calls to the helpline do not come from young people direct but rather from parents (particularly mothers), or friends, "*It is quite unusual in my opinion for the 15 or 16 years olds to call the helpline directly"* (FS12). Parents may be encouraged to "*come for support session*" (SM03), "(to) *find out that a child or young person has been raped or sexually assaulted, in a once off incident or continuously abused by a relative is every parent's nightmare. Typically, they are upset and terrified and frequently don't know where to turn. The National 24-hour Helpline receives many such enquiries, and directs people to services, as well as supporting them in their distress"* (SM03).

The helpline was described as "*very approachable and easy to use*" (FG01). Some participants spoke of the awareness of the helpline, "*Everyone knows the there is a helpline"* (FG01) while others spoke of the need for advertising the website, particularly in relation to young people.

The free access to the helpline was noted by many, and this was compared to other helplines where there is a charge. A limitation of the helpline identified was that records are not kept distinguishing calls in relation to young people and those in relation to adults. The system "*records number of telephone calls but does not separate out who is under 18*" (SM01). This service manager explained that it was in response to the high number of calls to the helpline that they began providing a service to young people five years previously, "*they had nowhere to go*" (SM01). Participants noted that they would like to be able to record statistics from their helpline but do not have the resources (SM06). It was noted that much family support work via the helpline is not recorded (SM04).

One young person described the importance of a dedicated helpline for young people so that they could speak to a person directly rather than being redirected to the person they needed to speak with, "*I feel like a huge thing that is like a phone number for teenagers to call. Like 24/7 and for it to be free because I know when it happened to me, my step sister sent me loads of numbers to call but like I called a few of them and they were like, amm I rang them and they were like, like it said that they were like counsellors to talk to about rape. I rang it and they were like, acting confused and they were like what do you want? And I was like, is this the number like to talk to somebody about this and they were like, 'Oh, you want a counsellor' and I was like 'yeah'. They put me on to the counsellor and the counsellor told me to make an appointment at a hospital and to ring back when I had that done*" (YP09).

The responsivity of the service was seen as being supported by the availability of a local helpline, "*we respond within a week to all messages left on our helpline and when we have resources available to, we have somebody available to take calls on the helpline. This person is not always a trained counsellor but our qualified counselling coordinator will always call them back*" (SM15).

Young people's experiences of attending the centres

The key themes identified through thematic analysis of the young people's interviews (n=16) included not wanting to attend, choice and not feeling pressured, it helps to talk, relationship with counsellor, specialist help, explaining things and coping skills.

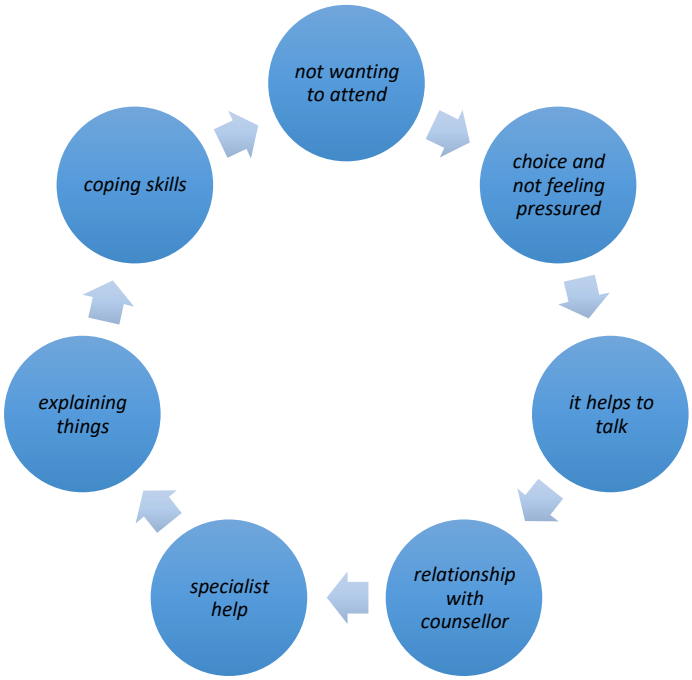

Figure 5. Themes depicting young people's experiences of attending

Not wanting to attend "I don't want to go"

Many of the young people (n=12) spoke of not wanting to attend **"***I didn't wanna come here…"* (YP14). *"oh I don't want to go!" (*YP07)

Two young people spoke of being offered counselling after their experience of abuse but refusing to attend, "*But I was just like really scared and nervous. I didn't know what to expect*." (YP04), **"***Originally after it happened, we were offered something… I was just a little kid, I didn't really want to talk to someone*" (YP12). The label of Rape Crisis Centre was off-putting for some: **"***oh, we're sending you to the Rape Crisis Centre and I was like, wait a minute!.. I was shocked"* (YP04).

The first session(s) appeared to be crucial in helping these young people overcome their reluctance to attend, "*I didn't think I needed help but then I started bottling it all up and then I agreed with my Mam that I wanted to go*" (YP06), *"And then after the first session I*

knew I needed it" (YP06); "*when I called her I was like, I am nervous and I don't know what to say so you are going to have to ask me question*" (YP16).

One young person spoke of how she battled with her parents when attending for the first time, *"And I said, I'm not getting out of the car, I just went into this state of panic... For me, talking about it makes it real…even though I had agreed to come, I was kind of back tracking on it… I remember just being so scared to be here. I just didn't want to have to be here"* (YP02).

However, this struggle continued, "*And I used to just hate the fact that I had to come here….. It wasn't the fact that I hated coming, it was I hated that I had to"* (YP02).

Choice and not feeling pressurised: "I can talk about whatever I want to talk about"

The idea of choice permeated young people's narratives (n=9). Some spoke of having a choice about whether to have their parent present, "*she gave me the option if I wanted him to stay for the rest of the hour or if I wanted him to go"* (YP02), and a choice to change counsellor if it isn't working out, "*If you don't like who you're talking to, you can change. It's not a problem*" (YP05). Some young people spoke of how the counsellors helped them understand they had choices in their lives, "*I felt trapped and she helped me understand that there were other options*" (YP01). The choice to take a break from counselling was also highlighted, "Like*, I stopped coming here for a few months, then I started again, I was ready to come back, because now I am starting to feel myself again slipping… you should be able to stop, and come back when you're ready...because, like I said, it's very tough going"* (YP02).

One young person offered advice as to how to help young people exercise their choice in counselling, "*I guess just asking them how they prefer the sessions to go, like if they would rather do the talking or they would rather listen. .. Rather than presuming... So, do you want me to just listen to you or would you kind of like me to help you work through this?"* (YP10). "*She is great, she works with me, she's like when do you want to come…. Do you want to stop, take a break, do you want to come more often, she kind of leaves it all up to me"* (YP16).

