



# The Right to Recover

Therapeutic services for children  
& young people following sexual abuse

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An overview of provision in the West of Scotland

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The content of this report is the work of the authors alone.

# The Right to Recover:

## Key Points and Recommendations

### Introduction

This report looks at what currently happens for children who have already been sexually abused to help them overcome the problems arising from it, and to prevent them from suffering long term harm.

It reports the findings of research which aimed to investigate first, how the emotional needs of children and young people are assessed following disclosure or discovery of sexual abuse, and second, the availability of services when children need help to recover. Its focus is on the West of Scotland, an area which includes 17 local authorities and contains 51% of the Scottish child population aged 18 years and under.

A mapping exercise and survey of services was undertaken, together with facilitated discussion groups with professionals including social workers, police officers, child and adolescent mental health services (CAMHS) practitioners, paediatricians and other health professionals, all conducted during summer and autumn 2016.

Included in the study are all services which offer ongoing face to face therapeutic support or intervention to children and/or young people who have experienced sexual abuse. This includes services for children up to and including the age of 18, who:

- have experienced any form of sexual abuse, including child sexual exploitation;
- have been identified as at risk of sexual abuse/exploitation;
- have displayed sexually worrying or harmful behaviour.

This includes both 'specialist' services, those which have developed a specialism in sexual abuse, and which devote either all, or a substantial proportion, of their time to this; and 'generalist' services, those which help children with a range of difficulties and adversities, and where recovery from sexual abuse is a part of what they do, and may not necessarily involve a substantial proportion of their time.

### The Child's Pathway after Disclosure

- There is currently no standard expert assessment of emotional and mental health provided to children 18 years and under following disclosure of sexual abuse and no routine follow up in the months and years following sexual abuse.
- Readily accessible advice, support and treatment for non-abusing parents and carers is essential to enable them to support their child's recovery, and constitutes early intervention for the child.
- Resources for carer work are concentrated within services designed for the most vulnerable children and young people, and in services which take a holistic whole family assessment of the child.
- Pathways to specialist help for children with child protection concerns are clear, however practice varies between areas.
- There is no clear pathway for children who do not have ongoing child protection concerns.
- Where local services exist, some of the barriers to referring children to services include professionals' lack of knowledge of available services, issues around the assessment of suitability and timing, complex referral processes and resource pressures.

### The Child's Access to Help

- A total of 39 services in the West of Scotland provide face to face therapeutic support to children following sexual abuse; this includes 21 specialist and 18 generalist services.
- The majority of these offer long term open-ended support tailored to each child's specific needs, and include outreach work.
- The 21 specialist services are small, with an average therapeutic staff resource of 1.5FTE for face to face work. The vast majority do not have sufficient capacity to meet demand, which means in most areas children cannot access immediate support.
- Most specialist service provision for children under 18 is offered by adult-focused sexual violence and survivor organisations.
- Of the 21 specialist services, 8 provide a service tailored specifically for children which offers open access (i.e. eligibility is not restricted to 'high tariff' cases).
- Local access to specialist help is best for the secondary school age group: 11 out of 17 West of Scotland local authority areas have provision for the 12 year + age group, and 14 out of 17 have provision for the 13 year+ age group.
- Just 6 out of 17 local authority areas have provision for the primary school age group.
- In only 2 out of 17 local authority areas can children aged 5 and under and their non-abusing parent/carers access a local specialist service.
- Services with staff dedicated to the work of engaging with highly vulnerable children at risk of/experiencing child sexual exploitation do not exist in most areas.
- Total therapeutic staff numbers dedicated to work with children with disabilities in the West of Scotland area as a whole comprises two posts (1.5 FTE in total).

### Funding and Sustainability

- The majority of specialist and generalist provision is in the third sector and is dependent upon short term, fragmented and insecure sources of funding.
- In over half of the third sector services (56%, 14 out of 25) the main source of funding is due to end in 2018 or before.
- The ethics of accepting children for intensive long-term support and treatment in circumstances in which the security and sustainability of the service is in doubt was raised by practitioners in both the statutory and third sectors.
- Where specialist services have one major source of funding, The Scottish Government and Trusts & Foundations are the most common major funders.
- A Scotland-wide mapping study of post-sexual abuse services conducted in 2008 found there was no consistent or coordinated approach to provision in Scotland and the services which existed were unable to meet demand.
- While the Scottish Government and some key Trusts and Foundations have aligned funding with national priorities around sexual abuse, this has not been sufficient to change the overall picture of patchy and insecure service provision. The broad picture remains the same as in 2008.



## Recommendations

1. Following a disclosure of sexual abuse, *every child* should receive an expert assessment of their emotional and mental health needs and, in line with Getting It Right For Every Child, this should consider the support needs of the child's non-abusing parents and carers (see point 3).

The expert assessment and the standards around this should be developed, preceded by discussion of who should be involved in developing these, at which point in time the assessment should be undertaken, who should undertake the assessment, and associated training needs.

2. Because the impact of abuse may not be evident immediately, there should be *routine follow up of each child* at set points, to review changes in their needs over time. The evidence base indicates this is necessary, as for a range of reasons, the full impact of abuse often does not affect a child until a later developmental stage, when they are able to understand what has happened to them.

The model for this process could be the assessment and routine follow up which occurs (in some areas) whenever a child is hospitalised following an incident of self-harm.

3. *Standard information, advice and support* should be available to non-abusing parents and carers following disclosure so that they are equipped to know and understand how their child is likely to be feeling and behaving, and are able to make sense of and respond supportively. A named point of contact for any queries or help down the line should be made available to them.<sup>1</sup>

4. In every local area there should be an integrated therapeutic care pathway for children following disclosure of sexual abuse. This could be specific to sexual abuse, or integrated into a broader local care pathway for children's emotional and mental health needs.

5. Strategic coordinated action at national, regional and local level is needed to ensure that, wherever a child lives, they have access to the right help, in the right place, at the right time from specialist children's services after sexual abuse. Detailed planning work is required giving attention to the following gaps:
  - services for younger children (under 12s) with a particular focus on care-giving relationships;
  - child-focused services for older children (12 years +);
  - tailored provision for disabled children, including learning disability and communication difficulties;
  - Child sexual exploitation: services able to do the arduous, persistent work needed to engage with children identified as at risk, working with police and social work;
  - Intensive therapeutic services for the most vulnerable children.
6. Central collation, routine updating, and dissemination of information about available services to the multi-agency professionals who need this.
7. This mapping of service provision, including provision for harmful sexual behaviour, should be carried out for the rest of Scotland, to complete the national picture. It is vital that this includes a thorough exploration of the role of specialist CAMH services throughout Scotland in supporting children who have experienced sexual abuse, as the Scottish Government has identified this as the main vehicle for improving access to support services for sexually abused children.
8. Improvements in data recording, collation and reporting by agencies and services about child sexual abuse should be undertaken. The Scottish Government should investigate how to fill the gaps in knowledge about the population prevalence and incidence of child sexual abuse in Scotland and maximise the potential of existing data sources to help our understanding of the nature of child sexual abuse and the contexts in which it takes place.

<sup>1</sup> The role of the named person could be considered here.

# Introduction

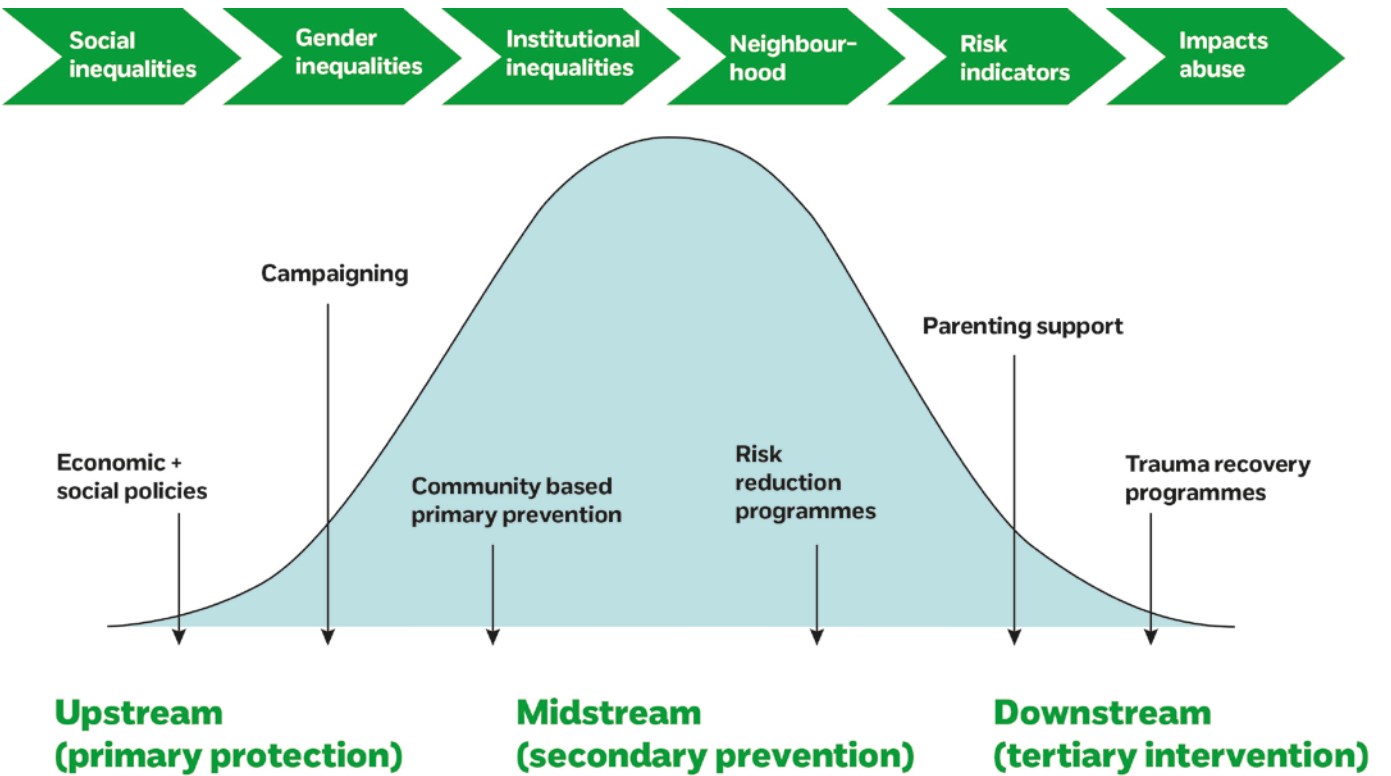
Therapeutic support can help rebuild the lives of children and young people who have been sexually abused. By providing children with the opportunity to safely express and manage their feelings, therapeutic work can help them to understand and move on from difficult experiences. The response of non-abusing parents and carers is critical to children's recovery, and our service provision must also reflect this.

Such are the barriers to disclosure; very few children tell about experiences of sexual abuse during childhood. As few as 1 in 8 children are estimated to come to the attention of statutory agencies.<sup>2</sup> Those children whose abuse does come to light are therefore the 'tip of the iceberg' of a much larger number who are sexually abused whilst growing up. For these children, young people and families we have the chance to act, and to

prevent problems developing or enduring in adulthood, at substantial cost to the individual and society.<sup>3</sup>

It is important to state that sexual abuse, like all forms of violence, is a preventable social problem that can be and must be addressed by society as a whole.<sup>4,5,6</sup> While this report focuses on the tertiary level of prevention, after abuse has taken place, it is crucially important that this is seen as *one part* of a systems-wide co-ordinated public health approach to prevention which looks at everyone's role in eliminating abusive sexual behaviour. It must be well coordinated because we know that effective primary and secondary prevention work, such as school-based interventions, can lead to more disclosures by children; we have an ethical responsibility to ensure the capacity is there to provide appropriate responsive help where and when it is needed.

Figure 1. A Public Health Approach to Prevention



Source: Taylor, J. (2010) Physical abuse in high risk families. London: NSPCC p.12. Adapted from Public Health Model of Diabetes Control (2001) and Tropical Disease Research Centre (2010).

<sup>2</sup> Children's Commissioner for England (2015) Protecting children from harm: a critical assessment of child sexual abuse in the family network in England and priorities for action. London: Children's Commissioner for England.

<sup>3</sup> Saied-Tessier, A., (2014) Estimating the costs of child sexual abuse in the UK. London: NSPCC.

<sup>4</sup> Brown, J., (2011) Child sexual abuse a public health challenge. London: NSPCC. <https://www.nspcc.org.uk/globalassets/documents/research-reports/sexual-abuse--public-health-challenge-evidence-review.pdf>

<sup>5</sup> Brown, J. and Saied-Tessier, A., (2015) Preventing child sexual abuse towards a national strategy for England. London: NSPCC <https://www.nspcc.org.uk/globalassets/documents/research-reports/preventing-child-sexual-abuse-towards-a-national-strategy.pdf>

<sup>6</sup> Nelson, S.,(2016) Tackling child sexual abuse. Radical approaches to prevention, protection and support. Bristol: Policy Press.



This report looks at what currently happens for children who have already been sexually abused to help them cope with and overcome the problems arising from it, and to prevent them from suffering long term harm.

The focus is on the West of Scotland, an area which includes 17 local authorities, and contains 51% of the child population aged 18 years and under – in total over half a million children and young people (562,000).

It is concerned with two main things:

Firstly, to explore how children and young people's emotional needs are assessed following disclosure or discovery of sexual abuse; including the needs of their non-abusing parent or carer;

Secondly, to provide an overview of the available service provision for children who need help following an experience or experiences of sexual abuse.

These are services which offer *ongoing face to face* therapeutic support or intervention to children and/ or young people, who have experienced sexual abuse, at any point in their childhood. This includes specialist and generalist services for children up to and including the age of 18, who:

- have experienced any form of sexual abuse, including child sexual exploitation;
- have been identified as being at *risk of* sexual abuse/ exploitation;
- have displayed sexually worrying or harmful behaviour.

As part of the focus on prevention, the report considers the provision of specialist services for children who exhibit worrying or harmful sexual behaviour (HSB).

Some CSA services also offer interventions for HSB. This is because of the risk posed to other children and young people, and also because there can be, and often is, a link between CSA and HSB (although it must be strongly emphasised that not all children who present with HSB have been sexually abused and, correspondingly, not all children who have experienced sexual abuse exhibit HSB). One of the largest investigations into the profile of children and young people displaying HSB in the UK found that two-thirds had experienced some kind(s)

of abuse or trauma, while around half had experienced sexual abuse.<sup>7</sup> A recent study of children and young people accessing an NSPCC HSB service found lower levels of disclosed CSA but underlined an association between HSB and broader experiences of trauma and/ or abuse. The children receiving a service presented with a range of emotional, behavioural and peer-related difficulties alongside their HSB.<sup>8</sup>

Throughout the remainder of this report, for ease of reading, the term 'child' is used to refer to all children and young people aged 18 and under, and the term parent/ carer refers to non-abusing parents, including foster carers.

### Definition of sexual abuse

How child sexual abuse is defined varies between organisations, governments and administrations. Scottish Government National Guidance for Child Protection (2014) defines sexual abuse as:

*...any act that involves the child in an activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical **contact**, including penetrative or non-penetrative acts. They may include **non-contact** activities, such as involving children in looking at, or in the production of indecent images or in watching sexual activities, using sexual language towards a child or encouraging a child to behave in sexually inappropriate way.*

This broad definition encompasses the many different contexts and situations in which sexual abuse occurs. This includes within the child's family, circle or community; peer to peer abuse perpetrated by other children, including within teenage intimate relationships. It includes sexual abuse and exploitation conducted online, a new platform for abuse both by peers and adults which includes, for example, causing or coercing a child to watch a sexual act, and grooming a child online.<sup>9</sup> Child sexual exploitation (CSE) is a type of abuse which is recognised as taking a variety of different forms and takes

<sup>7</sup> Hackett, S., Phillips, J., Masson, H., and Balfe, M. (2013) Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review* 22(4): 232-245.

