



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

# COSC

## *Sex Abuse Treatment and Prevention Service*

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In relation to Q5, Nota Ireland are actively promoting the introduction of the “Stop it Now” campaign in the Republic. As this campaign has already been implemented in the North it would be worth considering how the excellent materials and resources of “Stop it Now” could be utilised further to contribute to prevention and to the process of dispelling myths and changing social attitudes. However, the availability of accessible services for those who have perpetrated sexual abuse and those who are at risk of abusing is essential in the “Stop it Now” campaign is widely implemented.

In relation to Q19 it is therefore of interest that the emphasis in the paper is on perpetrators within the criminal justice system. The reality is that the vast majority of those who perpetrates sexual abuse never reach the courts, particularly when we take into account the number of adolescents and children with sexually harmful behaviour. It is also of note that the U.K. is not the norm in Europe where there tends to be an inquisitorial rather than an adversarial approach taken in dealing with child sexual abuse cases, and an emphasis on the need for treatment for all, not just those prosecuted. To this end Nota Ireland supports a Public Health Approach in relation to the prevention of sexual abuse, with the implementation of publicity campaigns, such as “Stop it Now” being backed up by assessment and treatment of all those who pose a risk of sexual violence to others, both convicted and unconvicted. There is a difference in emphasis however in who should take the lead in the provision of assessment and treatment services. Nota Ireland see the context for assessment and treatment as being best located in the broad base of public health service provision, while being integrated with criminal justice services. The current system in the Netherlands provides a good model for this where national assessment and treatment services for all perpetrators, be they adult, adolescent or child convicted or unconvicted is provided by ‘De Wag’ , an integrated Health and Justice service.

There is therefore a lack of emphasis in the consultation paper on the role of Health Services in the provision of treatment as an integral aspect of child protection policies. The work of the programme for the Prevention of Sexual Abuse is not noted in the paper other than in reference to the delivery of the P.B.N.I. community based treatment programme outside of Belfast being through a partnership with the Sperrin Lakeland Trust (3.58), and the work of the P.P.S.A. with individual partners of perpetrators. The experience of those working within Health Services is that many perpetrators of sexual abuse who are not prosecuted can be motivated to engage in treatment, particularly when there is a Child Protection Mandate. Decisions in relation to access to children are informed by the results of assessments of risk carried out on perpetrators and decisions on the eventual re-integration of families are also informed by assessments of progress and treatment.

The significance of risk assessment of men who have not been convicted and of establishing the effectiveness of community treatment is reflected in the work of a current CAWT administered cross-border research project, T.I.S.O. (See appendix for details).

In summary in response to Q19 I would suggest that the benefits of assessment and treatment of all perpetrators being provided within the context of public health service provision, through integrated delivery agreed by the D.H.S.S.P.S. and the P.B.N.I. should be considered. The cost effectiveness of such an approach is evident when the relatively small number of perpetrators in the community is considered. It also allows for the pooling of the expertise already available in the area in order to ensure greater public protection. It acknowledges the role of the Health Services in relation to adolescence and children with sexually harmful behaviour who will never reach the criminal justice system but to whom there is a duty of care. Experience on the ground in other jurisdictions and in some centres in the U.K. have evidence that convicted and unconvicted perpetrators can be successfully treated together, ensuring more effective use of resources.

In Part 2 Prevention, “Breaking the Cycle of Sexual Violence”, the role of the D.H.S.S.P.S. in decision making in relation to contact between perpetrators and children is unclear. The role of Social Services in intervening and monitoring in families where sexual abuse has occurred is also not explicit. The role of Social Work in the re-integration of families is also not explicit. There is huge potential for the further development of protocols between the P.B.N.I., the P.S.N.I. and the D.H.S.S.P.S. to facilitate the follow-up and treatment of newly

released prisoners, as many of these will already be known to the D.H.S.S.P.S. Social Work Services.

Consideration should also be given to the development of circles of support and accountability in which trained and vetted volunteers help perpetrators (both convicted and unconvicted) reintegrate into their communities and also monitor for dangerous behaviour.

Finally, in Part 4: “Support, Q33, Q34, I would suggest that consideration should be given to the importance of those working directly with victims/survivors receiving training in relation to perpetrators of sexual abuse and vice-versa.

General training in the dynamics of sexual abuse from both the victim and perpetrator perspective is essential for all those working in what is the two sides of the one coin of the tragedy of sexual abuse.

Thank you for your consideration of these views.

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**Chair, Nota Ireland**