For some young people, their therapist was the one person in their lives who privileged their right to choose, "*They [family] all just had their input on what they think I should do in this situation... I did what I wanted to do and the therapist helped me with that. Just taking a step back when needed but being close enough that I could reach out if I wanted to"* (YP01). One young person highlighted the importance of having a choice in a context when choice had been taken from them, "*Whatever you want to talk about, it's up to you. It's your choice…because (Counsellor) always said you're here because you didn't have a choice. So now it's your choice what you want to talk about*" (YP02).

Young people spoke of how helpful it was not to have to talk about things they did not feel comfortable talking about, "*that was very important to me that Counsellor didn't make me feel uncomfortable or make me talk about things that I didn't want to talk about"* (YP02); "*It wasn't forced on me to talk about anything…It was more so, you lead and they'll follow"* (YP05); "*It's kind of a mixture, she kind gets me on topics, talk about stuff that happened because like I kind of avoid it as much as possible… she has to literally force me to talk to her about it, not force me but she has to keep like bringing it back, like day to day stuff with her*" (YP16).

"the girl I see in CAMHS, she told me not to talk about the rape because of the law or something. ..And then it kind of even at home with my parents, it was like, I thought I wasn't meant to talk about some stuff with them as well but in here the counsellor that I see, she told me that I can talk about whatever I want to talk about with anyone" (YP09).

Related to the theme of choice was the experience of not being pressurised. This was conveyed by young people as a relaxed approach, "*It was more relaxed, take your time… There wasn't a formula or anything"* (YP05), taking a step back, having patience and taking things slowly, "*my therapist was the only person that I had in my life at that stage who took a seat back when I was going crazy about something*" (YP01), "*They go into it a lot slower as well, like. And my therapist didn't kind of make me like explain what happened...we kind of slowly went in to what actually happened*" (YP11); *in particular whether to talk about the abuse experience… this isn't a service where you come purely to talk about what had happened to you..like it is counselling*" (YP13).

Sometimes this involved not putting pressure on the young person to talk when they did not feel able to, "*I don't think counselling is all talking, about getting everything off your chest. I think it is sometimes taking an hour, just relax and don't think about anything really. I think that's how the therapist helped me the most. She gave me that hour a week that was just like, you are not going to look at your phone, you're not going to think about this or about that, we are just going to sit and talk… when I walk in these doors that I don't feel pressure to talk about anything that I don't want to talk about or I don't feel pressure to do anything"* (YP01).

"*She's always like...it not like she forces you. She's not one of those people where you're thinking, how can I respond? Where they're asking you questions and you have to answer*" (YP07).

This extended to feeling pressurised to attend "*sometimes you think maybe young people might be coerced or forced nearly to do it by parents or guardians are like: this is what you need to do*" (YP06).

Not being put under pressure was seen as distinct for some young people who acknowledged how helpful it was to be challenged by the counsellor. For one young person, this related to the counsellor pointing out how the young person was giving away

her control, **"***Like* (Counsellor) *always said he's already taken enough from you. Don't let him take your education or everything that you've worked for. He's already taken enough from you, don't let him take any more… It was things like that that made me think, yeah, she's right, he did take a lot from me already. So yeah, I think things like that* (were helpful)…*And I think I just needed that push from* (Counsellor)" (YP02).

"...because I over-think so much…I'm kind of looking at things from a different perspective. And then it's making more sense to me, I find that really helpful…Because I already have the answers myself, just helping me getting to them" (YP13).

It helps to talk: "It makes you feel a little less heavy"

Most young people (n=14), when asked how counselling had been helpful, referred to the experience of finding it helpful to talk, of having someone other than family to talk to, seeing things from a different perspective and experiencing a relief from talking or letting things out, "*getting little things off my chest so that I can work out the bigger things*" (YP01). Talking was seen as 'opening up', 'letting go', "*Open up as much as you can because I was really reluctant at the start. But I know now, as I went on through it, it was like definitely helpful…everyone bottles everything up now so much and you're going to explode at some point. Like you can't keep it all in and that's something I learnt while being here*" (YP02). "I can't stress this enough, like, talking about just letting go of everything" (YP04); "*somebody to talk to… ahh, because I don't feel comfortable talking to people about it but in here it's like, it's what they are for. … they give you advise on how to get back to the person that you were before*" (YP09).

"…Before I actually came here, I used to barely talk …I think it happened because I came here and sort of spoke my mind, so that sort of came into everything. Like I speak a lot more openly and a lot more loudly than I used to!" (YP07); *"It's nice to like to come in and just like say stuff that on my mind, its absolutely get it all out. Like I have actually cried in here a few times because I have been so frustrated with stuff. So, it's just nice to come and just chat."* (YP15).

"just someone to talk to about what happened because I don't really feel comfortable talking to my Mum about it. I talk to my Mum about a lot of things but it just seems a bit much to talk about it, with her. I don't know. Because I always get this sense that she's upset that it happened in the first place because I'm like her baby, you know. ..and I don't really want to upset her, even though I know she would care more...I would feel bad putting that on her. And also, I don't really want to talk to my friends about it either, like it's a bit of a heavy thing to put on people. … I think that's what I find most helpful… That it kind of, not lifts your spirit, but it makes you feel a little less heavy. Like walking around isn't as hard when you're able to share your thoughts with someone else, because keeping them in all the time does get very burdensome" (YP10).

Talking was seen as helping to get a different perspective on the experience, "*it's not as scary if you have that support around you and you talk about it. It is a really big thing when you are not talking about it. But the more you talk about it, the smaller and smaller it gets and that's what you want it to be, you want it to be this tiny little thing that is in the back of your head because that is all it deserves*" (YP01), "*it was a big hole in my stomach that I had to get up at some stage. And that's what it really was like*" (YP03).

Relationship with counsellor: "we get on"

Most young people (n=13) referred to their experience of the counsellor as being very helpful, many saying this is what helped the most "*once I built that relationship with Counsellor, that was it, that was me…she really listened to me"* (YP02), "*So I feel like being listened to, I'm actually getting help"* (YP04), **"***The first therapist …she didn't really want to hear about the stuff. She was just very retraining how to think. But here they really listened which was great*" (YP08). Experiences of the counsellor/therapist included feeling listened to, supported, feeling understood, " *she understood me and she knew where I was coming from. And like, if there was a day when I was down, she'd know exactly what to say*." (YP03).

Several young people referred to having trust issues and having difficulty trusting others. Some referred to learning to trust the counsellor, *"I found that was really important for me, was to be able to trust"* (YP02); "*I've been in and out of different counselling services before for like different reasons. … So it's a lot less abrasive than any other service I've been to so I kind of…I like it a lot more then*." (YP10): "*She kind of makes an easier atmosphere sometimes…. She's just very nice*" (YP12): "*I get along with my counsellor* (name) *really well*" (YP13). "*Like you know I'm able to like talk to her more and tell her what is actually going on. Before I wasn't like that. I didn't trust people. That's why I didn't like open up with her much, but now I do like trust her*" (YP14).