<sup>8</sup> Hollis, V. (2017) The profile of the children and young people accessing an NSPCC service for harmful sexual behaviour. London: NSPCC. <https://www.nspcc.org.uk/globalassets/documents/research-reports/the-profile-of-the-children-and-young-people-accessing-an-nspcc-service-for-harmful-sexual-behaviour-summary-report-regular-text-version.pdf>

<sup>9</sup> The legal definition of sexual offences is set out in the Sexual Offences (Scotland) Act 2009 <http://www.legislation.gov.uk/asp/2009/9/contents>, section 52 of the Civic Government (Scotland) Act 1982 (c. 45) (taking and distribution of indecent images of children); and section 9 of the Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005 (asp 9) (paying for sexual services of a child).

place in a variety of contexts including organised crime. The Scottish Government definition of CSE is:<sup>10</sup>

*...a form of child sexual abuse in which a person(s), of any age takes advantage of a power imbalance to force or entice a child into engaging in sexual activity in return for something received by the child and/or those perpetrating or facilitating the abuse. As with other forms of child sexual abuse, the presence of perceived consent does not undermine the abusive nature of the act.*

Explicit in these definitions is the misuse of power. Kitzinger (1988) has argued:

*If we are to tackle the roots of child sex abuse we have to think about the position of children in society. Perhaps the first step is to change the terms of the debate by replacing the concept of 'vulnerability' with terms such as 'oppression' or 'powerlessness' and by replacing restrictive notions of 'protecting' with liberating notions of 'empowering'.<sup>11</sup>*

The social position of children involves not only their reliance upon adults for all of their basic material and emotional needs, but subordination to adult authority, a relationship often reproduced in dynamics between older and younger children. Additionally, inequality between the sexes and therefore the social position of women, and not only children, shapes the context for sexual abuse. Globally CSA is recognised as a form of gendered violence rooted in sexual inequality.<sup>12,13</sup> Evidence overwhelmingly points to child sexual abuse as a problem affecting a significant minority of the population, both female and male, but with a higher prevalence (2–3 times higher) amongst females.<sup>14</sup> Over 90% of all sexual abuse is perpetrated by males, with around one third involving physical force. Approximately two thirds of CSA is extra-familial, with young people's intimate partner relationships, and therefore socialised gender relationships, forming a key context.<sup>15</sup>

## Methodology

The information presented comes from a mapping exercise and survey of services, and facilitated discussion groups held with professionals including social workers, police officers, child and adolescent mental health services (CAMHS) practitioners, paediatricians and other health professionals, all conducted during summer and autumn 2016. All information relates to the time of data collection. A full description of the methodology is included as Appendix 1.

A companion report to this, *The Right to Recover: Voices of Professionals*, explores in greater depth the experiences of professionals who support children following disclosure of sexual abuse.<sup>16</sup>

For consistency and continuity, this mapping and survey of services is based on the method and approach of the 2008 and 2015 studies of post-CSA services in the UK commissioned by the NSPCC and undertaken by the University of Bedfordshire.<sup>16,17</sup> The definitions, parameters and data gathering tool are based on these previous studies, and any key differences are noted below.

## Definitions and terminology

In this report the term 'specialist service' refers to services which have developed a specialism working with children in relation to either sexual abuse, or worrying or harmful sexual behaviour. These are services which spend a substantial proportion, or indeed all of their working time providing a service to children who have experienced sexual abuse, or who present HSB. These can be adult or child-specific services.

The term 'generalist service' refers to services which help children with a range of types of difficulties and adversities. These services undertake work with children, who have experienced sexual abuse, or present HSB, but it is a part of what they do, and they do not necessarily spend a substantial proportion of their time doing so. Again, these can be adult or child-specific services.

<sup>10</sup> Scottish Government (2016) Child Sexual Exploitation. Definition and Summary. Edinburgh: Scottish Government. <http://www.gov.scot/Resource/0050/00508567.pdf> [Accessed 20/09/2017].

<sup>11</sup> Kitzinger, J. (1988). *Defending innocence: ideologies of childhood*. *Feminist Review* 28, pp. 77–87.

<sup>12</sup> UN Declaration on the Elimination of Violence Against Women (DVAW), General Assembly resolution 48/104, UN Doc. A/RES/48/104, 20 December 1993

<sup>13</sup> World Health Organisation (2016) Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneva, Switzerland: World Health Organisation. <http://apps.who.int/iris/bitstream/10665/252276/1/9789241511537-eng.pdf?ua=1>

<sup>14</sup> The ratio of boys: girls amongst children affected varies according to the age of the child at the time of the abuse. It is smaller amongst very young children, and increases thereafter, with the highest ratio of girls to boys during the teenage years.

<sup>15</sup> Radford, L., Corral, S., Bradley C. et al. (2011) *Child abuse and neglect in the UK today*. London: NSPCC.

<sup>16</sup> This is available at <https://www.nspcc.org.uk/globalassets/documents/research-reports/right-to-recover-sexual-abuse-voice-professionals.pdf>

<sup>17</sup> Stafford, A., Morgan-Klein, N. Kelly, S. et al. (2009) *Mapping therapeutic services to children and young people who have been sexually abused*. Services in Scotland. Edinburgh: University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection.

The meaning of the term ‘therapeutic’ differs between disciplines. In the absence of a common language, services were invited to define their own approach to providing therapeutic help. This study did not presume what a child or young person needs, pre-define what constitutes ‘therapeutic’, or what it means to ‘recover.’ The only inclusion criterion was for ongoing face to face work to be undertaken with children who had experienced or were at risk of CSA, or who presented with HSB.

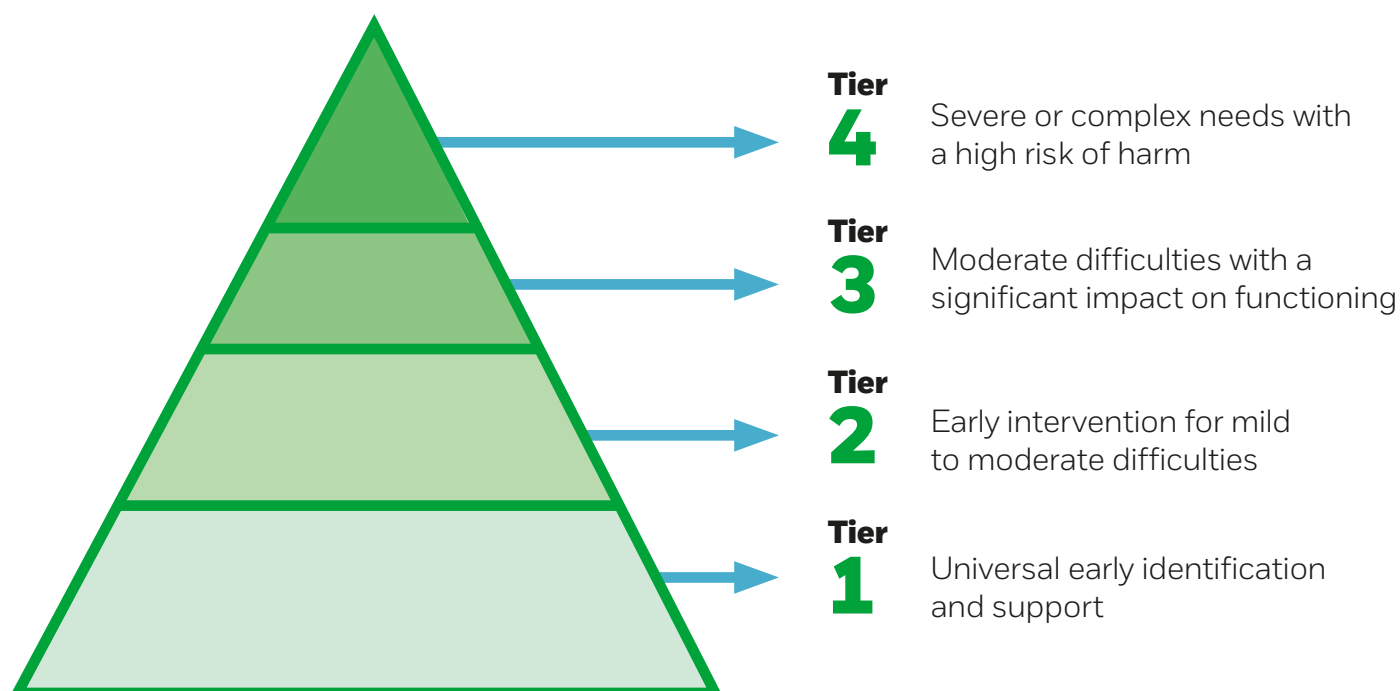
The terminology of a tiered or stepped care model of service provision is used to describe services. This model originates within healthcare but is lesser used in social care. The model is represented pictorially in **Figure 2**; with each ‘Step’ or ‘Tier’ relating to the severity of difficulties experienced:

- Tier 1 services involve early identification and support and are the responsibility of universal services;

- Tier 2 services have a role in early intervention for children showing ‘mild to moderate’ difficulties;
- Tier 3 services support children with moderate to severe difficulties, at a level which is affecting day to day functioning, including participation in education;
- Tier 4 services help children with severe or complex needs including those with a high risk of harm.

Services at Tier 1 and 2 tend to provide universal or open access. Access to services at Tier 3 and particularly at Tier 4 is typically restricted, in line with criteria embedded within the referral process. Tier 4 services are usually statutory sector social work or health interventions and in this context are mainly provided to children where there are child protection concerns.

**Figure 2. Stepped care or ‘tiered’ model of service provision**



<sup>7</sup> Hackett, S., Phillips, J., Masson, H., and Balfe, M. (2013) Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review* 22(4): 232-245.

<sup>8</sup> Hollis, V. (2017) The profile of the children and young people accessing an NSPCC service for harmful sexual behaviour. London: NSPCC. <https://www.nspcc.org.uk/globalassets/documents/research-reports/the-profile-of-the-children-and-young-people-accessing-an-nspcc-service-for-harmful-sexual-behaviour.-summary-report-regular-text-version.pdf>

## Parameters

- NHS Child & Adolescent Mental Health Services (CAMHS) are not included in this report. CAMHS may be involved in supporting children and families who have experienced sexual abuse. However the structures, referral criteria and referral processes of CAMHS vary widely in Scotland and few services engaged with this study.<sup>19</sup> The role of specialist CAMHS within the overall picture of service provision for children with experience of sexual abuse is considered separately in Part Six.
- A range of children's services may, in the course of their work, suspect or receive disclosures of sexual abuse and provide responsive help. There are well-evidence associations, for example, between domestic abuse and experiences of sexual abuse, and of alcohol or substance misuse as a coping strategy by young people who have had sexually abusive experiences.<sup>20,21</sup> Other services such as street work with young people, sexual health services and youth offending are also likely to come in contact with children at risk of, or who have experienced sexual abuse (including CSE). However reluctantly, for capacity reasons, these types of services are excluded from this study. The only exceptions to this were identified HSB services situated within youth justice.
- Statutory and third sector services are included in this report, but not private sector services. The report therefore includes social enterprises and voluntary organisations, but excludes for-profit enterprises and freelancers.
- The focus of this report is on *services*. However it must be acknowledged that a very wide range of health and social work professionals, including LAAC nurses, sexual health staff and area team social workers also support children affected by sexual abuse as part of their practice.
- The report provides an overview of service provision. It is not an evaluation of services, and cannot comment on children's experiences of services.<sup>22</sup>

- The report does not consider the accredited training and qualifications of workers within the services identified as this was not a main focus of the mapping survey. NHS Education Scotland (NES) undertook a national survey focused on knowledge and skills, in parallel to this mapping work, to inform the development of the Transforming Psychological Trauma Framework which sets out the generic knowledge, skills and competencies required for all trauma informed and trauma specific practice, including trauma arising from sexual abuse.<sup>23</sup>

A difficulty faced in analysing data on service provision is the lack of Scottish data on the prevalence and incidence of CSA, at both a national and local area level.<sup>24</sup> The only existing source of population prevalence data for CSA is UK-wide. The best available source of information on the incidence of child sexual abuse is police recorded crime data. However this is limited in value because of the under-reporting of sexual offences, but also because data on reported sexual offences against children cannot be routinely disaggregated by age and sex of victim (and perpetrator). Because of these major gaps in data for Scotland, the analysis of children's access to specialist services in Part Three focuses on the general child population, and asks, 'If a child resident in a West of Scotland local authority seeks help following sexual abuse, would they be able to access a specialist service in their own area?'

## The impact of child sexual abuse

It should be acknowledged at the outset that not all children need a specialised service following an experience of sexual abuse. Some are able to make sense of and 'self-manage' their experiences, particularly when they have the support of a non-abusing parent, foster parent, or a trusted adult in their life. Work with these carers is absolutely essential to support the recovery of the child and the report considers how services meet their needs.<sup>25</sup> It has been estimated that anything between 20% and 40% of children who have experienced sexual

<sup>19</sup> Murphy, R., (2016) Child and Adolescent Mental Health – Trends and Issues. SPICe Briefing 28 August 2016, Edinburgh, The Scottish Parliament.

<sup>20</sup> Saied-Tessier, A. (2014) Estimating the costs of child sexual abuse in the UK. London: NSPCC. <https://www.nspcc.org.uk/globalassets/documents/research-reports/estimating-costs-child-sexual-abuse-uk.pdf>

<sup>21</sup> Nelson, S. and Hampson, S. (2008) Yes you can! Working with survivors of childhood sexual abuse, 2nd edition. Edinburgh: Scottish Government. <http://www.gov.scot/Publications/2008/04/07143029/0>

<sup>22</sup> A UK-wide study of children's experiences of post-CSA services, Learning from the Experts, is presently being undertaken by the University of Bedfordshire with funding from the Economic and Social Research Council and the NSPCC.

<sup>23</sup> NHS Education Scotland. (2017) Transforming psychological trauma: A knowledge and skills framework for the Scottish workforce. Edinburgh: NHS Education Scotland.

<sup>24</sup> Radford, L., Dodd, S., Barter, C. et al. (2017) The abuse of children in care in Scotland: a research review. Preston: University of Central Lancashire. <https://www.childabuseinquiry.scot/media/1210/prevalence-of-abuse-in-scotland-executive-summary-professor-lorraine-radford.pdf>

<sup>25</sup> Furnivall, J & Grant, E (2014) *Trauma sensitive practice with children in care*. Insight, vol. 27, vol. 27, Glasgow.

abuse do not develop psychological problems<sup>26</sup>. Its impact will be mediated by a range of individual factors (such as the age of the child, interpersonal and emotional competence, and external attribution of blame), systemic factors (such as being believed by adults, support from family and wider social environment), the nature and frequency of the abuse, and the relationship between victim and abuser<sup>27</sup>.

None the less the impact of childhood sexual abuse can make itself evident at any stage, including into adulthood, and a majority of children do need help.<sup>28,29</sup>

While children and young people may experience physical symptoms of the abuse, it is more often than not the emotional and psychological consequences which have the greatest impact on young people especially when their abuse remains undisclosed or uncovered.<sup>30</sup>

Children and young people who have been sexually abused often struggle with strong feelings of guilt, shame, betrayal and fear, and these are often the feelings which prevent a child from making a disclosure.<sup>31</sup> If these feelings are not addressed they can have a range of negative implications for mental health which may include depression, eating disorders, post- traumatic stress and difficulties coping with emotions and stress.<sup>32,33</sup>

Most harmful is the complex trauma that can result from prolonged and repeated abuse, caused by a figure of trust. For children on the verge of care, or who enter the care system, chronic neglect and abuse is likely to have become the norm of life, and sexual abuse one of multiple adverse incidents and experiences, both a symptom and a result of an enduring absence of good enough caregiving and protection.

For some children the point at which they need to access (or return to) support may be further down the line, when they hit a particular developmental stage. The response to sexual abuse needs to accommodate this, which is why consultation from specialist services is so vital.

The response must also address the whole continuum of needs following sexual abuse, from emotional support and reassurance to intensive trauma recovery.

### Structure of the report

A historical overview of service development is presented in **Part One**.

**Part Two** explores children's pathways to therapeutic support after abuse.

**Part Three** presents an overview of service provision in the West of Scotland and looks in detail at specialist services, asking:

- What help is available to a child, depending on their age and where they live?
- Do children have to wait for help?
- How do services manage waiting times?

**Part Four** considers the approach services take to supporting non-abusing parents/carers

**Part Five** explores what kind of therapeutic help is available to children and looks at:

- What happens before therapeutic work begins?
- Modes of intervention
- What are the occupations of those who deliver help?
- For how long do children receive help?
- Where and when do children receive help?

**Part Six** looks at the landscape of service provision including funding and the role of statutory Child and Adolescent Mental Health Services.

**Part Seven** discusses the key issues and makes recommendations.

<sup>26</sup> Finkelhor et al, (1990) Early and long term effects of child sexual abuse: An update. *Professional Psychology: Research and Practice*, 21, 325-330.

<sup>27</sup> Domhardt, M., Manzer, A., Fegert, J. M., and Goldbeck, L. (2015) Resilience in survivors of child sexual abuse: A systematic review of the literature. *Trauma, Violence, & Abuse*, 16(4), pp.476-493

<sup>28</sup> Allnock, D. and Hynes, P., (2012) Therapeutic services for sexually abused children and young people. Scoping the evidence base. London: NSPCC.

<sup>29</sup> Forbes, F. et al. (2003) *Early intervention service for non-abusing parents of victims of child sexual abuse*. *British Journal of Psychiatry* 183: 66-72.

<sup>30</sup> Goodyear-Brown, P.(ed.) (2012) *Handbook of child sexual abuse: identification, assessment and treatment*. Hoboken, New Jersey: Wiley.

<sup>31</sup> *Out in the Open*, Ouaine Bain and Maureen Sanders' guide for young people who have been sexually abused, published by Virago in 1990, remains one of the most useful and accessible explorations of children's feelings following abuse.

<sup>32</sup> Allnock, D. et al, (2009) *Sexual abuse and therapeutic services for children and young people. The gap between provision and need*. London: NSPCC.

<sup>33</sup> Allnock, D. and Hynes, P., (2012) *Therapeutic services for sexually abused children and young people. Scoping the evidence base*. London: NSPCC.



# 1: Origins and Development of Services

In the early 1980s the sexual abuse of children within the family had only recently been “discovered” as a social problem requiring a response. As awareness grew, it was gradually added as a category to the reasons for referral and for registration within child protection processes in Scotland and England. Throughout the decade sexual crime against children was an increasing cause for concern by statutory and voluntary agencies. In the West of Scotland, registrations of children on Strathclyde Regional Council’s child abuse register for sexual abuse increased sharply while registrations for other reasons were static.<sup>37,38</sup>

While the focus was on prevention and protection, little help was available for children who had been abused. Speaking to a ‘Children in Scotland conference’ on child sexual abuse held in Edinburgh in 1992, The Right Honourable Lord Justice Elizabeth Butler Sloss, who had chaired the Cleveland child sex abuse Inquiry, highlighted the poor provision of therapeutic services for children following sexual abuse, when she observed:

*“We must not assume we have done our duty when we find that a child has been abused. There is a whole lot more that needs to be done ...children who have been sexually abused need a great deal of help and the therapeutic work available for children who have experienced it is patchy, inadequate and haphazard.”<sup>39,40</sup>*

Seventeen years later there had been no significant improvement in provision. A mapping of provision in Scotland in 2008 found:<sup>41</sup>

- There was no consistent or coordinated effort to assess the need for therapeutic support for sexually abused children and young people;
- Low or no priority is accorded to child sexual abuse from commissioners of specialist children’s services;
- Fragmented and insecure funding is the norm for specialist therapeutic services, which exist mostly in the independent and third sector.

## The beginnings of services

To understand current service provision in the West of Scotland it is helpful to consider how services for sexually abused children first began to develop in the region. The impetus for this came from three inter-linked and contemporaneous developments:<sup>42</sup>

- Feminist activism around sexual violence against women (‘second wave’ feminism) which led from the mid-1970s to the creation in Glasgow of Rape Crisis, Women’s Aid and incest survivors’ groups;
- Social work departments and NHS paediatric and child mental health services beginning to recognise and form a statutory response to CSA;
- Initiatives taken by children’s charities, including the RSSPCC (now Children 1st) which was in the process of adjusting to the development of child protection as a statutory responsibility.<sup>43</sup>

<sup>34</sup> The existence of sexual abuse was rarely acknowledged in the 1950s and 1960s, it has been argued because to do so would have involved challenging the authority of fathers within households See Stafford, A. & Vincent, S., (2008) Safeguarding and protecting children and young people, Dunedin, Edinburgh, pp11-12.

<sup>35</sup> Parallels have been drawn with the issue of physical abuse which, in the early 1970s, was the subject of a relatively limited, but gathering, level of awareness. Still, J., (1985) Child sexual abuse within the family. A report to the Winston Churchill Memorial Trust (NSPCC archive).

<sup>36</sup> The system of child abuse registers (now child protection registers) maintained by local authorities was introduced following the 1973 inquiry into the death of Maria Colwell. The Scottish Office issued guidance to local authorities on establishing these systems in 1975. Ten years later Government issued guidance to local authorities circa1985-86 recommending that child sexual abuse be introduced as a criterion for child abuse registration, although individual local authorities had already begun to adopt this practice. The NSPCC added child sexual abuse within the family to its own remit, set out in its original 1886 Royal Charter, in 1984.

<sup>37</sup> Finlay, C. (1989) *Child sexual abuse: present knowledge* in Stone, F. (Ed.) Child abuse: the Scottish experience, London: British Agency for Adoption and Fostering, pp 33-42. Finlay cites figures for the year Dec 1985-Dec 1986, when registrations for CSA rose by 11%, from 54 to 114 and CSA as a share of all registrations increased from 7.5% to 12.6%.

<sup>38</sup> Between 1987-1990, 25% of the 6,000 child abuse investigations by Strathclyde Regional Council concerned sexual abuse, and cases involving sexual assaults of children by their carers or siblings increased five-fold. Strathclyde Regional Council Social Work Department (1990) Final evaluation of Women’s Support Project, Urban Project No 534/83, Report by Supervising Officer, para 1.1 (b). Archive of the Women’s Support Project, Glasgow Women’s Library.

<sup>39</sup> Lord Justice Elizabeth Butler Sloss chaired the Cleveland Inquiry. In 1992 she spoke at a national conference on the lessons for Scotland from Cleveland and Orkney, organised by Children in Scotland and the RSSPCC, which was held in Edinburgh. Professor Asquith, S. (Ed.) (1993) Protecting children. Cleveland to Orkney: more lessons to learn? Edinburgh: Children in Scotland and HMSO.p.59.

<sup>40</sup> Edinburgh University carried out the Scottish end of a UK-wide study led by Debra Allnock of the University of Bedfordshire, and commissioned and published by NSPCC <http://www.nspcc.org.uk/services-and-resources/research-and-resources/sexual-abuse-therapeutic-services-gap-provision-need/>

<sup>41</sup> Stafford, A., Morgan-Klein, N., Kelly, S., (2009) Mapping therapeutic services to children and young people who have been sexually abused. Services in Scotland. Edinburgh: University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection.

<sup>42</sup> Allnock, D. (2009) Sexual abuse and therapeutic services for children and young people. The gap between provision and need. London: NSPCC p.6.

<sup>43</sup> Child protection became the responsibility of the new social work departments established in local authorities in the early 1970s following enactment of the 1968 Social Work (Scotland) Act.



During the 1980s with referrals for sexual abuse rising, the first steps were taken in the West of Scotland to develop a multi-agency response to CSA. The Scottish Office, Greater Glasgow Health Board and Strathclyde Regional Council began commissioning and funding sexual abuse services specifically designed for children and families in the West of Scotland. These included the multidisciplinary national specialist centre run by the RSSPCC (the Overnewton Centre), which was a source of consultancy to local authorities throughout Scotland, and the first NCH Action for Children sexual abuse service, both in Glasgow.<sup>44</sup>

A Child Sexual Abuse Group was formed within the Department for Child and Family Psychiatry at Yorkhill Hospital, and Strathclyde Social Work Department and the hospital authorities launched the *Yorkhill Initiative*, seeking a purpose built unit at the hospital for the examination and interview of children suspected to have been sexually abused. The Social Work Department and Strathclyde Police worked together on a pilot scheme in the North West of Glasgow, centred upon the hospital.<sup>45</sup>

The Women's Support Project was created by Glasgow Rape Crisis in 1983. It brought the experience of child sexual abuse (CSA) acquired by both Rape Crisis and Incest Survivors Groups into the world of statutory child protection, in an effort to shape the statutory service response through a new kind of partnership, bridging the voluntary and statutory sectors.

A dedicated national phone service for children, Childline, was created in 1986 as a direct response to child sexual abuse and its first Scottish base was opened in Glasgow in 1990.<sup>46</sup>

In summary the 1980s and early 1990s saw a growing interest and activity in developing a therapeutic and a criminal justice response to CSA tailored to the specific needs of children.

Recently this interest and activity has been revived as a series of high profile cases and inquiries into the sexual exploitation of children and historic sexual abuse have helped re-focus political attention on these problems across the UK. In Scotland this has produced a number of strategic national initiatives.

- A National CSE Working Group has been created, an updated National Action Plan to prevent and tackle CSE published<sup>46</sup>, a sub-group of the Chairs of Child Protection Committees established to oversee implementation, and a national mapping of CSE resources undertaken.<sup>48</sup>
- The Public Inquiry into Historic Child Abuse in Scotland began in October 2015 and commenced public evidence hearing in May 2017. The Inquiry is hearing evidence about abuse of any type which occurred in care settings (including health and education establishments) up until 31 December 2014.
- Equally Safe<sup>49</sup>, a national strategy for the prevention and eradication of violence against women and girls has been established by the Scottish Government (2014) and a national action plan is being implemented.
- Stop to Listen a national initiative led by Children 1st aims to improve and develop the local multi-agency response to child sexual abuse and exploitation, working with four local authority partners.
- The Scottish Football Association is the latest national institution to establish an independent inquiry into non-recent child sexual abuse, following disclosures which have raised awareness of boys as victims of sexual abuse (2017).
- A National Action Plan on internet safety has been published (2017).<sup>50</sup>

The main focus today, as in the 1980s, is on prevention and early intervention. However sexual abuse is happening now, and the response must also include making sure that therapeutic services are available for children who need them in the present.

Article 39 of the United Nations Convention on the Rights of the Child (UNCRC) is concerned with the rehabilitation of child victims. It makes governments accountable for:

*Providing children who have been neglected, abused or exploited special help to physically and psychologically recover and reintegrate into society. Particular attention should be paid to restoring the health, self-respect and dignity of the child.*

<sup>44</sup> Notably it was the Scottish Office department responsible for health rather than social work (which fell under Education) which took the initiative in funding this specialist children's service.

<sup>45</sup> Stone, F. (Ed.) (1989) *Child abuse: the Scottish experience* (London: BAAF), Postscript, p.83.

<sup>46</sup> The Glasgow base was created thanks to the generosity of Clydebank group Wet Wet Wet, who donated the proceeds from their 1988 single, *With a little help from my friends*.

<sup>47</sup> Scottish Government (2016) *Scotland's national action plan to prevent and tackle child sexual exploitation*. <http://www.gov.scot/Publications/2016/03/4765>

<sup>48</sup> Fotopoulou, M., (2016) *Mapping of child sexual exploitation resources across Scotland*. Stirling: WithScotland.

<sup>49</sup> <http://www.gov.scot/Publications/2014/06/7483/0>

<sup>50</sup> <http://www.gov.scot/Publications/2017/04/1061/0>

The UN Committee on the Rights of the Child periodically monitors and reviews the performance of countries in meeting their obligations under UNCRC. This includes the UK, which became a signatory in 1991. In 2008 and again in 2016 the UN Committee drew attention to shortcomings in provision under Article 39 and asked the UK and devolved governments to take action to address the gaps by providing comprehensive access to services “for recovery, counselling and other forms of reintegration in all parts of the country.”<sup>51,52</sup>

The UNCRC is the foundation for Scotland’s national approach to prevention and early intervention *Getting It Right For Every Child* (GIRFEC).<sup>53</sup> GIRFEC brings a focus on child wellbeing and makes this the shared responsibility of all professionals who are tasked with identifying needs early. Since 2014 all public authorities in Scotland, including health and social care partnerships, local authorities and health boards must report to the Scottish Government every three years on their progress in implementing the UNCRC, including Article 39, as part of the 2014 Children and Young People’s Act.

While the Act places new reporting duties on local agencies, this survey of therapeutic service provision in the West of Scotland also coincides with a period in which improvements to both the justice and health response to victims of sexual abuse are being considered nationally:

- The Evidence and Procedure Review led by Lord Carloway has looked at modernising trial procedures for children and vulnerable witnesses.<sup>54,55</sup>
- Forensic medical services for child and adult victims of sexual crime were subject to a recent strategic review by HM Inspector of Constabulary in Scotland (HMICS).<sup>56</sup> This highlighted the inadequate and, in some respects, unacceptable nature of this provision.

HMICS has recommended:

*It is vital that the work being led by Justice in relation to the improving the support for child witnesses in court, is joined up with the work the National Network Board and the Managed Clinical Networks are doing to improve the forensic medical examinations of children.*<sup>57</sup>

In response, the Scottish Government’s Chief Medical Officer has established a national taskforce to undertake a strategic overview of provision of forensic medical services to victims of sexual crime. This met for the first time in April 2017 to set a work programme which encompasses both adult and paediatric (child) services.

Although it looks at just one part of Scotland, this report provides a missing piece of the jigsaw in terms of a joined-up child-focused response: an overview of existing services that provide ongoing face to face therapeutic support to children following sexual abuse.

<sup>51</sup> The comments were made as part of the Committee’s Concluding Remarks on the record of the UK Governments, in 2008, the date the UK’s record on implementation was last examined. See <http://www.togetherscotland.org.uk/about-childrens-rights/monitoring-the-uncrc/>

<sup>52</sup> [http://www.togetherscotland.org.uk/pdfs/Concluding\\_Observations\\_2016\\_FINAL.pdf](http://www.togetherscotland.org.uk/pdfs/Concluding_Observations_2016_FINAL.pdf)

<sup>53</sup> <http://www.gov.scot/Topics/People/Young-People/gettingitright/publications/uncrc-girfec-report>

<sup>54</sup> Scottish Court Service (2015) Evidence and Procedure Review Report <http://www.scotcourts.gov.uk/docs/default-source/aboutscs/reports-and-data/reports-data/evidence-and-procedure-full-report---publication-version-pdf.pdf?sfvrsn=2>

<sup>55</sup> Scottish Courts and Tribunals Service (2016) Evidence and Procedure Review: Next Steps <http://www.scotcourts.gov.uk/docs/default-source/SCS-Communications/evidence-and-procedure-report---next-steps---february-2016.pdf?sfvrsn=2>

<sup>56</sup> HM Inspectorate of Constabulary in Scotland (2017) Strategic overview of provision of forensic medical services to victims of sexual crime. Edinburgh: HMICS. [www.hmics.org.uk](http://www.hmics.org.uk)

<sup>57</sup> Ibid.

## Development of services

### Key points:

- Reported cases of child sexual abuse in the West of Scotland escalated during the 1980s.
- Specialist services for sexually abused children grew out of feminist activism around sexual violence in the 1970s, the activity of statutory agencies, and initiatives by children's charities, including the creation of Childline.
- The provision of therapeutic services for children was criticised in 1992, after the Cleveland and Orkney inquiries, for being 'patchy, inadequate and haphazard.'
- A mapping study in 2008 found there was still no consistent or coordinated approach to provision in Scotland and the services which existed were unable to meet demand.
- The UNCRC places a duty on governments to provide 'special help' to children to enable them to recover psychologically and physically after abuse.
- Interest and activity around a therapeutic and criminal justice response to child sexual abuse has been re-energised following a series of high profile cases and inquiries, and there are currently a number of important strategic Scottish Government initiatives focused on sexual abuse.
- This mapping study aims to provide a missing part of the jigsaw in terms of developing a 'joined-up child-focused therapeutic response to child sexual abuse.