The importance of the first visit and first impressions for the young person was highlighted by this young person's experience: "*But I was just so, so scared … they introduced themselves and they were just so lovely, offered me tea and biscuits…* (Counsellor) *came out and introduced herself and she was so lovely. And I knew straight away that I was in like a safe place and that they were not going to judge me and they were so lovely and caring…So I think that first half an hour with her was really important for me to build my trust with her and let her know the type of person I was and let her get to know me and me to get to know her*" (YP02). "*You just get like you start trusting a person I suppose. Yeah you start trusting a person, that's when you start opening up*" (YP14).

Specialist help

A dominant theme was reference to the specialist nature of the services the young people were attending. Many young people had attended other services either prior to attending a RCC or while attending a RCC (such as CAMHS). Most young people experienced these other services as unhelpful, either because they did not get along with the Counsellor or that they were told the Counsellor could not see them again, that they needed specialist help. While for many, they experienced the latter as unhelpful at the time, they were glad to have found a service where they felt better understood. Specialist help was seen as either specialist in terms of dealing with sexual assault or specialist in terms of dealing with young people.

Many young people described how they were referred to a RCC by another counsellor,

"*she was just outrageous…It was just we didn't get along and then, you see, when I first went to her, I hadn't gone to the Guards yet. And then the second time, I went to her I told her I went to the Guards... And then, the third time I went, she called me and my Mammy in and told me that wasn't taking me for counselling any more… It was a bit of a knockback…she said she wasn't really specialised in this sort of thing and I was better off going to the Rape Crisis Centre …It would have been so much easier if I had came here in this place*" (YP03).

"*she didn't really want to hear about the stuff…. I think when she found out about that and then the self-harm. She didn't really talk about it that much. I think she didn't want to get into that, you know*" (YP08); *"I just felt a lot worse after...Rather than the same or any better...I know you're not going to feel better after the first day,* "(YP11). When this young person went for their appointment in the RCC, **"***She just kind of got me to talk about it the first day*" (YP11). **"**We *went to a doctor and all, about it. But we weren't told. He sent us somewhere, a therapist in (town). But like, it wasn't to do with sexual abuse or anything. She was just a general counsellor, I think. We didn't find that great so I stopped going but like, we were really in need of something"* (YP11).

When asked what they found had been most helpful for them, this young person responded, "*I think the fact that it is a rape crisis, sexual abuse centre.. because it feels like I actually am going and getting help for what I need. Like if you've a problem with your eyes and you're going to your GP… if you've a problem with your eyes, you go to an eye doctor"* (YP13). Specialist help was also understood by young people as about age, "*here and CAMHS have been great because they're specialised for adolescents… My counselling at (local community service) didn't have those skills for sexual abuse. She was a child counsellor"* (YP13).

One young person spoke of how gender appeared to be treated differently in the RCC than in a previous service, which the young person found less helpful. *"There was just one or two times when I was reminded that women tend to take rape harder. Like emotionally,*

they're affected more than men. Didn't really find that where I was before and I suppose it's a bit discouraging to other men trying to come here, facing the stares in coming here. …. I just...I didn't feel one hundred per cent comfortable, with...yeah…I just... Just things like...again, just being reminded that women deal with it harder than men do…maybe if you're talking to a client, just don't talk about the gender. I think... a victim's gender, just..., I don't think that should play a part in therapy. Because at the end of the day, those people are still victims" (YP08).

One young person spoke of how going to a specialist centre rather than an individual private therapist was more helpful in terms of helping a young person feel that others are also going through counselling for these issues, **"***for children, I think it's much less intimidating in a place like this ……it doesn't feel as intimidating when you know that other people are going through services as well"* (YP13); "*Just like more confident and like if I talk about something that is really deep, she doesn't like get shocked or something about what I say whereas in CAMHS the girl that I see there, she is like, it's like, she gets upset over it in front of me. Whereas they are not like that here*" (YP09).

Explaining things to me

Many young people referred to the importance of things being explained to them. This may have been in relation to what to expect from attending the centre, helping young people understand their emotions and what they are going through, reassuring them that others also feel this way when they have had similar experiences, or preparing for legal processes.

Young people spoke of the value of the Counsellor explaining legal processes and helping them with making decisions as to whether to make a formal complaint, "*She helped me a lot with whether to or not to make a statement*" (YP01); "*(Counsellor) was just talking about this and everything that comes with it. About how, because I was under eighteen, just the point of contact, all the legal stuff that comes with counselling*" (YP02), "*even just explaining anxiety to me, that was a big thing*"(YP08).

Young people spoke of how helpful it was for Counsellors to explain how counselling would work: "*everything she said to me in that first session was how it went, really. So I think that first half an hour with her was really important for me to build my trust with her … I mean she let me know anything I wanted to know about her and the work she does, and things like that. So, that first half an hour was good*" (YP02). One young person described how on the first day the Head of the centre met with the young person and their mother **"***I was nervous but at the same time, we talked to (name), the head before we actually started going in to counselling. And she kind of explained everything*" (YP11); **"***She explains things very well and sort of makes it seem less scary… Like when I'm nervous in school, she explained it all, like the worst thing is say a teacher asks you a question and you get it wrong….*" (YP12).

"*my therapists explains why I feel certain ways and I think that's really helpful…I didn't know why I was feeling certain ways and to come in and explain why I was feeling certain ways was really helpful…I feel like I'm starting to understand why certain feeling come to me and why I feel a certain way sometimes*" (YP04).

Some young people suggested other ways of helping young people, such as focusing on how counselling might help the young person, "*maybe having to explain more like the after effects of it, because I was like how is this going to help me? But now I know that it did "*(YP02); "*I think professional telling their clients that they will come out of it, that eventually, there is a light at the end of the tunnel. That would help younger people knowing that and could prevent like suicides"* (YP07).

Another young person spoke of the need to hear from other young people who have had these experiences: *"And like, I feel like that young people don't hear enough from other young people, that like they are not the only ones out there that this has happened to. And that it is not just adults that it happens to, there are a lot of other young people too"* (YP09).

Coping Skills

More than half of the young people referred to being helped with coping (n=10) in terms of managing their own distress, becoming more self-aware, managing school or helping cope with relationships with family or friends. Several talked about how learning to cope with anxiety or distress was really helpful for them, **"**Yeah*, he was still in the year. So, for that whole year, basically what we talked about was me surviving each week, me surviving the school, me going to school…..So Counsellor was just trying to get me to cope*" (YP02).