## 2: The child's journey after disclosure – pathways to recovery services

Sexual abuse represents a fundamental violation of the child's right to physical integrity and to be protected from abuse and harm. There is a continuum of sexual abuse, and the services discussed in this report see children who have endured a range of types of incidents, acts and experiences, both 'contact' and 'non-contact' in nature, and which can be physically and emotionally as well as sexually abusive. Children may have experienced a single incident or pattern of incidents/repeat victimisation over a long period of time. It may for some children be an isolated incident, or for others part of a complex picture of enduring adversity and neglect.

Children's responses to sexual abuse can also differ. For example, the existence of protective factors, such as, the presence of a consistent and supportive adult can help to explain why some children are able to cope with adverse life experiences such as sexual abuse better than others.<sup>58</sup> However as with children it is normal for adults to react in different ways to disclosures of abuse and this can therefore significantly impact their ability to support their child effectively.

A study by the Child Sexual Abuse within the Edinburgh CAMHS service found high levels of psychopathological symptoms in non-abusing parents/carers of children who disclose sexual abuse, indicating the need for readily accessible support and treatment for them as a form of early intervention for the child. While not all children who have been sexually abused will require therapeutic support it is likely that their parents/carers will require at the very least some level of basic emotional and practical support to come to terms with the disclosure and to help them support the needs of their child.

Many professionals within the discussion groups echoed the imperative of carer support. A carer's emotional wellbeing – in relation to how they cope with the trauma of sexual abuse and respond to their child's emotional need – is understood by professionals to be a critical factor in child's therapeutic recovery; ensuring that carers are supported and thus considered a core aspect of responding to children's emotional wellbeing needs following sexual abuse.

*"There is some research where-a lot of time you can almost track the child's trajectory by how the parents are coping, because of the level of containment and support".*

(Health Discussion Group)

Health professionals regarded information and support for the non-abusing parent/carer from the very earliest stages following abuse, where they specifically felt to lack information about the potential emotional impact on the child, in the immediate longer term at key developmental stages. The group felt strongly that support for carers should form part of a holistic response to children who have experienced abuse, where the needs of child and the non-abusing parent/carer are considered in the round.

Support for the parents/ carers, often the foster carers, of children experiencing trauma and abuse was stressed repeatedly by CAMHS professionals in discussion groups. Whilst a 'naïve' interpretation of what traumatised children need (a loving carer) is not helpful, at the same time professionals pointed to the imperative of fully supporting and equipping carers in their vital role:

*"...how to support foster carers to look after –or who the alternative care givers-to look after these children: is the key. We all know that children with trauma and attachment difficulties are the very hardest to love and they ask for love in the most unlovable ways...they need as stable as possible caregivers-or if they can stay with their original family – lots and lots of support for those caregivers"*

(CAMHS Discussion Group).

Assessing the child's emotional wellbeing and mental health needs, as well as assessing how their non-abusing parent/carer(s) are coping is therefore a crucial step to identifying support needs and generating referrals to appropriate support services. A child-centred assessment is always needed and the responsibility for doing this almost always rests with social work.

<sup>58</sup> Scottish Government (2012) Getting it right practice briefing: Resilience matrix [Accessed 20/09/2017].

## The roles and views of professionals

A range of professionals are involved in a child's journey following disclosure/reporting of concerns around sexual abuse. This part of the report draws wholly upon the insights gained through facilitated discussions with some different professional groups.

The intention behind discussion groups was to explore the issue of therapeutic support for children, from the point of view of different professional groups who work closely with children, at different points in their journey following sexual abuse. Broadly, the discussion sought to explore and understand: how children's emotional health needs are currently assessed following sexual abuse; how children are currently referred to therapeutic support where this is required; different professional roles and processes in the assessment and referral of children and young people; different professional's knowledge of and views about local therapeutic service provision. The discussions also gave consideration of the specific support needs of non-abusing parents/carers.

Child protection processes are referred to throughout this section, but are not intended as a detailed step by step account of the child protection response to sexual abuse.

Professionals across discussion groups presented a fragmented picture of how the emotional needs of children are assessed following sexual abuse. Indeed, it is not clear if, how and when the emotional needs of children are routinely assessed.

They also described the extreme turmoil which families often face after disclosure, especially in cases of familial abuse, and the highly complex nature of the work in engaging with families around child sexual abuse:

*"We see a lot of young people that have made a disclosure and it rips the family apart, and they are left feeling not believed. A lot of the time they are not believed, no way did that happen: that's really damaging for emotional wellbeing and their mental health. A lot of them, although they are all individuals, they have very similar stories: "I wasn't believed; I told my mum and she said "no, that didn't happen", so I told my gran, and she said "don't you dare say that again". You can almost see the horror to the family: how do we deal with that?"*

(Health Discussion Group)

Reported concerns or allegations of sexual abuse require a multi-agency decision making body (an initial referral discussion, or IRD<sup>59</sup>) to convene to assess the immediate safety of the child and the level of future risk, and to determine whether or not to proceed to under child protection procedures.

This multi-agency group of professionals, involving police, social work and paediatricians should be held at the earliest opportunity following referral. It acts as an information sharing forum for the child whom there are concerns regarding sexual abuse. Relevant information will also be gathered and shared about any siblings, child, young person or adults who are closely linked to the child.

At this stage important decisions will be made including: whether there is assessed to be any need for further action; whether or not there is need for a joint investigative interview and/or; whether the circumstances of the disclose forensic medical examination is required.<sup>60</sup>

<sup>59</sup> Professionals across discussion groups referred to IRD as the multi-agency forum where information gathered from all appropriate agencies involved with a child/family will be discussed between key agencies, to inform a shared assessment of the level of risk to a child and determine how to proceed. Whilst CP guidance at local authority level outlines protocols/ processes around IRD, there is no direct reference to IRD in National Child Protection Guidance.

<sup>60</sup> If greater than 7 days post-assault or abuse, it is unlikely a child protection CSA examination would take place.

From the professional discussion groups it is clear that which core agencies are involved at this initial stage varies between local authority areas. While social work and police are almost always jointly involved and are responsible for deciding whether a joint investigation is required, the inclusion of professional representatives from health and education is not routine in all areas.

*“IRD takes place between police and social work in the vast majority of cases. Health is only involved if it is relevant. When you are looking at a family dynamic it may be there as a health dimension”.*

(Police Discussion Group)

Regardless of variation in local processes, any decisions at this stage should be carried out in consultation with health services and any other agencies relevant to the child and their family.

The assessment of each child's situation at this stage generally results in two broad groups of children:

- Children where there are ongoing child protection concerns, requiring social work involvement; some children may already be known to social work or have an allocated social worker. In these cases a social worker will be responsible for assessing the emotional and mental health needs of the child and their family and referring to therapeutic help, as appropriate, as part of their continued involvement.
- Children assessed as having no ongoing child protection concerns, and therefore not in need of social work involvement. This group may commonly include children where the perpetrator is outside of the child's circle of trust, for example rape or sexual assault by a peer or stranger, and where parents are assessed to have the capacity to support the child.

Following this point the therapeutic pathways are different for these two groups of children and their families. The therapeutic pathway is clearer for children and families where concerns are progressed through child protection processes, as social work are clearly responsible for all of the ‘aftercare’ in these cases.

It is also important to point out that whilst all children experiencing child sexual abuse should be coming to the attention of social work through the process of IRD, some professionals were concerned that IRD may be less likely to take place in cases of non-familial abuse.

*“Even getting them (children experiencing non-familial sexual assault) to IRD is difficult, so even having the multi-agency discussion is difficult when it's a non-family member (who is perpetrator). Or not someone in a position of trust, because they sit out-with the public protection, it's not familial, so it doesn't come here. It's CID, its uniform, it's someone else, so Police will deal with that on their own. There's a shift towards a wider safe guarding issue but again it's a come and go, which team or teams will accept that. So there's different practice”.*

(Health Discussion Group)

### Children with on-going social work involvement

There was strong consensus across discussion groups that social workers are the key professionals leading on the assessment and referral of children to therapeutic support, where this is indicated, in child protection cases.

Assessment of a child's emotional wellbeing is described by some social workers not as a ‘formal’ one off event but a process based on liaison and discussion with a range of professionals most closely involved with the child, as well as the child themselves wherever possible:

*“As social work you are reliant on hearing from everyone else that has a role with the child. You need to speak to all others around the child to see how they are coping: foster carer, teacher etc. They know the child much better than we do”.*

Whilst assessment can be informed by other agencies, however, the responsibility for assessment and referral of a child to therapeutic intervention is overwhelmingly the responsibility of social work.



*"I would say that assessment is informed by other agencies- but 9 times out of 10 the reality though, it is going to be the social worker that takes that on-does the referral-initiates the discussion around it".*

*(both quotes Social Work Discussion Group 1)*

Social workers appear to have the primary role in the assessment and referral of children for support, even in the very small number of cases where children undergo forensic examination. According to a Consultation Paediatrician, the focus of forensic examination is on the physical assessment of the child and on evidence gathering. A baseline assessment of the child's physical needs will be carried out at this point, as well as an automatic assessment for neglect. The paediatrician then makes a detailed report detailing the findings of the examination, which is submitted to police and social work, and with parental consent, the G.P. At this stage, the allocated social worker takes over to deal with any on-going needs, includes any wider support needs and referral for therapeutic input, if necessary.

Similarly, whilst police often have a great deal of early contact with children and families affected by child sexual abuse, in all reported cases, and many have input in identifying potential emotional needs, police stressed that in general social work is responsible for all of the after care of the child by way of referral to other services.

CAMHS professionals also acknowledge social works key role, but query whether staff involved in the referral of children to therapeutic services routinely have the skills and confidence to assess children in relation to sexual abuse and trauma:

*"Part of the difficulty is the referrer-usually social work-don't feel skilled enough to do things like routine enquiry or ask about psychological functioning, like for example traditional symptoms like flashbacks".*

*(CAMHS Discussion Group)*

Discussions with social workers indicate that, while there are variations in social work practice between different local authority areas, the broad picture is one which:

- The standard general assessment of each child which is conducted by social workers tends to present generic information about wellbeing, for example, on a child's progress at school. Some social workers indicated that only if an individual social worker is 'very emotion focused' will an assessment of the child's emotional wellbeing pull through in the report
- There is no 'set standard' for assessing a child's emotional wellbeing with regards to the impact of sexual abuse, nor any standardised tool used to assess the child's emotional needs.
- There does not appear to be a direct role for health in undertaking assessment.

### **Children about whom there are no child protection concerns**

The therapeutic pathway is less clear for children who fall into the second category (no child protection concerns), where there may be a police only investigation with no on-going social work role. While the assumption is that parent/carers will be the main support for these children, it is unclear what advice and support, if any is made available to their families, to help them support the child.

Health professionals expressed concern for this group of children, regarding how assessment and referral of children to therapeutic services would be managed, which was echoed in the police discussion group.

*"There are a lot of police only investigations that social work aren't involved in, especially for stranger abuse where it is not familial; so where is the support network here. These children are being treated very differently".*

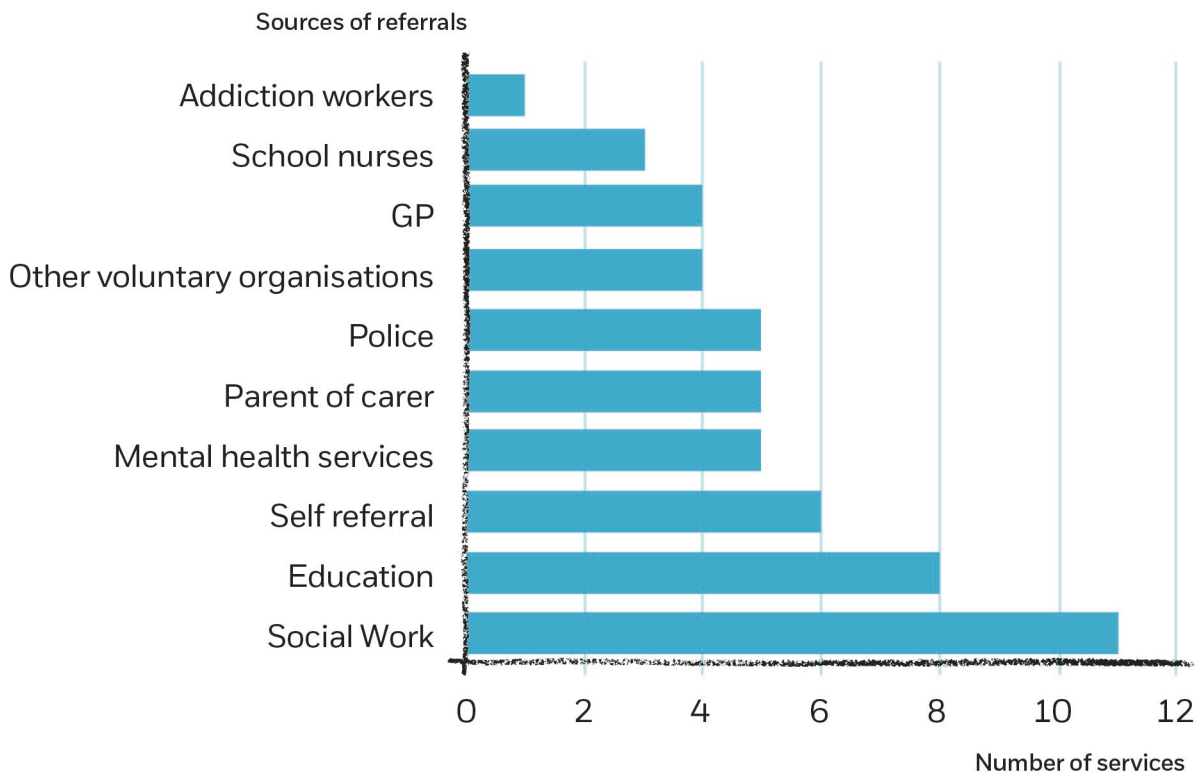
*(Health Discussion Group)*

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According to police, co-ordination of therapeutic support is more difficult in cases where there is no-ongoing social work involvement and it can be harder to ensure children and family’s needs for emotional support are met. This may particularly impact on children and young people who have experienced non-familial abuse. However, the young person is still highly likely to need support either early on or at a later stage, when they may begin to experience emotional problems related to the abuse.

A likely scenario is that many of the children who do not have ongoing social work involvement find their way into therapeutic services much further down the line, after developing difficulties, following referral by their school, GP, CAMHS, a self-harm nurse, or self-referral by the child or family. This hypothesis is borne out of the picture of referrals into third sector specialist services for children aged 12 years + in the West of Scotland shown in Figure 3.

**Figure 3. Referral sources reported by third sector specialist services for children aged 12 years**



We must also not forget the children who belong to the largest group of all: those who never disclose their abuse but who may find themselves in contact with professional help down the line due to presenting issues associated with their abuse such as alcohol and substance misuse and disruptive behaviour at school or offending.

### Suitability and timing of referrals

Where there are ongoing child protection concerns, referrals to therapeutic support will often be discussed early on, at each case conference stage, where a social worker will be tasked to identify what is available in the locality. There are also many cases where referral may not happen until much later in a child's journey, for the following types of reason:

- The need for therapeutic support may not be considered until a child starts to show signs that they have been affected by trauma. Children can also be judged 'too young' for therapeutic intervention, and it may be considered appropriate to wait and see how a child is coping before considering the need for intervention.
- Therapeutic intervention may be considered inappropriate in some cases where a child has a lot of other issues to cope with – "If the child is away from home in foster placement there's a lot going on. We don't want to do everything at once: it would be too much for the child to cope with".
- The child may not be ready, willing or able to engage in therapeutic support.

Referral on to other services for therapeutic support may not necessarily be considered by social workers to be the best thing for the child, for example where a child has a stable, supportive caring environment.

*"A really good foster placement, or a birth parent, is the best therapeutic intervention for a child. Sometimes we are always thinking of referring to something, but sometimes the best resource is there in terms of dealing with things"*

Social workers also stressed that they can provide focussed interventions with children and consider themselves best placed to do so in some cases, where they have established strong, trusting relationships with children. However whilst social workers often very much want to work in this way, the capacity to do so in many areas is undermined by the demands of the role, and the capacity within teams.

*"It is all the stuff we came into social work to do – you did, I did. But in the resource context can you? No, you can't."*

*"Social workers are bad for thinking 'we always have to refer on to someone else', in terms of specialist stuff. But if you had the opportunity of doing focused work with kids-that would be brilliant...We could do that work and we can do that work: not everything has to be a specialist thing. But...if you can't meet your high end child protection needs you're hardly going to be doing the let's finish off this quality bit of work"*

Despite a chronic lack of capacity to deliver focussed work, some social workers may try to 'take on everything'. Where a trusting relationship with a child has been painstakingly built up, professionals can at times feel reluctant to refer on, both because of their desire to do focussed work but also, essentially, because there is a risk in referring a child on to a service with which they may not engage.

## Barriers to referrals

Professionals commonly reported either few services in their area, or provision with long waiting lists. Where services do exist, for some professionals resource pressures also shape the options available in terms of referral. Social workers said that choice of service depends not only on knowledge of what is available but also whether a cost is attached. Both social workers and health professionals mention this as a key consideration and this applies also to sourcing freelance specialists such as play therapists to do work with an individual child, which often involves protracted approval processes.

It was clear from discussion with professionals that established relationships with well known, trusted services are important in informing referral choices. Equally, where little is known about a service or where there is hearsay about a service, it can put potential referrers off using a service.

Complicated referral processes were also identified as a barrier to accessing some services and may in some cases dictate the choice of service.

While many professionals were clear about a lack of therapeutic service provision in their area, others said a low level of awareness about services can be a barrier to referral in some cases. Knowledge about services is often patchy – with uncertainty as to what is provided and whether services they had previously known still existed.

*“I also think the lack of knowledge and awareness of what is out there for child sexual abuse is a barrier for workers. I went round the team asking different working in terms of what they knew of therapeutic support for children and young people – what is there, what have they used if they are working with a child or young person- and nobody seemed to know what was there...”*

(Social Work Discussion Group 1)

## Child’s journey after disclosure

### Key points:

- Readily accessible advice, support and treatment for non-abusing parents and carers is essential to enable them to support their child’s recovery, and constitutes early intervention for the child.
- There is no standard assessment of emotional and mental health provided to children following disclosure of sexual abuse.
- Pathways for children with child protection concerns are clearer, however practice varies between areas.
- There is no clear pathway for children who do not have ongoing child protection concerns. No-one is responsible for assisting the child and their family, including providing or referring them to appropriate therapeutic help and family support.
- There is no routine follow up of children in the months and years following sexual abuse.
- Where services exist, some barriers to referring children to services include professionals’ lack of knowledge of available services, assessment of suitability and timing, complex referral processes and resource pressures.

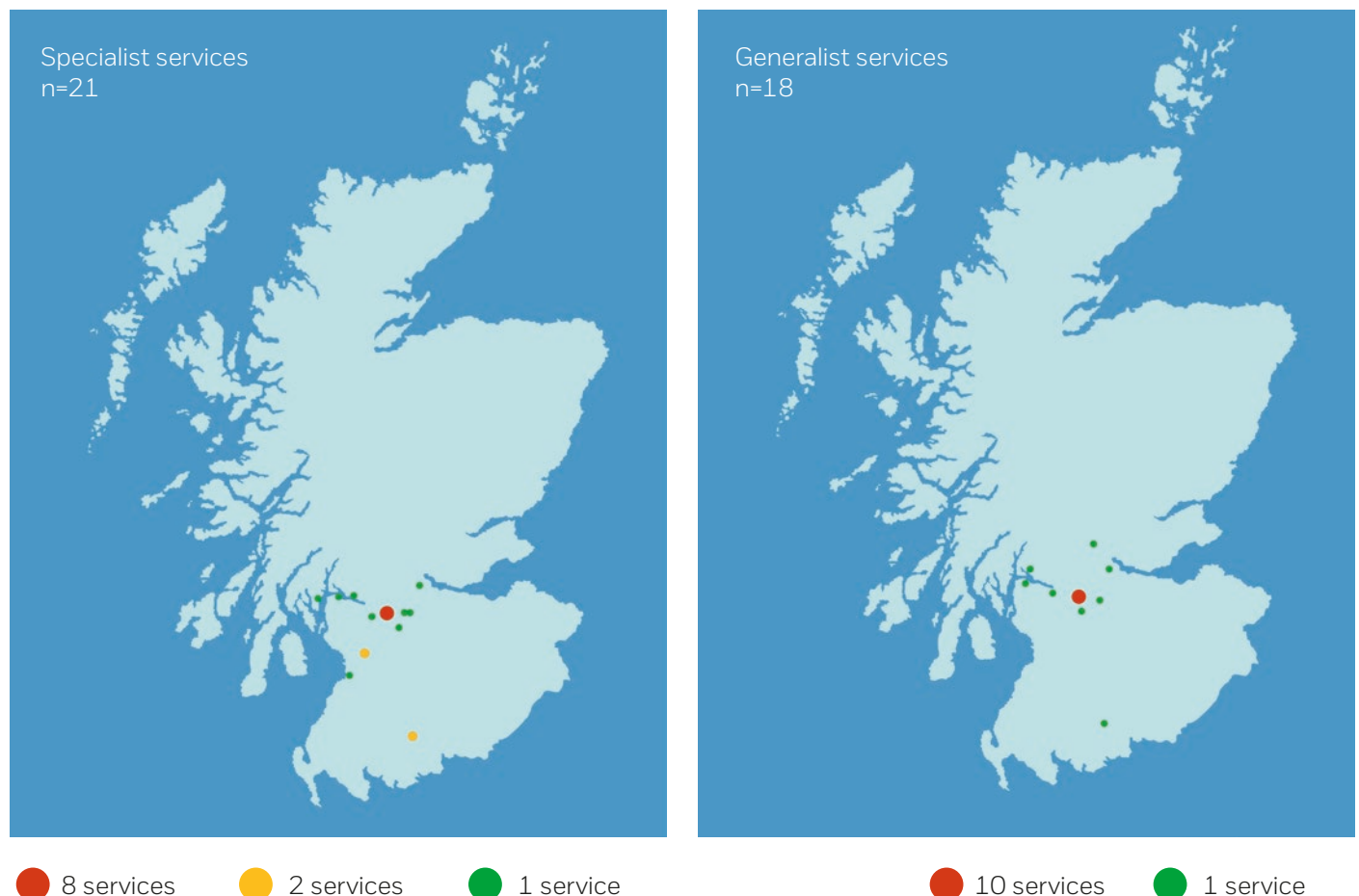
# 3: Children's access to recovery services

## General overview

For children who do need support following sexual abuse there are a total of 39 services providing face to face support. These include:

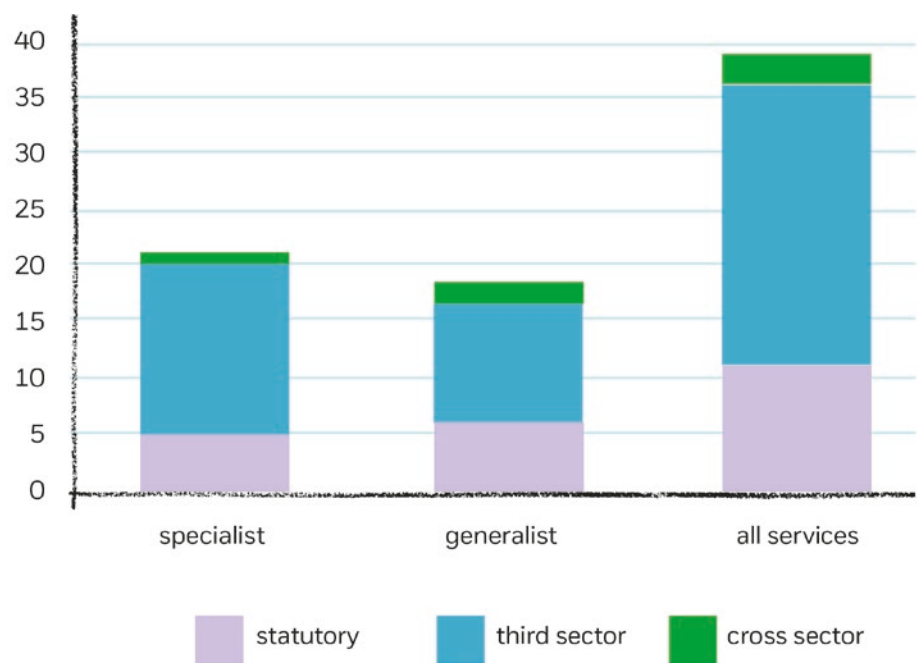
- 21 services with a specialism in CSA or HSB, and which spend all of their time, or a substantial proportion, providing a service to children who have experienced CSA or who present with HSB ('specialist services') and;
  - 18 'generalist' services which help children with a range of difficulties. Support for children after sexual abuse or with HSB is a part of what they do, but they do not necessarily spend a substantial proportion of their time doing so. Some generalist services work with sexual abuse to a significant extent within their caseload, others infrequently and in very small numbers.
- Of these 39 services, just over one third (14 services or 36%) are targeted interventions for vulnerable children who have experienced many adversities including chronic or enduring neglect and abuse. Some have been developed by statutory agencies specifically for children and non-abusing parents and carers where there are child protection concerns. They include:
- 2 statutory specialist sexual trauma services specifically for children;
  - 9 generalist services which are 'intensive' social work or mental health interventions designed for specific populations of highly vulnerable and 'at risk' children and their families;
  - 3 specialist services for children at risk of or experiencing sexual exploitation (CSE).

**Figure 4. Distribution of services across the West of Scotland**



Provision of therapeutic services is dominated by the third sector. Almost two thirds of all services (25, or 64%) are third sector; while 11 (28%) are statutory services. A more extensive overview of the service landscape is provided in Part Six.

Figure 5. Overview of service provision, number of services by type and sector



Eligibility criteria

Access to services depends on various eligibility criteria, the most common being age, area of residence, and for some, social work involvement and/or assessment.

A child’s sex is rarely an access criterion: 87% of all services support both males and females (34 out of 39). This includes 81% of specialist services and 94% of generalist services.

Specialist help for children

In this section we primarily focus on the provision of specialist post CSA services because, by their very definition and origin, these are the services which have been set up or commissioned to work with the specific support needs and vulnerabilities of children following sexual abuse. We firstly look at the overall picture of specialist services, by type and origin, and then consider what specialist support is available to children: by age group and area of residence.

We then look at the provision of generalist services in the West of Scotland. Many of these services play an important role in helping children recover from sexual abuse, often supporting children with extremely high levels of need.



The 21 specialist services are in the main small, with a median staff resource for face to face therapeutic work with children of 1.5FTE.

Seventy percent of specialist services are provided by the third sector. Two local authority areas have statutory specialist services for children within their mainstream social work provision.

In the most recent year, 682 children were accepted by specialist services after referral. This is based on completed returns by 13 of the 21 specialist services (62%). The actual number of children accepted by services is therefore higher than this. 12 services provided a breakdown of accepted referrals by sex; this showed that 76% of referrals were for females, and 24% for males.

**Table 1. Typology of specialist services in the West of Scotland.**

Type of service	Number (%)
<b>Type A</b> – Adult sexual violence services which can also be accessed by adolescents, typically from age 12 or 13 years upwards.	8 (38%)
<b>Type B</b> – Services designed specifically for adolescents (from 12 years +) created and delivered by adult sexual violence or survivors' organisations	4 (19%)
<b>Type C</b> – Specialist services that support both adults and children (across the life span, from birth)	1 (5%)
<b>Type D</b> – Post-CSA services specifically for children: five of these eight support the entire 0-18 year age range.	8 (38%)
Total – all services	21 (100%)

A large number of services have their roots in the Rape Crisis movement, and a smaller number in statutory services, or in voluntary sector children's social care. This categorisation of services considers whether they were developed within the context of adult sexual violence services or within children's social care. The two main types are:

#### **Adult sexual violence services (Types A & B)**

A majority of support, 60% of services (12 in total) is provided by adult sexual violence services. These are all open access voluntary sector services, and can be accessed by children aged 12 or 13 years upwards:

- 8 of these are adult services which are accessible to adolescents.
- 4 are tailored services for children, developed and delivered by either adult sexual violence or survivors' organisations. One is accessible to children aged 11 years and over, 3 are services for children aged 12 or 13 years upwards.
- 3 of the 4 tailored services for children were established around 2007-2008, and all 4 are open access.

#### **Post-sexual abuse services across the life-span (Type C)**

One open access specialist service in the West of Scotland offers support tailored to the needs of every age group across the life span, including children. There is only specialist service of this type.

#### **Post- sexual abuse services specifically for children (Type D)**

- A minority of services, 8 out of 21 (38% of the total) are specialist post-sexual abuse services designed specifically for children.

Of these eight, two are Tier 4 statutory services targeted at the most high risk children, one of which is a Harmful Sexual Behaviour (HSB) service. Access to these targeted interventions is usually contingent upon a child being known to social work and/or having an allocated social worker as a starting point, but typically with a further screening and assessment process embedded in the referral pathway to ensure that criteria and thresholds are met.

A further 3 services are interventions specifically for children at risk of, or who have experienced, sexual exploitation. Children are referred following episodes of running away, going missing, or frequenting the city centre and are therefore by definition children who are highly vulnerable and at risk.

This means there are just 3 specialist services specifically designed for children which offer open access (“lower tariff” services). Two are in the third sector, and 1 is a statutory service. All three services also provide support to children affected by domestic abuse.

### **Summary: Total Number of Open Access Services tailored for children**

In conclusion, across both main sectors (sexual violence and survivors’ organisations, and children’s social care) in the West of Scotland:

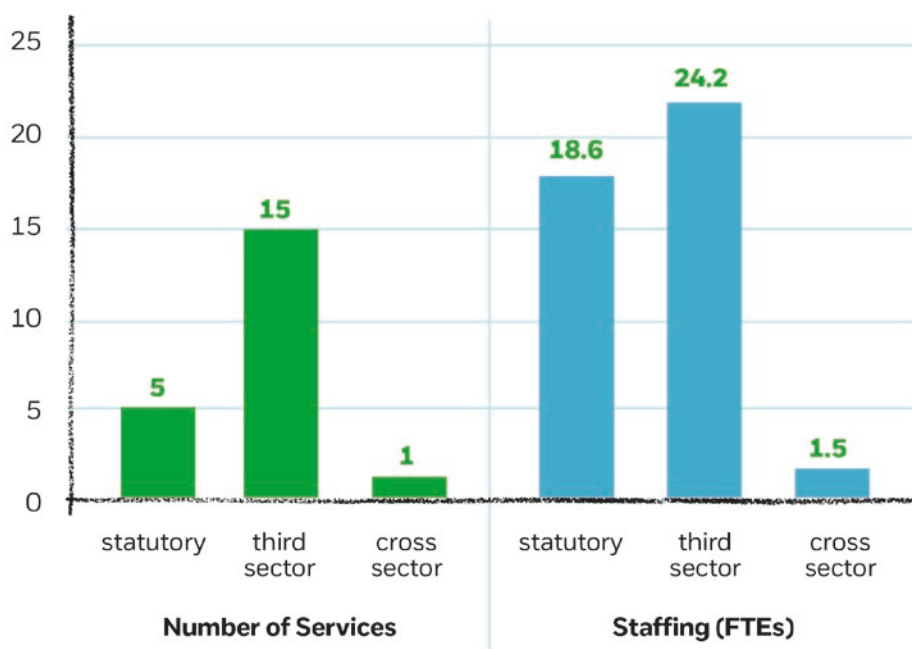
- there are a total of 8 open access specialist post-CSA services specifically for children:
  - 4 are tailored services for children, developed and delivered by either adult sexual violence or survivors’ organisations.
  - 3 are specialist children’s services; all of which support children affected by domestic abuse as well as children experiencing difficulties following sexual abuse.
  - 1 is a specialist service offering tailored support to individuals across the life-span, including children.
- The average therapeutic staff resource in each service is 1.5FTE.
- 1 is a health board-wide service offering access across NHS Greater Glasgow & Clyde only.
- 1 is a national service based in and receiving a majority of its referral, from the West of Scotland.
- 6 are local services which can be accessed by children in 7 local authority areas (out of 17).
- 4 services are for adolescents only, while 4 also provide a service to younger children.
- Of the 8 services: 6 are third sector, while 2 are statutory services;

### Specialist Therapeutic Staff Resources

The total dedicated therapeutic staff resource across all specialist sexual abuse recovery services for children is 43.3 full time equivalents (FTEs). This is for the 0-18 age group as a whole. These posts are supplemented by the time of 11 sessional counsellors and 11 volunteer counsellors.<sup>61</sup>

These figures solely relate to posts doing face to face therapeutic work with children, and not adults.<sup>62</sup> They do not include posts solely concerned with administrative, advocacy or service management.