Specific strategies included: "*I wasn't sleeping because I was so stressed, so things like getting lavender and scented things and like candles. She got me like a spray to put on my pillow*" (YP02), *she got me into journaling and recording my feelings and things. The art therapy, she got me into that there. And so many things for when I'm having a panic attack, like just to breathe, like to ground myself, like if I was in my room, put my feet on the floor…Things like listening to music. She helped me to make playlists and things like that there, of what's going to calm me down and make me happy…she made me a list of my favourite ones and ones I should watch when I'm feeling upset or like things like that there*" (YP02).

"*She taught me breathing exercises and stuff*" (YP02*). I bottled up a lot of anger because of it and she gave me this sheet about how to get your anger out. And like that really helped as well*" (YP06), "*like slowly knowing to cope with it*" (YP07); *well here they really taught me how to deal with anxiety and stuff* (YP08), **"**Just *grounding rules were a big one. And I also got a leaflet and I think it's called a panic box, or something? But it was great. I passed that on to a friend who suffers from really high anxiety too so I passed it to him too*

and it really helped him" (YP08); "*They helped me deal with my fears. I think it was my own anxiety and helped me deal with my anxiety and then, because of that, everything else kind of calmed down, (YP08) kind of just giving me...not advice, but kind of suggestions almost; or even things I could...like trying to change the way I am thinking, things like that*" (YP10), "*I was having panic attacks at night and all. And I got told how to handle them and it's helped a lot…she said, when it's only just starting, to take deep breaths in and make sure I'm concentrating on my breathing and just saying in my head: I'll be OK*" (YP11); "*I think it's put me in the right mindset to kind of get better and help myself. It's got me out doing things, so…. going out with my friends a lot more where I would have just been in my room all weekend*" (YP11); "*Like, we do the arts stuff as well. That was really nice. So that was handy like I could do whatever the hell I wanted on the page*" (YP15).

Coping skills were also relevant in helping young people deal with relationships: "*I've got a greater handle on my relationships with people… I used to take just everything on everyone. I've stopped doing that because when all comes to all, I've come to realise I'm just stressed out, the person hasn't actually done anything to me, for it to be alright for me to be forgiving, I was awful for doing that with my family, my relationship with them has changed a lot. And my Mam has changed a lot as well. We used to fight a lot and now, it's a lot better. I talk to her a lot better. I'm a lot more calm than I was before I started coming here*" (YP13).

Some young people spoke of getting help with relationships: "*I can talk about things that happened in school with friends and I'm getting help with that as well*" (YP04).; " *Like as well as what happened to me, other stuff that happened at home, she helped me with that as well…Yeah she helped me because me and my Mam didn't really get along and like she helped with that….So she also helped with a family issue as well as that*" (YP06).

What needs improvement

The areas that were seen to be in need of improvement included a better awareness of sexual violence and the services offered by the rape crisis centres; the need for specialised training to work with young people; more interagency liaison; improving access to services, particularly in rural areas but also in relation to opening hours in terms of accommodating young people at school and parents at work; clearer protocols in relation to mandatory reporting, and funding to support the development of the services, staff training, improving their facilities and therapeutic tools for working with young people; reducing the stigma for young people thus enabling them to access support; facilitating young people's need to be heard; and a concern about overreliance on volunteer services.

A limited awareness of the services offered by the RCCs was highlighted by most participants across all cohorts in this study – service managers, frontline staff, stakeholders and young people, "Most people don't even know what these services are" (FG03), "*Not advertised enough"* (FS15). One service manager noted that the RCC by its nature is a 'very secret place', so she doesn't think people understand what they do, even in other agencies (SM08). Where participants felt the service was well known, they noted that the public and professionals were not aware that they provided services to young people. Awareness of the existence of the service, how to access the service and what type of support is offered was deemed to be poor. Participants spoke of the brand of the RCC as being well established and well known, which benefits many centres. Some centres changed their name as 'rape crisis' was considered "harsh" (SM10) while others noted that removing 'rape crisis' from the title "sanitised the crime" (SM11). "*I just think a lot of younger people and older people don't know exactly what it is. And I think more people should be like taught about it, like people come into schools and give a talk about it*" (YP06); "*Like if it wasn't for my neighbour I wouldn't have known that this was here…. It's not really known*" (YP16). Interestingly, one young person noted that they see advertising for SATU but not for counselling in bar bathrooms. Several young people referred to their mother's efforts to find help for them.

Young people spoke of concerns that other professionals (school counsellors, family doctors) were not aware of the service, "*like no one told me at CAMHS about here. I'd never heard of here"* (YP13).

Some participants referred to misinformation that may inhibit families from accessing services, such as the timeframe within which to access SATU services for a forensic examination, "*This means that patients miss out on the collection of valuable forensic evidence because of poor information given out on the helpline*" (SH02).

Stakeholders, for the most part were unaware that the RCCs provided services to young people under 18. They saw RCCs as adult service providers who occasionally provided crisis support or advice to young people and families. The recently revised national Sexual Assault Treatment Unit (SATU) guidelines were referred to as recommending RCC services for psychological support of adults and Children at Risk in Ireland (CARI) services (where operational) for crisis support for those under 18 years. Some professionals in the focus groups did not regard the RCCs as child-centred in their approach, and wondered if the RCC environment was set up for young people in terms of physical space, qualifications and training of staff, and whether they appreciated the need for a systemic approach. One stakeholder noted that it may be frightening for a child to "*enter adult services, the environment might be threatening to them*" (FGSH). It was also noted that the language 'rape crisis' may be reductive for children who have been sexually abused but not raped. Some uncertainty was expressed as to whether RCCs provided services to males.

Many expressed concerns about engaging in awareness raising as they do not believe they would be able to respond to the increased demands for services this would bring (FG02), "*unless increased referrals are matched by increased resources it will be counterproductive in that we will have young people on waiting lists for months in the knowledge that when we eventually can offer them a service many will choose not to engage*" (SM06); "*it would open the flood gates and we are already over stretched…. We don't advertise the service it would become too overwhelming considering the current response to the service*" (SM13); Time to promote the service was seen as a challenge.

Suggestions for improving awareness included developing a booklet (FG02) that could be made available to schools and parents and anyone involved with young people. Young people suggested mechanisms such as social media, business cards handed out to kids, and advertising in schools. Many service managers referred to getting involved in activities for the purpose of promoting the service, speaking on radio, attending community events. Attending meetings with other agencies was seen as an opportunities to update and bring Meetings and opportunities to update and bring knowledge and awareness to both sides (SM14). A service manager that they are working on rebranding their service to accommodate young people, providing answers to common questions asked and a flow chart of what to do if a young person presents with a young person reporting sexual violence/abuse (SM04).