**Figure 6. Distribution of services and therapeutic staff numbers (FTEs)**



The median staff resource in specialist services is 1.5 FTE and this gives an idea of the capacity of services. The median therapeutic staff resource in specialist statutory services is 2FTE, compared with 1.5 FTE in the third sector.

While just five of the 21 specialist services are in the statutory sector (24%) these five services account for 43% of all posts. This reflects the duties upon statutory services which focus resources upon the most vulnerable and at risk children.

The capacity of third sector adult sexual violence services for face to face work with children is small; the average therapeutic staff resource in third sector adult sexual violence services for work specifically with children is

1.5FTE. In most local authority areas this is the only general access help available to children who have experienced sexual abuse.

Similarly in general access services specifically designed for children the average therapeutic capacity is 1.5FTE. It is important to note that this resource is not dedicated solely to sexual abuse, as three of the services also support children affected by domestic abuse.

*'If we could choose and had infinite resources, we would employ many more staff. This work is extremely resource intensive. In the last 3 years since I have come in to post there has been a large increase, year on year, of referrals to the service.'* (Specialist service)

<sup>61</sup> It was not possible to quantify their time in terms of full time equivalents.

<sup>62</sup> Although we are aware this expertise is often drawn upon to support children.

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Help available to different age-groups

Children under 12 years of age

There are 385,000 children aged 12 and under in the West of Scotland. The gap in specialist services for these children is clear from this overview, which shows the age criteria of each of the 21 specialist services in the West of Scotland. The pale green area represents the age range of each service.

The expanse of dark green area indicates the absence of service provision for children between the ages of 0-11 years, and particularly for the under-fives.

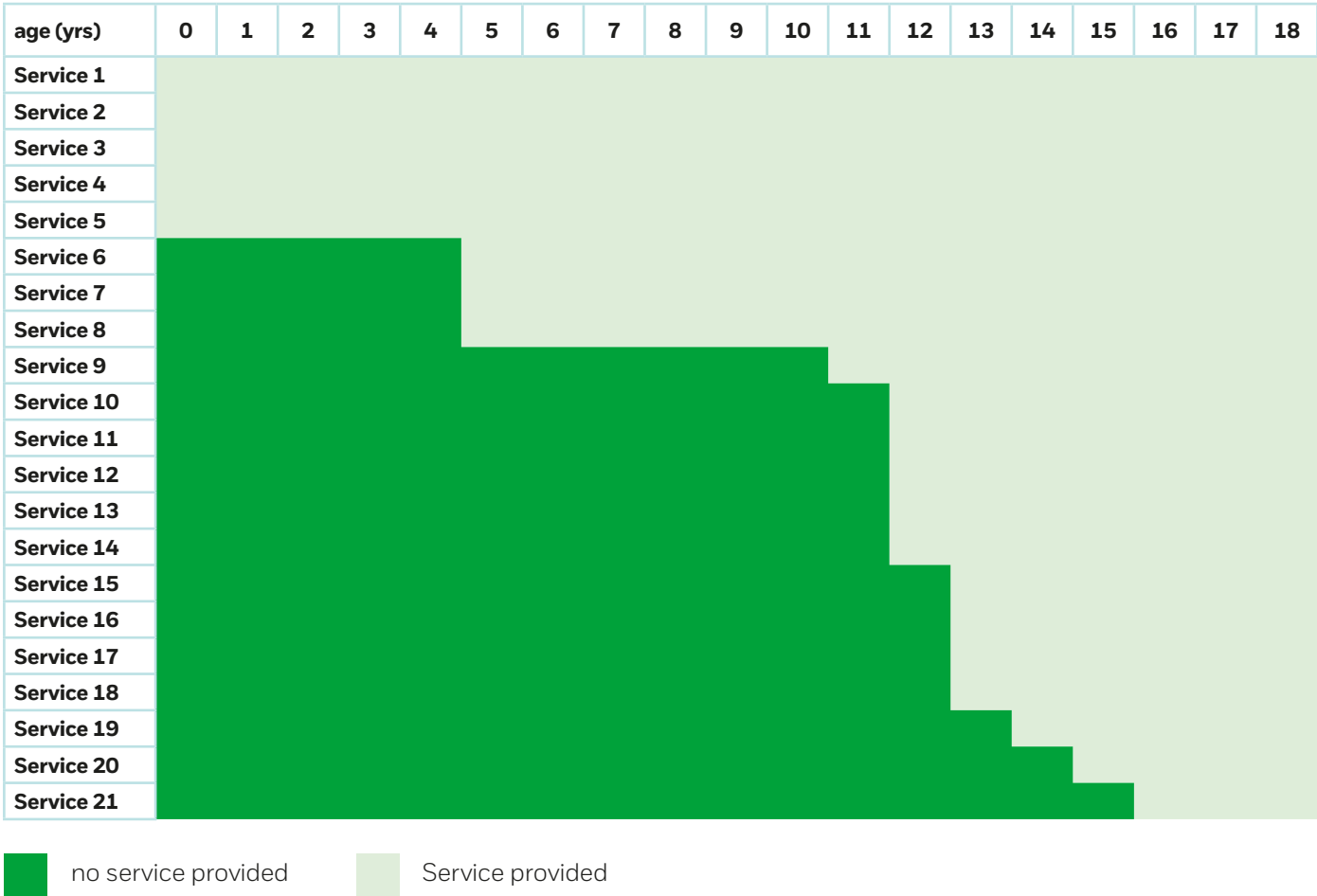
The discussion groups supported this finding by painting a picture of geographic inequalities in service provision. In particular, they expressed strong concerns about a lack of therapeutic support services for younger children experiencing sexual abuse.

*“The real gaps that are there are for younger children. With young people aged 13 and above, there are things there. But for younger children there is really nothing at all. There really needs to be something in place, where there is intensive support that can be offered”*  
(Police Discussion Group)

Across the West of Scotland as a whole, total dedicated therapeutic staff accessible to younger children (0-12 years) is **21.1FTE**.

- Just over half of this (11FTE) is in services with high thresholds.
- 10.1FTE is in services with lower thresholds.

Figure 7. Age criteria of specialist services



The block of pale green down the lower right hand side indicates the services provided by adult sexual violence and survivors' organisations, which almost all begin at ages 12 or 13 years (Services numbered 9-21).

In practice access to specialist services is further limited by threshold (as some services are focused on the highest risk children) and by area of residence, as many services can only be accessed by children within a specific geographic area.

### Help available to children based on age and where they live

Sixteen of the 21 specialist services are local services accessible to children in specific local authority areas, while 5 are regional or national services.

Because of the major gap in population prevalence data for CSA at national and local area levels in Scotland, this analysis of children's access to specialist services by age and area of residence focuses on the general child population, and asks,

'If a child resident in a West of Scotland local authority seeks help following sexual abuse, would they be able to access a specialist service in their own area?'

### Prevalence of Child Sexual Abuse

The most recent prevalence research for the UK underlines how common experiences of sexual abuse are during childhood.<sup>64</sup>

9.4% (1 in 10) report experiences of sexual victimisation (from an adult or peer) in the past year, 16.5% (1 in 6) experience this at some time during childhood.

5% (1 in 20) report victimisation from their own intimate partner (boyfriend or girlfriend) in the past year, 7.9% (1 in 13) experience this before reaching the age of 18.

These rates cover the whole age span from 11 to 17 years but prevalence rates vary considerably with the age of the child, with older children and young people reporting higher rates for most types of past year victimisation (apart from victimisation by siblings) than rates reported for younger children.

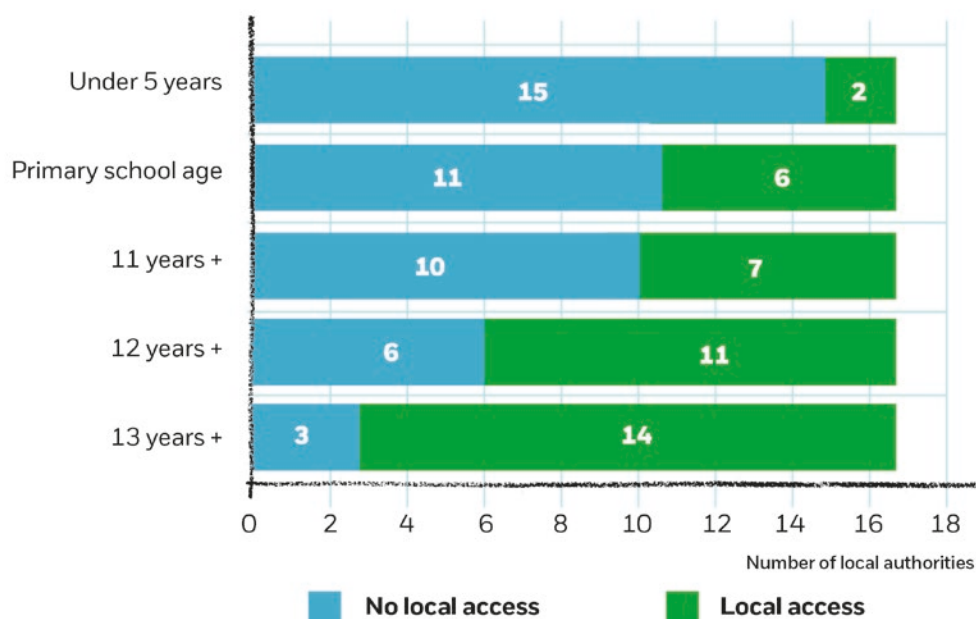
7.2% of girls and 2.8% of boys in the 11-17 year age group report contact sexual abuse during childhood, ranging from sexual touching to penetrative rape, with 18.6% of girls (1 in 5) having this experience before the age of 18 in age group 18-24 compared with 5.3% of boys (1 in 20).

Extracted from: Radford, L., Dodd, S., Barter, C. et al. (2017) p44-47.<sup>65</sup>

<sup>63</sup> Source: National Records of Scotland, 2016 mid-year-estimates of population.

<sup>64</sup> The most recent study, whose findings are presented here, is Radford, L., Corral, S., Bradley, C. et al (2011) Child Abuse and Neglect in the UK Today. London: NSPCC [www.nspcc.org.uk/childstudy](http://www.nspcc.org.uk/childstudy)

<sup>65</sup> Radford, L., Dodd, S., Barter, C. et al. (2017) The abuse of children in care in Scotland: A research review. Preston: University of Central Lancashire.

**Figure 8. Access to specialist services by child's age and place of residence**

There are 17 local authorities in the West of Scotland area. Figure 8 presents an analysis of local specialist services provision for different age groups by area of residence.

It shows that:

- **Children under 5 have no local access to specialist services in 15 out of 17 local authorities**

This means in the West of Scotland area, comprising 17 local authorities, 73% of all children under 5 have no local access to specialist services – a total number of 106,400 children under 5.

- **Primary age children have no local access to specialist services in 11 out of 17 local authorities**

This means in the West of Scotland area, two thirds of all primary age children have no local access to specialist services – a total of 141,300 (67% of all primary age children).

Glasgow, West Dunbartonshire, Inverclyde and Renfrewshire are exceptional in providing or commissioning specialist sexual abuse services for primary age children.

- **Secondary age children**

11 year olds have no access in 10 out of 17 local authorities (this means in the West of Scotland area, 57% of 11 year olds have no access to specialist services – a total number of 16,500.

12 year olds have no access in 6 local authorities. In the West of Scotland area this means 23% of all 12 yr olds have no access to specialist services – a total number of 6,600 children.

From 13 years upwards children have no local access in 3 local authorities. Across the West of Scotland area 9% of this age group have no local access, a total of 16,200 children.

In addition to local service provision, and in areas where there are no local specialist services, it may be possible



to access support from one national and 4 regional specialist services. However most of these services have particular eligibility criteria. Just one is an open access service available to children of all ages (0-18 years) across the whole of the West of Scotland.

### **Dedicated help available for children with disabilities, including learning disabilities and communication difficulties**

Children with disabilities are at elevated risk of all forms of abuse and neglect. Studies have found disabled children to be between 2-3 times more likely to be sexually abused than non-disabled children.<sup>66,67,68,69</sup> Children with learning disabilities are among the highest risk groups for sexual abuse and exploitation. Their greater vulnerability can also mean they can become involved in abuse as a perpetrator.<sup>70</sup> In terms of specialised support for children with intellectual disabilities we found:

Amongst specialist post-CSA services there are 2 therapeutic posts dedicated to support children with disabilities at risk of or with experience of sexual abuse. Both posts were under threat:

- a 0.5 FTE post for children with a learning disability aged 12+. We are aware that the organisation has successfully found funding to continue this post beyond its initial 3 year funding period, which ended in 2016.
- 1 FTE post dedicated to adults with a learning disability, which in response to need now also support 15-17 year olds with a learning disability. Funding for this post ends in 2017.

Five other services said they provide tailored support to children with learning disability or complex needs. Three are generalist services, and two specialist services, including a service for HSB.

### **HELP AVAILABLE FROM GENERALIST SERVICES**

The schema below gives an overview of the main types of generalist service that provide support to children after sexual abuse. The numbers of services of each 'type' are not stated, as one or two services straddle these.

Half of the 18 generalist services in the West of Scotland are targeted interventions for children with child protection concerns (Type A services in the broad schema below). Some local authority areas have invested in developing resource-intensive specialist (and generalist services) specifically tailored to the needs of the most vulnerable children.

The other half are general access services providing face to face support to children for a wide range of difficulties; these are the Type B services in the schema.<sup>71</sup> We look at each of these two groups of services in turn.

**Table 2. Broad types of generalist service**

**Type A-** 'Intensive' social work or mental health interventions designed for specific populations of highly vulnerable and 'at risk' CYP and their families. There are two distinct sub-categories within this group.

- Services which aim to prevent young people from entering secure accommodation. These are mostly Tier 4 services within a stepped care model of service provision
- Generic trauma recovery services, which include therapeutic support for sexual trauma. These services sometimes straddle tiers, but are commonly Tier 2-3 within a stepped care model.

**Type B** – Services offering support for a wide range of difficulties, with open access to all children.

These include counselling services offered to pupils of secondary school age and community based counselling services offering a range of types of support including therapeutic based on assessed need. Although often designated 'Tier 2' services, some services are working with higher tariff cases.

<sup>66</sup> Sullivan P.M. and Knutson, J.F. (2000) Maltreatment and disabilities: a population based epidemiological study. *Child Abuse and Neglect* 24, 10, 1257-1273.

<sup>67</sup> Brown, S. et al., (2016) *Child sexual abuse and exploitation: understanding risk and vulnerability*. London: Early Intervention Foundation.

<sup>68</sup> Jones, L et al (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *The Lancet* July 2012.

<sup>69</sup> Stalker, K., Green Lister, P., Lerpiniere, J. et al (2010) *Child protection and the needs and rights of disabled children and young people: a scoping study*. Glasgow: University of Strathclyde.

<sup>70</sup> Wissink, I., van Vugt, E., Moonen, X. et al, (2015) Sexual abuse involving children with an intellectual disability (ID): A narrative review. *Research in Developmental Disabilities*, 36: 20-35. <http://www.sciencedirect.com/science/article/pii/S0891422214003977>

<sup>71</sup> This schema is general and numbers are not assigned because some services straddle these types, indeed some services would resist classification in this way.

### Generalist services for children with child protection concerns

Half of all the generalist services which help children recovering from sexual abuse (n=9) are targeted interventions for highly vulnerable and ‘at risk’ children and their families, including those with the most severe, enduring and/or complex difficulties. The majority of these are in the statutory sector and comprise targeted NHS mental health or intensive social work interventions for children with complex and serious difficulties.