The need for specialised training was highlighted across the dataset, both in terms of specialist training in trauma work and specialist training to work with children and adolescents "*accreditation of therapists is important, they need specialised training to work with young people*" (SHG). Funding was identified as a major barrier in this regard, "*If we had the money, we would have it*" (FG01). A number of staff are currently pursuing training in child and adolescent counselling, although this appears to be at the initiative and cost of individual therapists. The addition of specifically qualified counsellors that work with young people was generally perceived to lead to improvements of rape/sexual assault services for young people, a "*Specific Child and Adolescent counsellor in each centre"* (FG01). It was acknowledged by both staff within the centres and external stakeholders that working with under 18s requires different training and expertise to working with adults, "*We are quite limited as we are not specifically trained to work with adolescents"* (FG01), "*There needs to be a 'complete shift in regard to the qualifications of therapist... it's systemic in terms of parenting, education. It's 'black and white when working with young people under 18 and over 18's*" (SHG), "*because young people have a very different need and this has really been highlighted since we got the Child & Adolescent counsellor*" (FG01). The limited training opportunities in Ireland for formal training in working with adolescents was noted, "*There are a lot of workshops but nothing in place for formal training for adolescents*" (SM07). The idea of specialist services for adolescents was highlighted by one young person, "*I think maybe it should be divided up into certain ages, just so that...it's not like, because I found some of the people there,*

because I talked to different people in the CAMHS. So I found some of them because they knew I was under eighteen, it was kind of a bit condescending maybe. Purely because it was like they were talking to a child. … Like you'd have some places that are set up for like sixteen to eighteen-year olds" (YP13).

Although interagency liaison was described above as one of the strengths of the services, some participants identified this as an area in need of improvement. They spoke of linking with other agencies as challenging in relation to individual cases. Some noted that time was a constraint when trying to build relationships with agencies, "*having time to build the relationship with agencies is a challenge*" (FG02), while others noted that better working relationships would enhance communication, "*More co-ordination and communication between the various services and the creation of feedback loops between the services*" (SM06). A better awareness of RCC services in other agencies was seen as needed in order to improve relationships, "*More awareness of our service needed. Resourced to talk/train gardai"* (SM12), "*Perhaps regular meetings with Garda/legal profession to highlight issues from both sides*" (SM08).

Large catchment areas for RCCs were seen as impacting on access to services *in terms of attendance,* ""*young people access to the support is limited in rural areas, hours traveling time to get to centre. Most likely a lot are not getting access to suppor*t" (FG02), although having to travel was also seen as an advantage, "*Some people like travelling for anonymity*" (FG03); "*I liked that it wasn't around where I lived because then it wouldn't be a reminder every day. So I liked that it wasn't that close to me"* (YP06). Opening times also presented a challenge, "*Limitations on times and days, the young people have to miss school to attend and can often be coming from miles away*" (FG01);

"*I guess maybe meeting times are hard because the only real time they have available for me is …. So I'll have to go home after school and the traffic and come back in where I'll have to wait around town for ages because there's just not enough people available, time slots and there's too many. So I think the only thing I would think would be more hands-on deck I suppose*" (YP10). Finding ways to help young people access services can in itself create extra work for RCC staff "*This RCC also works out the logistics of getting the young people to their sessions often scanning bus time tables extra to facilitate the young person's access as they can be travelling long distances*"(SM12). The development of outreach services in more rural areas was suggested as a way of facilitating access.

Mandatory reporting, whereby under the Children First Act 2015, designated professionals (including counsellors) are legally required to report knowledge, belief or suspicion that a child has been abused was seen as posing challenges both to young people and the professionals involved with helping the young person report, "*I went to the counsellor and it kind of like came out but they were about the legal side of it that they had to do so it didn't really stay within the room which really irritated me"* (YP16). "*Counsellors are concerned about their own obligations. …There is a fear around*

disclosure and a lot of confusion" (FG01). Some feel that crimes go unreported due to the strict procedures around mandatory reporting "*There's lots not being reported*", they feel young people shy away from services for this reason "*under 18 needing parental consent but the biggest factor in my experience as a therapist is that they would have to report*" (FS5), "*This can cause a re-traumatisation within the client"* (SM06).

Participants described anxiety on the part of other professionals who rely on therapists in the RCCs to offer advice, "*Yeah they often ask us to talk to the young person and ask us to reassure them*". "*These professionals are terrified and afraid of getting into trouble-mandatory reporting presents major challenges*" (FG01); "*I had a young person who had been through two other services although a report was not made until she came to me. There are hesitations and a lack of confidence around disclosure procedures…. It's a grey area*" (FG01). On occasion the staff member may not make the report if they know it has been done already. They check with the different agencies to confirm a report done (SM03), "*She often checks with Social worker to see if it has been reported already. Reporting forms are completed with the parents present* (SM04).

Some frustration was expressed in relation to how reports are addressed in the wider child protection and legal systems, "*lack of consistency and the time it takes when it comes to reporting is very challenging…... That is tough on them too, trying to explain where they are going. …. Not having consistency can bend the trust" (FG01).* Frontline staff expressed concerns about the lack of awareness around 'what happens next?' after a disclosure *"they don't really know what to expect". They wonder, 'going there, what is it, what are RCC going to expect of me [young person]". They really don't have any idea what is going on in RCC. 'it's quite alien to them"* (FG02).

This process is seen as complicating things for both families and therapists and putting the young person under pressure when "*they just want to get some psychological support*" (FG01); "*I am not reporting it. …The whole system annoys me….I wouldn't report because of what I was wearing"* (YP16). "*Court too. The amount of time it takes and the amount of adjournments. It's very stressful for the young people as they can be put back and prolonged by six months. And this is usually after the young people and their parents have taken time off schools and work; this is completely disregarded by the court process. It does so much damage as they feel they can't move on*" (FG01); "*Young person becomes more distressed and it spirals. Self-harm."* (FG02)

The long drawn out nature of the legal process was also experienced as frustrating for young people, Dealing with the legal system was described as frustrating for young people, "*It is a very, very long process. Especially when it comes to the garda. It's been very, very long. I got in contact with the garda in September and we were waiting on a phone call and we didn't get the phone call until the end of November. She wanted to just have a meeting first about it and that meeting didn't happen until the end of January. And now I am waiting to make a statement and so now we have to wait for another phone*

call. We don't know when that is going to be and then we have to make the statement after that so we don't know when that will happen so it is a really long process when it comes to the garda. But other than that, it is, yeah, it's good but slow (YP01).

Funding was the most commonly identified area in need of improvement "*Funding, funding, funding…*" (SM13). Additional funding would, from participants' perspectives, enable them to respond to a growing demand in their services , "*the requirement is growing all the time*" (FG01, FS09); "*we only have a little space and we can only do so much, we are constantly trying to shoehorn young people in*" (FS06) through recruiting more qualified therapists, "*more full-time posts with highly qualified therapists would benefit the service greatly*" (SM12); providing training opportunities for staff, "*funding for specialised training is key*" (FG03, FS05); improved facilities, "*better equipped buildings/environment for the service.* (SM13); and therapeutic tools for working with young people, "*materials are very expensive, figurines. Funding more tools to work with young people, no dedicated room for adolescents, it's being used for adults too*" (FG02). Some participants also pointed out that additional funding for administrative support would support the gathering and analysis of data to inform service development, "*We could also use more administrators as working with young people creates a huge a workload. We are always trying to improve services for young people*" (SM10), "*More admin would allow more community outreach and development of services. Service suffers because of lack of admin*" (SM12).

Working with young people was perceived as adding to the complexity of the workload, "*More complex because they have to meet with family. They have to explain about consent & confidentiality issues such as reporting back to parent if concerns arise"* (SM03), "*they sometimes work with schools and social workers, it's getting more and more time consuming, we need more resources*" (SM10).

More resources would improve young people's and parents/carers' access to services through providing more outreach services and extending the opening hours of the service "*that there are geographical options for accessing the service and that the young person doesn't have to miss a half day/full day in school to access the service… for flexibility for parents and work*" (SM12). Concerns were expressed about current waiting lists, "*We sometimes have to ask young people to wait two to three weeks for a service*"(FG01), which in turn impacts on staff, "*the staff find it stressful when you feel there are no services available to the client*" (FG01), and on young people, "*If a young person is waiting 3 or 4 months by the time you contact them, they often don't want to come in*" (FG02). The importance of responding to young people as soon as possible after the approach to the service is made was highlighted, "*young people are a spur of the moment*" (FG02). Feedback from young people to one service reflected that if they had to wait for even a month, they may not engage. "*I think it's our responsiveness that works so well. Other services can face a month waiting list. Once the incident has been reported to the Gardai and we have parental consent we are ready to go*" (FG01).

Stigma continues to be a challenge for young people in seeking help, according to participants, the "*fear of not being believed*" (FS11) and the "*stigma attached to sexual violence, locked into a secretfFear of what happens in the aftermath of the disclosure* (FS14). Fear and stigma were noted as reasons staff feel young people are hindered from accessing the services.

Young people's need to be listened to was an issue highlighted by both service providers and young people themselves. Service managers spoke of the importance of providing the young person with information around policies and procedures*, "they must speak to the young person before attending a service. They have to hear their voice, they must know the child wants to attend at which time they explain what to expect. It's not against their will."* (SM03); *"Any of the discussions we have had with the young person about what they need it comes up that the ongoing counselling is not what the young person want. I don't know what they want. They need to be asked, often they don't know what they want themselves. What I feel they need and want is information, I'm interested in what is going to be placed on school curriculum and how that will be delivered… we keep the client informed at all steps as we are client centred. Consistent updates are crucial to the young person"* (SM09).

There were varied responses from participants as to how services for young people should be structured. Some suggested running child and adolescent service alongside the adult services due to the level of expertise, knowledge and experience of the RCC "*The services can run alongside adult services as expertise is necessary with Government funding*" (FS14), while others acknowledged the need to tailor services specifically to young people, "*Not necessarily separate to adult services but tailored specifically to this cohort with very clear procedures and policies to support the therapeutic work. Since this sector is already under financial pressure additional funding is needed to support any expansion*" (FS17).

"*More resources are needed for extending the service so that it is accessible to all young people regardless of where they live in the County i.e. the service being County-wide. The service having a dedicated young person therapy room that is conducive to working with young people and healing the trauma*" (SM12).

While the volunteer service provided by the RCCs was identified as a strength, some concerns were noted on what was seen as an overreliance on volunteers (FG01) due to lack of funding, "*Not enough of staff due to a lack of resources. Depending on volunteers is not good enough"* (SM04). "*More funding needed. They are over stretched and under resourced. Would feel it would be a lot easier if they were not reliant on voluntary hours*" (SM12), "*need staff to work with young people, rather than volunteers so that consistency maintained* (FG02), "*A lot of volunteers move on after the two years as it is very intense work"* (FG01), "*We would like to have more staff available to support clients. We depend too much on volunteers and on people willing to work limited contract hours.*

As a result, the service can lack cohesion in many ways" (SM15), "*We need serious resources put in it*" (FG01).

The restriction on the helpline, for those available during office hours was identified as a challenge (FS13) as "*young person is in school, they can't access it. Extended hours would help them use the helpline more. After school hours, might be better*" (FG02). "*Undoubtedly, there could be improvements made to referral pathways. The National 24-Hour Helpline receives many request for information from all kinds of professionals, including doctor, social workers, therapists, school guidance counsellors etc not sure about the services available, how to make a referral or how to deal with a disclosure of abuse by a child/young person. There should be much more readily accessible information available to ensure professionals know where services are located and how to make a referral*" (SM03).

One young person spoke of the need for services in schools: "*I think that there should be, in schools… someone in schools who were trained in adolescent counselling rather than, like...my school, a community school, one of the biggest in the country and we have like four guidance counsellors. But none of them are actually trained in counselling. So even when you're in like class and for people who, like there'd be a lot of children who would have social problems in my school, it wouldn't even be an option for them to go to counselling, that would just be totally out of the picture. So even they wanted to go and talk to someone in school, people aren't actually trained. From a secondary school point of view, I think that's really like...there seriously needs to be like something in schools...There just needs to be more services for younger people. That's just the bottom line. There does need to be more services for younger people"* (YP13).

Conclusions and Recommendations

The findings presented in this report provide an overview of the 15 of 16 rape crisis centres that participated in this study. The mission statements provided by the centres show threads of commonality: the provision of a safe space and a supportive environment to those who have experienced rape and/or sexual violence and the aim to eradicate sexual violence from society. Service provision for young people in the centres includes court accompaniment, advocacy, group therapy, individual therapy and parental support with the latter being delivered both through face to face engagement and helplines. The therapeutic interventions offered to young people by the services are primarily adapted from adult models that typifies rape crises centres. The models embedded within this approach are largely client centred, with the use of CBT approaches proving to be common. This approach is closely aligned with that seen in the literature in the field of sexual abuse (MacDonald et al., 2016) and also in the literature on child and adolescent counselling in general (Patalay et al., 2016). The qualifications of therapists and volunteers across centres varied, ranging from master's degrees to those without a formal qualification although with considerable experience in the field. A process of induction and training is undertaken when new staff begin working in the centres; the length and type of induction and training varied across centres. Many participants referred to extensive engagement with continuous professional development (CPD) training opportunities to bridge the gap in providing specialised services to young people under 18 years. The majority of therapists, where information was provided, had at least 10 years experience working as a therapist and had at least 10 years experience working with young people. Most therapists were accredited with either the Irish Association for Counselling and Psychotherapy or the Irish Association for Humanistic and Integrative Psychotherapy and most were described as humanistic and/or integrative. A study of counsellors providing school based counselling in the UK found a similar profile among therapists; between 25 and 67% of school-based counsellors in the UK described themselves as representing a humanistic orientation (Cooper, 2009). Participants identified access to supportive managers, clinical and peer supervision as important supports.