- These services exist in just 6 out of 17 local authority areas.
- Glasgow is the only local authority to have multiple services of this type.
- Two services are regional and one national, and these do highly intensive complex trauma recovery work.<sup>72</sup>
- Half work with adolescents only and half with the full age range 0-18 years.

Access to these targeted interventions is usually contingent upon a child being ‘known’ to social work and/or having an allocated social worker as a starting point, but typically with a further screening and assessment process embedded in the referral pathway. Thresholds for accessing these services are high. They include youth justice services supporting children who are at high risk of harm to themselves or others and these have very specific pathways linked to the justice system.

7 out of this group of 9 generalist services are in the statutory sector or are partnerships involving statutory agencies, and staffing levels in these services reflects the intensive nature and high levels of risk around the children supported.

For these services, sexual abuse is a common presentation but typically as part of a complex picture of adverse experiences. Sexual abuse, including sexual exploitation, was reported as being present in between one third to two thirds of either referrals, or current caseload. One service estimated around 10% of referrals, while another said almost all the young people referred had experienced and/or were at risk of sexual abuse.

*“Yes, this is very common. Chronic neglect is the most common root of the trauma exhibited by children and young people accessing this service and commonly sexual assaults are a function of this neglect especially for girls.”*

*“Yes, but this is always part of a complex picture.”*

### Generalist services with ‘open access’ provision

These services differ in their purpose and approach and, in contrast to the group of targeted services for children with child protection concerns, pathways into these services require to be much wider to fulfil their role, which is to provide early intervention for children with difficulties (Tier 2 within a stepped care model of service provision).

For most of these open access generalist services sexual abuse is not commonly presented and forms a very small part of their caseload.

*“Not to a great extent...the service accepted 850 referrals in 2015/16 and there were 21 presentations of sexual abuse and 16 of sexual health issues, which include sexual exploitation and early teen pregnancy”.*

However there are exceptions. Two services estimate sexual abuse accounts for around 10% of their caseload, and in one counselling service it accounts for approximately 50% of its referrals

Almost all of these services say there are cases where CSA is disclosed or comes to light during the course of working with a child or young person. Very few generalist services could provide exact numbers of children accepted after referral for reasons related to sexual abuse and a specific recommendation is made about this.

<sup>72</sup> We have been made aware that following recent changes one of these services no longer provides this.

They include:

- Tier 2 counselling services available universally to children experiencing a range of difficulties. A number of these are counselling services offered to pupils of secondary school age, either local authority-wide, or in specific secondary schools only.
- Counselling services serving specific local communities.
- Services for whom the relationship or connection with the local community is fundamental to their work. Three of the services work with children in the context of a community based family support model, all in specific localities of the same local authority. Two of these work only with partner nursery or primary schools and the therapeutic service is part of a broader 'wrap around' model of practical and emotional support for children and their families. One service provides counselling services primarily to Black and Minority Ethnic (BAME) young people in specific secondary schools.

With one exception these are all third sector services. Some are commissioned or co-commissioned or have service level agreements with statutory agencies. Others have no financial relationship with statutory agencies.

Most of the Tier 2 counselling services, while designated early intervention services, are in fact supporting higher tariff cases.

### **Help for children with worrying or harmful sexual behaviour**

Harmful Sexual Behaviour (HSB) is a highly specialised area and how local areas respond to HSB varies. Some may have in-house consultancy teams within their social work departments including specialist expertise in HSB. Others areas buy in expertise as needed from freelance specialists.

Professionals in both police and health discussion groups raised concern about a lack of services for children with sexually harmful or sexually worrying behaviour. Early intervention with children in this area was regarded as critical in meeting children's need for support and in underpinning abuse prevention. This was an issue of frustration and concern which was understood by police as a lost opportunity to intervene early and prevent child sexual abuse.

*"I can think of lots of cases where we refer children to social work because of sexually inappropriate behaviour/problem behaviour, at a young age. Social work will assess and where they consider mum and dad to be acting responsibly, nothing happens; there is no pathway to support. A lot of times we will end up referring these children to the Reporter, but again where mum and dad are seen to be acting appropriately, we have them referred back to us. There's nothing being done at an early stage; no support for these children".*

Services also say that disclosures of sexual abuse can be common in children who display harmful sexual behaviour. Worrying behaviour in younger children can be due to the sexualising aspect of the abuse and trauma they have experienced. In adolescent on-set HSB, childhood sexual abuse is not quite as significant, as other pathways can be involved out-with childhood experience, for example loneliness or very poor social functioning. However the experience of services is that many adolescents with HSB have also experienced sexual abuse in childhood.

### Number of HSB services

While the primary purpose of this mapping study was not to assess provision of HSB services in the West of Scotland, 9 services were identified which provide interventions for harmful sexual behaviour.<sup>74</sup> The 9 services include:

- 5 specialist services (including 2 statutory social work services) and;
- 4 generalist services (3 of which are statutory social work services, or partnerships with social work services).

Three additional services work occasionally with worrying or inappropriate sexualised behaviour in young children, and in one case young people with learning disabilities. A fourth service frequently works with young children displaying sexually harmful behaviour, but refers on if more directive work is needed.

### Access to HSB interventions by area of residence

7 of the 9 services are area specific, and they provide a service to 8 different local authority areas.

Based on this information, of the 17 local authorities:

- 8 have a service providing a HSB intervention.
- 9 do not have a service.

And for younger children:

- 5 out of 17 authorities has a service providing a HSB intervention for Under 12s.
- 1 out of 17 has a service providing an intervention for Under 5s with worrying sexualised behaviour.

### Help for children from Black and Minority Ethnic (BAME) communities

Socio-cultural specific reasons for the under reporting of sexual abuse and exploitation within black and minority ethnic families and communities have been explored in a number of recent reports and inquiries, including the Jay report into child sexual exploitation in Rotherham<sup>75</sup>. *Hidden in Silence*, a 2016 documentary film by Javita Narang and Nauman Qureshi, examines the barriers to disclosure and reporting of CSA in Scottish ethnic minority communities and highlights issues around attitudes leading to the denial of the problem, shame and family honour in some communities, and a lack of culturally specific services, and of information or awareness.<sup>76</sup>

*“Childhood sexual abuse comes up in relation to a huge amount of trauma – a crazy amount – during the course of counselling. In Scotland we have a very settled Asian community. People are tending to associate issues like honour based violence and forced marriage with culture – but CSA is a big part of the picture.”*  
(Specialist service)

Three services provide face to face therapeutic support specifically with children from black and minority ethnic backgrounds; two generalist services and one specialist service. Two are open access services; one is an intensive trauma recovery service with specific eligibility criteria.

There are also two further specialist services that provide a tailored service as part of their work.

<sup>74</sup> We do not have information about the nature of the interventions or who delivers these.

<sup>75</sup> Jay, A., (2014) Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013. Rotherham: Rotherham Metropolitan Council [http://www.rotherham.gov.uk/downloads/file/1407/independent\\_inquiry\\_cse\\_in\\_rotherham](http://www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham)

<sup>76</sup> Qureshi, N. and Narang, J (2015) *Hidden in Silence*. A documentary based on childhood sexual abuse in Scottish ethnic minorities. Dawn films.

### Do children have to wait for help? – an overview of generalist and specialist services

Regardless of whether children need support from generalist or specialist services, it is important that they do not need to wait to access support.

GIRFEC emphasises the importance of children and young people receiving “...the right help at the right time from the right people.”

#### Childline: Getting Help – What children tell us about accessing services after sexual abuse

Each year thousands of children speak to Childline about an experience of sexual abuse.<sup>77</sup> One main reason for doing so is to access emotional support while they wait to receive help from a service. Their experiences of waiting for help are explored in this report.<sup>78</sup>

Children and young people who had been referred to specialist services talked about feelings of unimportance and isolation. They believed nobody cared or really understood their situation. Areas children struggled to understand or deal with included:

- Being kept on waiting lists for too long;
- Not believing that intervention would make a difference;
- A lack of knowledge of what services do or how they could help;
- Appointments being rearranged or cancelled;
- The lack of urgent response making young people feel like nobody cared about them;
- Fearing judgement or repercussions;
- Services and support not being available at the times when they most needed it;
- Services ending too soon.

According to professional participants in discussion groups, long waiting lists for services present a particular problem for children and young people, as there can be a very short ‘window of time’ within which children will be ready/willing to see someone, or engage with a service.

*“It is all about timing. I mean a child can be really ready to see someone-but then it takes that service 6 months to be seen by the right person. So it’s not necessarily the assessment or the referral part-it’s the actual waiting to get the service. It’s a resource issue I think – a lot of the time”.*

(Social Work Discussion Group 1)

From a child’s perspective, having to wait for help can add to the emotional problems they are already experiencing and adding to their distress and vulnerability. For children who are already extremely vulnerable the level of risk involved is such that, for these reasons, as a matter of policy 7 of the 39 services (18%) do not operate waiting lists. These services adopt a number of strategies in order to maintain a no waiting list policy. A minority are highly resourced in order to meet statutory functions and therefore have capacity. Others combine triage with provision of a consultation service so that a teacher or social worker can safely ‘hold’ the young person, and/or do some direct work with the child themselves. Other types of ‘streamlined’ responses mentioned include offering short-term pieces of work rather than the ‘full’ service; including carer work and risk management work.

<sup>77</sup> In 2014-15, 11,400 children spoke to Childline about an experience of sexual abuse.

<sup>78</sup> NSPCC (2016) Getting help. What children tell us about accessing service after sexual abuse. London: NSPCC <https://www.nspcc.org.uk/globalassets/documents/research-reports/getting-help-childline-sexual-abuse-children-accessing-services.pdf>



### So how long does a child identified as having experienced sexual abuse have to wait before they actually begin receiving therapeutic support?

Only a small proportion of services have capacity to provide a service immediately. The majority of services (82%) have waiting lists.

None of the services who work therapeutically with children under secondary school age have capacity.

- 13 specialist services (72%) usually have waiting times.
- 11 generalist services (73%) usually have waiting times.
- Overall specialist services report lengthy waiting times, ranging from 2 weeks up to 1 year (average waiting time of 17 weeks). Generalist service waiting times are significantly shorter, ranging from 2 weeks up to 20 weeks (average waiting time of 9 weeks).

### Managing waiting times

Overall services described the daily challenges involved with managing waiting lists, particularly in the face of increasing demand. For many professionals this was a source of on-going anxiety.

“We are constantly being asked to prioritise our referrals, but the level of trauma being presented is very high. In practice it is very difficult, almost impossible to prioritise one referral over another, because they are all high tariff...”

Of those services which usually have waiting times, just four services (all in the third sector) state that there is a maximum waiting time after which their service would stop accepting referrals to avoid unduly long waiting times for children.

Reasons for services keeping their waiting lists open include having simply no-where else in the local area to refer on to.

“Wouldn’t stop accepting referrals, as nowhere to refer them on to for CSA.”

While for others the sad reality of the matter is that the

only way they could monitor demand and demonstrate the need for additional resources was by keeping their waiting list open. This was not a decision which was taking lightly.

Managing waiting lists to ensure that therapeutic support is provided within a timescale which is appropriate and sensitive to the needs of the child or young person is very much down to the efforts of individual organisations and individuals working within services.

*“The reason there is no waiting list is because staff see young people in their own time. We all work additional hours each week on a voluntary basis, and that’s how we manage. The ethos of the service is we never turn someone away. Capacity is an ongoing concern.”*

*...“We contact referrers suggesting other services – if sexual abuse or assault they would advise them to see [name of service] or direct to online resources. We also do consultations with parents or carers about how to support the child in the meantime, until they can be allocated a worker. We also do work/consultancy with teachers, social workers, and other people around the child.”*

*“...the service has had to be streamlined due to the lack of capacity, so fewer children are receiving the service”.*

### Implications for preventative work

Should demand increase, specialist and generalist services from both statutory and voluntary sectors express concerns that they would be unable to cope.

*“There is a real tension between the need to create and maintain as high a profile as possible so that people know that we are there. Children find it very difficult to disclose, so establishing the service as a trusted and familiar organisation young people know is there when they need it is very important. But we also know that raising the profile e.g. through the prevention work we do does have an impact in terms of producing an increased level of disclosure. Unless we have the resources to provide the follow up, it may not be responsible to raise the profile. This is an ethical dilemma”.*

*“If preventative work is done more widely with greater intensity then referrals will increase and there isn’t capacity to deal with that”.*



## Current service provision – access to therapeutic services

### Key points:

A total of 39 services provide face to face therapeutic support to children following sexual abuse, including 21 specialist and 18 generalist services.

The majority of specialist service provision is within adult sexual violence and survivor organisations.

Of the 21 specialist services, 8 provide an open access service tailored specifically for children.

Access to services is best for secondary school age children: 11 out of 17 local authorities have provision for the 12 year + age group, and 14 out of 17 have provision for the 13 year+ age group.

Just 6 out of 17 local authorities have provision for primary age children.

Only 2 local authority areas provide access to help for children aged 5 and under and their parents/carers.

The total dedicated therapeutic capacity for work with children with disabilities comprises two posts (1.5 FTE in total).

Three services provide therapeutic support specifically for children from BAME backgrounds.

The capacity of services is small, with average therapeutic staff resource of 1.5FTE for face to face work.

Children cannot access immediate support in the vast majority of local authority areas in the West of Scotland.

Common strategies reported for managing waiting times include:

- Introducing tighter referral /eligibility criteria
- Prioritising referrals at assessment, which in practise is very challenging due to high levels of trauma presented.
- Consultancy/work with parents, carers, teachers, social workers, and other people around the child about how best to support the young person in the meantime, until they can be allocated a worker.
- Staff working additional hours unpaid;
- Referring on to other organisations.
- Avoiding publicity of services/maintaining low profiles

## 4: Do services support non-abusing parents and carers?

All 39 services who support children following sexual abuse say they can also offer support to non-abusing parents/carers, although in practice this support is often limited due to financial and resource constraints.

Additionally, there appear to be important differences in the way services consider the needs of the child's wider support network, and this has potential implications for the approach services take to supporting parents and carers.

The first of these differences is between child focused and adult focused services. The second is between the intensive ('high tariff') services and open access services.

## Child focused services

The first difference is clearest within specialist service provision which is offered both by adult- and child-focused services. In line with the GIRFEC framework principles child-focused services demonstrate a holistic approach to the wellbeing of the child, ensuring that the child or young person-and their family-is at the centre of decision making<sup>79</sup>. It is clear that these services offer tailored support to parents/carers that is based on a clear understanding of the wellbeing needs of the child. In addition, child-focused services indicate that the individual support needs of parents/carers are considered at the time of the child's initial assessment. Services designed specifically for children typically offer a wide range of therapeutic interventions to safe carers.

*"This service recognises the vital importance of supporting families as a whole. If it is the child who has been abused, we would automatically assess whether families, including siblings, might need support."*

*"We also support parents who are struggling to know what to say to their children. This support can give them the skills to support their child as well as emotional support for them."*

**Figure 9. Getting It Right For Every Child (GIRFEC) – Child at the Centre<sup>80</sup>**



### Adult focused services

In contrast adult-focused specialist services generally do not describe working with parents/carers in the same manner. Support offered is often described as being on a 'can do' and 'as and when required basis' in response to the needs and wishes of the parents/carers, rather than as part of a child-focused assessment. Services infrequently referred to assessing the individual support needs of parents and carers. Adult-focused services also typically offer a more limited range of therapeutic interventions and in practice the support offered to parents/carers is often limited and short. A restricted number of counselling sessions being the most common intervention offered.

<sup>79</sup> The Scottish Government (2012) Getting it right for children & families: A guide to getting it right for every child (PDF). Edinburgh: The Scottish Government.

<sup>80</sup> Crown Copyright. Reproduced with permission of the Scottish Government, Better Life Chances Unit

*“The safe carer often just needs emotional support, someone to listen to them and talk to, and the service provides that. If someone needs more support we can sign post to another suitable service.”*

*“General support is provided to safe carers and wider families. They are given a space to talk through feelings, understandings and how best to support the young person in their life who has experienced sexual abuse.”*

Awareness and commitment to parent/carer support appears greater amongst the small number of tailored specialist services for adolescents developed and delivered by adult-focused organisations.