Based on survey responses, from 11 centres, a total of 299 children and young people attended 11 centres between January 2017 and December 2018. A small number (8) were under 14 years with the vast majority being over 14 years. The number of children attending varied according to the size of the centre, with less than five young people seen in three centres, 15-30 young people seen in five centres and between 50 and 90 young people seen across two centres. Parents were the most common referrer (33.3%), followed by SATUs (15.8%) and self-referrals (11.5%). Where information was provided in the survey (n=131 young people), the average number of sessions attended was 30,

ranging from one session to 87 sessions. The duration of attendance ranged from once off to 39 months; the average attendance period was 6 months. Not all centres record the number of calls taken; where information was available, 54 calls were taken in relation to young people who were not already attending the centre. Most young people attended weekly. Although information was only available for 55 young people in terms of whether they attended mental health services, 30% of these young people were attending mental health services.

Key strengths of the services, as identified by participants, included good working relationships (in particular with the gardai and SATU units) and effective communication with other agencies involved in responding to young people following experiences of sexual violence (in particular, child protection services and Gardai), the availability of court accompaniment, volunteers and helplines. These identified strengths were seen as essential to ensure positive experiences for young people and continuity of care. The key worker system was identified as particularly helpful in facilitating effective communication and trust building. The data relating to Garda and court accompaniment services shows that some participants perceived these provisions to be a strength of service, however, the findings also highlight the need to develop interagency relations which can be a constraint on both time and resources. The helplines (both the national and local helplines) were seen as another key strength of the service, considered to be both responsive and easily accessible. A significant number of participants noted that the helplines operate well, offering advice and support to professionals, parents and young people. There was variance in data relating to awareness of helplines, some feeling it works well while others highlighting the need for a dedicated helpline for young people. The volunteer network was also seen as a significant strength of the centres, although some participants expressed concern about an overreliance on volunteers to deliver services. Challenges noted related to the inability of some centres to record detailed information (demographic information such as age, experience of abuse) about helpline callers. This challenge also relates to recording and maintaining robust data in relation to service delivery and is urgently in need of addressing if services are to be enabled to present reliable accurate information to funders and the public. The research team experienced first hand the challenge that collating detailed information on service delivery presented for service managers.

Young people's experiences of attending the centres is captured well in the quotes presented above. Many of the young people interviewed had initially felt that they did not want to attend the service, some had at first refused. Other studies have referred to this initial reluctance to attend therapy, noting that for young people they are often brought for therapy rather than choosing this option themselves (Foster & Hagedorn, 2014). This highlighted the importance of the first session for young people in reducing their reluctance to access services. Choice was important to the young people in this study, choice in relation to parental involvement, attendance, session structure and not

feeling pressurised to discuss certain topics, essentially going at their own pace. Young people also discussed the fact that therapy challenged them in a positive way, allowing them space to off load to someone outside their family and social networks, enabling them to gain a different perspective.

The young people spoke resoundingly of their relationship with their counsellor as the most 'helpful' aspect of their therapeutic process, in line with many studies that explore young people's experiences of therapy following sexual abuse (Allnock & Hynes, 2011) and indeed counselling and psychotherapy in general (Horvath & Bedi, 2002). Young people felt listened to, supported and understood. Some noted that they are learning to trust again. Many referred to the importance of the specialist service provided in rape crisis centres and the need for such specialist help. This is an issue not highlighted in previous research – the value placed on the specialist expertise of those working in sexual violence services. Finally, young people spoke of the value of having things explained to them, knowing what to expect when attending, learning new coping skills to deal with their distress and anxiety, managing at school, developing new understandings and getting help with managing their close relationships. Overall, these themes resonate with the best practice guidelines offered by Seshadri & Ramaswamy (2018), that therapeutic work with young people who have experienced sexual violence focus on memory work, skills training, vision for the future as well as containment and emotional regulation.

The findings of this study point to areas in need of improvement as the rape crisis centres develop their services for young people. A lack of awareness of the service was highlighted by all participants: service managers, frontline staff, stakeholders and young people. Many young people noted that the greatest challenge of accessing the service was not knowing where to go for help. When they finally made contact with the service (through parents or professional), there was little delay in being seen. Most of the stakeholders consulted were not aware that the rape crisis centres provided a service to young people under 18 other than SATU accompaniment or crisis advice. Different views were expressed in relation to branding and how the service name of 'rape crisis centre' may inhibit or facilitate access. However, there was a clear consensus that more awareness was needed as to the services provided and raising awareness about sexual violence. Funding was mentioned as a barrier to current efforts to raise awareness. Many participants also expressed concern that if they engaged in advertising their services, they would not be able to cope with ensuing demand.

Interagency liaison while seen as a strength by many was also identified as an area needing improvement. Challenges relating to time and resources were seen as barriers to effective communication between agencies. Accessibility for young people and their parents in terms of geographical location (travel time) and having to take time off school/work was seen as a challenge, particularly in centres that covered a large catchment area. Development of outreach services was seen as a practical solution to this issue. Mandatory reporting was perceived by some frontline staff as potentially

inhibiting young people from attending services by centre staff and staff reported difficulties in relation to the responsiveness of statutory agencies. This issue was not raised in the young people's interviews. Funding was the most prominent issue identified in the data in relation to what needs improvement – funding for raising awareness, funding for extending services, funding to assist with training staff, funding to improve the physical environment. In relation to how services should be structured, opinion again varied with some seeing the volunteering system as a strength and others viewing it as a weakness, with an overreliance of this service being highlighted as challenging.

Recommendations

The implications of this study suggest several recommendations for policy and practice in service provision for young people who have experienced sexual violence.

1. Comprehensive, coherent services are needed for children and young people who have experienced sexual violence in Ireland. There are a number of developments in Ireland aimed at improving services for this cohort of children and young people. Many professional participants in this study were unaware of the services provided by Rape Crisis Centres to children and young people. Given the findings of this report, the specialist services provided by Rape Crisis Centres reviewed in this study should be acknowledged as providing a useful part of the response to sexual violence against children and young people in Ireland.

It is recommended that the services provided by the Rape Crisis Centres to children and young people who have experienced sexual violence should be recognised as part of the overall response to sexual violence against children and young people in Ireland.

2. Young people in this study were very articulate in describing their experiences of accessing and attending services provided by rape crisis centres in Ireland. One of the strengths of this study is the large number of young people who agreed to be interviewed, over a relatively short timeframe (five months). Various consultation processes with young people across Europe have highlighted young people's wishes and needs to be involved in matters that concern their lives. It is no longer sufficient to consult with young people; true participation involves working with young people to develop better services.

It is recommended that, given the positive feedback offered by the young people who participated in this study, therapeutic services for this cohort (primarily adolescents) continue to be provided by rape crisis centres and that the development of such services is informed by young people themselves, in line with Tusla's (2019) child and youth participation strategy.

3. At present, there is significant variability in how the rape crisis centres describe their mission and objectives. An agreed set of standards or principles that

a) clarify the philosophical underpinnings of the service;

b) describe and agree the model of service delivery; and

c) specify a differentiated service delivery model that acknowledges the differential needs of young people, as distinct from adults

could significantly enhance awareness of the services in both public and professional contexts.

It is recommended that collaborative initiatives are undertaken by all 16 rape crisis services, to agree a common set of standards or principles that inform their service delivery to young people.

4. The explicit model of service delivery should incorporate elements of best practice identified in this report:

- The importance of developing a trusting and supportive relationship that promotes a non-judgemental, sensitive, flexible attitude to the young person and their needs;
- Respecting the autonomy and agency of the young person by offering them choices wherever possible;
- Facilitating young people to talk about their experiences and their feelings;
- Sharing specialist knowledge about sexual violence to educate young people about these experiences and how they can impact on young people;
- Helping young people develop coping skills for both their everyday life challenges and difficulties that may have arisen from their experience of abuse;
- Using techniques from TF-CBT, in particular, to assist the young person manage emotional dysregulation;
- Collaborating with parents and providing parental support and psychoeducation.

It is recommended that rape crisis centres develop guidelines for practice that draw on international best practice in this field and the findings of this study, such as focusing on developing a trusting and supportive relationship, offering the young person choice where possible, facilitating young people to talk about their experiences, educating young people about sexual violence, emotional wellbeing and relationships; assisting young people in developing coping skills for managing emotional distress; and supporting parents to support their children.

5. Protocols need to be developed to ensure that all staff who work with young people have received adequate training in this specialist area of work. Training curricula for counsellors and psychotherapists working with young people differ from those in training programmes that prepare therapists to work with adults. In particular, there is a need to focus on child development and working with the family system, including providing parental support. The challenge of managing legislative obligations under the Children First Act 2015 in the context of a therapeutic relationship with a young person also needs consideration. A comprehensive analysis of current training needs, in consultation with the main psychotherapy/counselling professional bodies and trainers could inform the development of a training plan to upskill those therapists who have undertaken professional counselling/psychotherapy training that was targeted at working therapeutically with adults. The argument for specialist training is supported by the United Nations Beijing Platform (1995).

It is recommended that the rape crisis centres conduct a needs analysis of therapists' training needs and, in collaboration with Tusla and the relevant counselling and professional accrediting bodies and trainers in Ireland, with particular reference to the recent Irish Association of Counselling and Psychotherapy (2019) standards, develop a training plan that addresses the optimum and most cost efficient manner of upskilling and training therapists to work with young people who have experienced sexual violence.

6. Protocols for interagency working need to be developed, drawing on the successful experiences of many rape crisis centres where such interagency work is working well. Introducing a key worker system, regular meetings with key referring agencies, providing specialist training to professionals and co-delivery of training are some of the activities identified by participants in this study that enhanced interagency relationships.

It is recommended that drawing on the experiences of several centres, protocols for interagency referral pathways and models of working be developed to ensure optimal and consistent service experiences for young people. This should include initiatives that involve collaboration in multidisciplinary training.

7. Little mention of individuals with disabilities, other than mental health disabilities, was made by participants in this study. It is unclear whether the rape crisis centres provide services to young people who may experience disability other than mental health difficulties. Centres may need to consider how to facilitate access to their services by people with a range of disabilities and if necessary, upskills their staff or provide specialist training to staff in services that are accessible for these individuals.

It is recommended that rape crisis centres consider how their provision of services to young people could be made as inclusive as possible for those with disabilities or more 'hard to reach' members of our community.

8. In addition to an agreed mission statement and objectives statement, an information leaflet/app/website describing the services offered as individually tailored, drawing on evidence-based techniques and interventions, privileging the therapeutic relationship and person-centred approach while drawing on a range of evidence-informed interventions and techniques where and when appropriate. It is important that such material would emphasise the flexibility and inclusivity of the services offered, as this appears to have been experienced as particularly helpful for the young people interviewed in this study and was also valued by service managers and staff members. Information on mandatory reporting should be included in such materials.

It is recommended that rape crisis centres develop service user friendly information resources, in a range of language and formats, that describe the range of services offered and emphasise the flexibility and inclusivity of services.

9. The findings of this study support the need for additional resources to be made available to rape crisis centres, in particular to a) raise awareness of the services; b) provide training and continuous professional development to existing staff; c) develop record keeping systems that capture the breadth and depth of the work conducted (which in itself is needed to build a business case for additional funding); d) extend the helpline to provide a differentiated helpine for young people with youth friendly access points/ tools (Apps); and e) facilitate improved interagency working. Service managers spoke of services as considerably over-stretched, notwithstanding the priority they give to young people to ensure there is no delay in offering an appointment. The challenges experienced by the research team in completing this study also highlight the difficulty in responding to the demands of the data collection process.

It is recommended that Tusla consider the findings from this study and ascertain mechanisms for improving resources in rape crisis centres to facilitate service delivery to young people (counselling, helpline, volunteer and administrative services), service promotion, staff training and interagency working.

10. While a number of the rape crisis centres surveyed in this study use a standard database for recording and maintaining records of service delivery, other centres did not appear to collect such data on a regular basis and thus experienced considerable difficulty accessing reliable information for the purpose of this study, in particular

pertaining to clients attending the service. In the absence of such reliable data it is difficult to ascertain with any degree of confidence the extent of service delivery to young people under 18 across all 16 rape crisis centres and thus, the needs of centres in providing comprehensive responses to this population.

It is recommended that the rape crisis centres and their funding agency, Tusla, give consideration to the importance of developing standard mechanisms and tools for recording data in relation to service provision across all rape crises centres in Ireland, taking account of General Data Protection Regulation (GDPR) legislation and best practice recommendations for maintaining client records.

11. Awareness of sexual violence and awareness of where and how to access support for those who have experienced sexual violence continues to be a challenge in Irish society. Despite the publicity surrounding sexual abuse scandals and the increased availability of support services during the past two decades, families continue to struggle to find help and professionals continue to be unaware of the range of services available. A publicity/awareness raising campaign specifically addressing child sexual abuse/sexual violence against children and young people is long overdue in Ireland. Notwithstanding the pressure this would inevitably bring to services that are already overstretched, a commitment to preventing or eradicating child abuse and neglect, as articulated in child protection legislation in Ireland and the recent ratification of the Istanbul convention, is meaningless without a comprehensive public awareness campaign. Such a campaign would need to target both professional communities and the public, both adults and young people

It is recommended that Tusla, in collaboration with other relevant stakeholders give consideration to calling for a public awareness campaign on sexual violence against children that aims to assist in the identification of sexual violence against children and provides information about youth service provision.

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