*“There are two aspects to our work with safe carers. Supporting them with their own issues and emotional responses, and supporting them to support their child.”*

While services can provide emotional and practical support, they are clear that the level of input they are able to offer parents/carers is significantly constrained by funding and capacity. An exception to this is one specialist service which has a separately funded and well established Parent Support Service.

One of the main reasons for the limited support for parents/ carers is lack of capacity (and by extension, under resourcing). While recognising and identifying a strong need for offering this kind of support, the vast majority are over-stretched coping with the demands of therapeutic work with children (as indicated by lengthy waiting lists).

*“The reality is we just don’t have the capacity to support safe carers. There is a huge need for that work. We will chat to a family member, but we cannot offer a full service. It is a big gap – family members are left adrift, to pick up the pieces, with no idea how to support the young person or deal with their own feelings”.*

This finding is supported by the views in some professional groups, where concerns were voiced about the current lack of support available for non-abusing parents and carers.

Health professionals, for example, identified information and support for non-abusing parents/carers as being important from the earliest stage following sexual abuse.

Parents are felt to lack information at times about the potential emotional impact of abuse on the child, both in the immediate and longer term, at key developmental stages. Information and support for carers was regarded as an important aspect of a holistic response to children who have experienced sexual abuse, where the needs of the child and the non-abusing parent/carer are considered in the round.

There are very few specialist services which have specific funding to allow for this type of work. However where services do have funding for specific family support posts, the benefits of enhanced provision are clear.

*“While the child worker works with the child, our family workers are able to work with the parents/carers/ family members as needed. We were successful in getting funding to support the work with carers/family members. We commonly find that when we speak to the adult, they have unresolved issues of their own that need attention, in which case one of the adult counsellors can offer them support.”*

*“These roles are of vital importance throughout the child/families’ journey – relationship building, engagement, maintaining contact while CYP on waiting list, support, advice and on-going contacts.”*

### High tariff services

High tariff services, whether specialist or generalist, perhaps because of their roots within social care, have the most intensive and extensive involvement with parents/carers and make considerable reference to assessment processes and the Child's Plan. The majority take a holistic approach to working with young people and their significant others and have a strong emphasis on building resilience within vulnerable families. In many cases the child's safe carer is a foster carer or kinship carer and the work with the carer helps to support the care placement. The nature of the engagement with the carer is entirely dependent upon the child's needs:

"Work with safe carers forms on average about 70 per cent of our intervention with a child. Much of the focus of the work with carers is on attachment-based intervention. We will work with carers on core issues such as affect regulation; body awareness...much of the work is educative, in order that they can work with those aspects of the child's behaviour that are most difficult."

"Before any action is taken, an ecological assessment is made of the context in which the child and family find themselves. We take a whole family holistic view, considering the entire context for each child when considering how to work with them...it is the adult in the child's group who often needs the therapy, and if they can get help then the child improves. We often work with the carer for a while."

### Open access family support

Generalist children's organisations embedded in local communities (usually with a direct link to education) are generally in a stronger position to carry out a broader range of longer term family and parent development work. While these services do not offer specialist support in terms of recovery from sexual abuse, they do provide supports which are essential to building resilience in vulnerable families. Services provided examples of a range of activities including: helping parents/carers who may need support in relation to difficulties coping with their child's behaviours, their own mental health issues, family breakdowns and finance.

### Do services support non-abusing parents/carers?

#### Key points:

- Resources for carer work are concentrated within the high tariff services, and in services which take a holistic whole family assessment of the child. Most of these are generalist and not just for CSA, and also mostly within statutory services.
- there are too few resources/funding/capacity for carers/family work within specialist services for children – these are very small services and very stretched.
- additional capacity and resource is needed to enable adult-focused specialist services to expand their support for non-abusing parents/carers, where this meets the child's wishes.
- 3 third sector organisations have found additional funding for carer and family support posts, but these are short term.

## 5: What does therapeutic work look like?

This section reports on the therapeutic recovery work undertaken with children across both specialist and generalist services. It provides an overview of the modes of intervention offered and the occupational profile of the practitioners who undertake face to face work with children. However the key focus of interest is the relational approach to working with children and the timing, location, and duration of the work. Across the variety of services there are broad commonalities in terms of the psychological therapies used and the core principles of work with children, but also some differences. We report rather than evaluate these here.

### Before the therapeutic work

In the West of Scotland we have seen that, depending upon their age and situation, and the severity and complexity of their problems; children may find help from one of a range of types of service of different orientations. It is important to hold in mind the spectrum of types of experience which constitute CSA, occurring in many different contexts, to children in very different circumstances, the impact of which is highly individualised.

All of the 39 services identified described the importance of creating safety and security and building a trusting relationship with children as the foundation for therapeutic work. Respecting the confidentiality of the child, ensuring their agency and an active partnership with them in agreeing what happens, were identified in the survey as key principles underpinning the relationship with a child.

*“The fundamental, bottom line for us is that the young person is in control of their own support. The biggest issue there is for anyone who has been abused is their control has been taken away. We must not mirror this in any way in the support process.”*

*“The initial 6 sessions are about the young person getting a sense of what it’s about and how they would like to use the safe space, also to decide if they like the worker.”*

### Tier 2 early intervention services

*“Our most important purpose is to give a young person seeking support for sexual trauma the very best experience of help seeking. We want to give them a positive experience of being able to trust someone, to be responded to appropriately, not to be re-traumatised – so that even if they do not want to discuss it or go into it now, their experience will encourage them to seek help at a later point if they reach a point where they start to need it.”*

Some of the open access lower tariff services described an important ‘bridging’ role that they perform with children who may feel a mix of emotions of hurt, confusion, shame and uncertainty. This often is about offering a safe space for a child to talk about their feelings and receive reassurance.

*“I can provide a listening ear until they feel ready to take the next step, which may be counselling for example, or some other kind of support...it’s about offering the emotional support someone needs to feel reassured and to gain confidence to reach the point where they feel able to do the difficult work, if they feel ready.”*

*“Often what young people need first and foremost is to be seen and heard, and to receive reassurance and information...to have one person who is on their side, who is there for them, and who is there to listen, not to tell them what to do or give them advice. This relationship with a single person is the most important thing for a young person.”*

Sometimes this is the role of a sexual health nurse or a social worker or another professional within statutory services, which underlines the importance of trauma informed skills and training and an understanding of CSA being available across the whole system of children’s services.<sup>81,82</sup> Social workers pointed out that they are often the people who have developed key, trusting relationships with individual children, which is the essential factor in supporting children and young people – and that ‘referring on’ may not always be in the best interests of the child. There is an identifiable need for this type of initial support in every area.

<sup>81</sup> See Appendix 1 – Methodology.

<sup>82</sup> Ensuring the needs of individuals affected by traumatic experiences are recognised, understood and responded to in a timely and appropriate way is a key aim of the proposed National Trauma Training Strategy, which the NES Transforming Psychological Trauma Knowledge and Skills Framework will inform.



### Tier 3 & 4 services

A phase-based model of intervention and recovery underpins the Knowledge and Skills Framework, Transforming Psychological Trauma. The survey of services found that this model is in use in many specialist services, as well as some generalist trauma recovery services across the 39 services.<sup>83</sup>

*“The first level of work is focused on safety, helping people be safe, in relation to a whole range of areas including accommodation, feeling safe at home, addictions, relationships. People cannot meaningfully engage with trauma recovery if they are not safe. This first level of work can take a very long time.”*

Social workers in a discussion group described their critical role in safety and stabilisation work with children; engaging with children and families affected by child sexual abuse, and developing the trusting relationships with children that are fundamental both in helping them to disclose and begin their recovery journey. This is viewed as particularly important in relation to child sexual abuse, not least because children’s disclosures typically happen further down the line of social work involvement, when a relationship has been well established. However the protected time professionals are able to dedicate to on-going case work with individual children is constantly under attack, because of social work’s crisis intervention role.

For services working with children who are at risk of sexual exploitation a core and often very lengthy part of this involves proactively working to seek to engage and build trust with a child, followed by safety and stabilisation work. When children’s experiences have taught them not to trust adults repairing this is not straightforward.

*“These young people need to have had a service before they are ready for that stage/type of intervention; they are not able to engage with anyone with a ‘set plan and agenda.’”*

*“Staff use a range of advanced and interpersonal counselling skills to develop empathy for the young people as the first building block in developing trust and forming the basis for successful interventions.”*

However services which carry out this role do not exist in most local authority areas. In discussion groups, police officers raised specific concerns about these gaps; about what happens to ‘hard to engage’ young people locally, and whose responsibility it is to tenaciously persist in engaging with them.

### Modes of intervention

There are broad commonalities across all services (specialist and generalist) in terms of interventions offered and the core principles of work with children such as needs based, long term support.

It is important to note that for many of the 39 services, the terminology of psychological therapies or interventions and the emphasis on modalities does not sit well with their approach to working with children in which the emphasis is on the importance of building relationships with children and their families and on providing a continuum of services that provides for the range of experiences children may have following sexual abuse.

*“It is less a case of these discrete things are offered as ‘interventions’ to clients, but that they are integrated into the tailored work that staff do.”*

*“This is needs based and staff are trained in a variety of approaches.”*

<sup>83</sup> The Judith Herman and the Human Givens approach were cited by a small number of services unprompted, but their use may in fact be more widespread amongst the 39 services.



A key reference document for health services working with children experiencing trauma, is *The Matrix Evidence Tables for Children and Young People: a Guide to Delivering Evidence-Based Psychological Therapies in Scotland*. The Matrix summarises the “best available evidence for clinical practice in child and adolescent mental health” and gives specific guidance about children with sexual trauma, and with complex trauma.<sup>84</sup> It recommends a child-led “multi-modal approach to treatment using a range of specific approaches to meet individual needs”. It should be noted that just a few NHS services (n=4) were among the 39 identified and, as mentioned, this study does not include CAMH services.

Our survey looks at modes of intervention in order to enable a comparison with practice across the UK. Debra Allnock and Patricia Hynes conducted a survey of therapeutic services for sexually abused children in 2012 and found that there are two broad categories of therapies used within the UK<sup>85</sup>:

- talking therapies (most commonly CBT, psychodynamic psychotherapy and counselling) and;
- creative therapies (including play therapy, art therapy and drama therapy).

The 39 specialist and generalist services in the West of Scotland fit with this picture. Counselling, cognitive behavioural therapy (CBT) and creative therapies are the three most common interventions offered by services. For a majority of services this is within the context of the provision of a range of therapeutic supports tailored to the individual needs of the child.

- 29 of the 39 services (74%) offer counselling, making it the most common type of intervention provided but often in the context of a range other tailored support, Person centred or integrative counselling were the terms most commonly used by services to describe what they offer. Integrative counselling is a combined approach to psychotherapy that brings together different elements of specific therapies.
- 25 out of 39 services (64%) offer CBT (group/individual). Two services also have staff trained in Dialectical Behaviour Therapy (DBT) a talking therapy based upon CBT but adapted for individuals experiencing very intense emotions.
- 25 out of 39 (64%) services offer some type(s) of creative therapy. We look in more detail at creative therapies including play therapy below.

**Table 3. Types of therapeutic interventions offered to children (number & percentage of services, by type)**

	Specialist (n=21)	%	Generalist (n=18)	%	All services (n=39)	%
Cognitive Behavioural Therapy	15	71	10	56	25	64
Attachment based intervention e.g. Video Interactive Guidance	6	29	9	50	15	38
Counselling	17	81	12	67	29	74
Creative therapy (art, play, drama)	12	57	13	72	25	64
Family therapy	7	33	7	39	14	36
Group work	7	33	6	33	13	33
Psychodynamic counselling	8	38	5	28	13	33
EMDR	2	10	4	22	6	15
Harmful sexual behaviour intervention	5	24	4	22	9	23

<sup>84</sup> NHS Education Scotland (2014) Children and Young People Matrix Evidence Tables. A guide to delivering evidence-based psychological therapies in Scotland. Edinburgh: NHS Education Scotland. p.68.

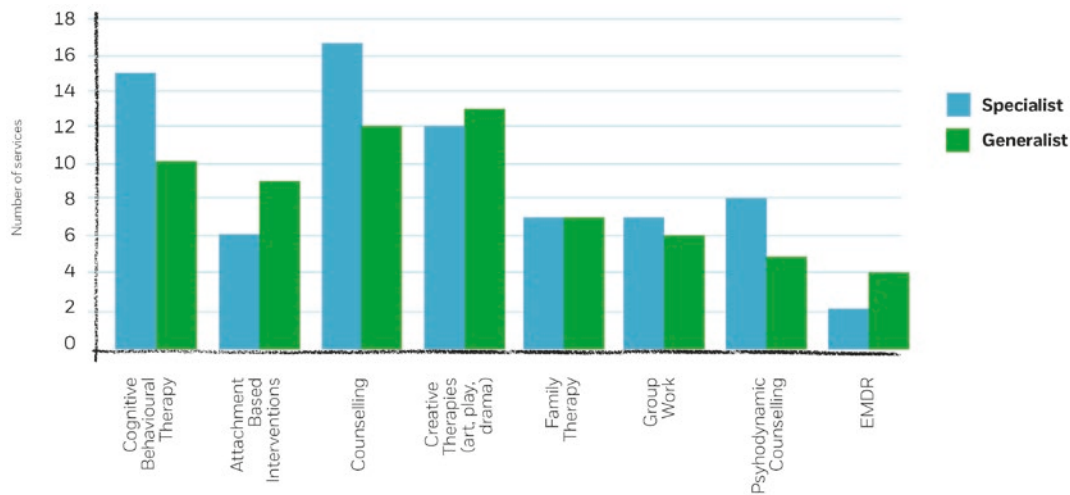
<sup>85</sup> Allnock, D. and Hynes, P. (2012) Therapeutic services for sexually abused children and young people: scoping the evidence base: summary report. London: NSPCC.

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Variations by type of service

- Counselling and CBT are more prevalent within specialist services (81%, 71% compared with 67% and 56% of generalist services).
- Creative therapies are more prevalent amongst the generalist services (72% of services compared to 57% of specialist services)

Figure 10. Psychological therapies offered by number and type of service

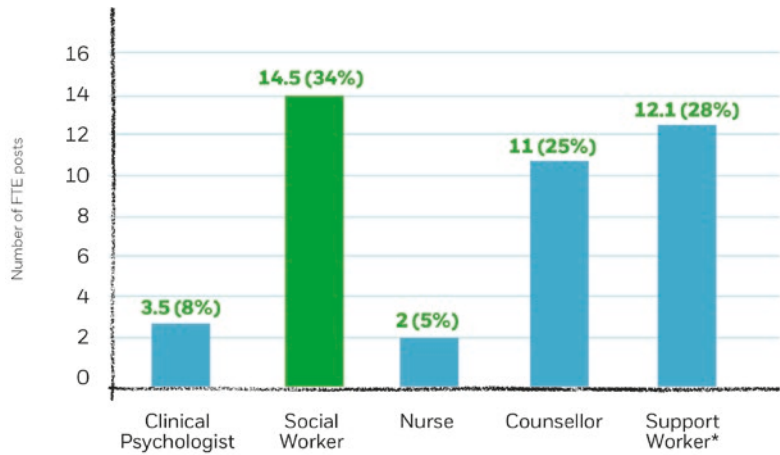


Additional therapies mentioned by specific services dyadic developmental psychotherapy, neuro psychological therapy and thought field therapy.

Who delivers help?

Occupations within specialist services

Figure 11. Specialist services, therapeutic staffing by type of post (FTEs)



There are very clear distinctions in occupations within specialist services:

- Support to children in the 4 'high tariff' child-focused services is delivered entirely by social workers. All of the social work posts are in these 4 services.
- The support offered by most other specialist services is delivered by counsellors and support workers (including 'project workers' and practitioners'). Consequently counselling therapies are the most common within this group of specialist services.
- 'The generic job title 'support worker', or sometimes 'project worker' is used particularly in sexual violence services.

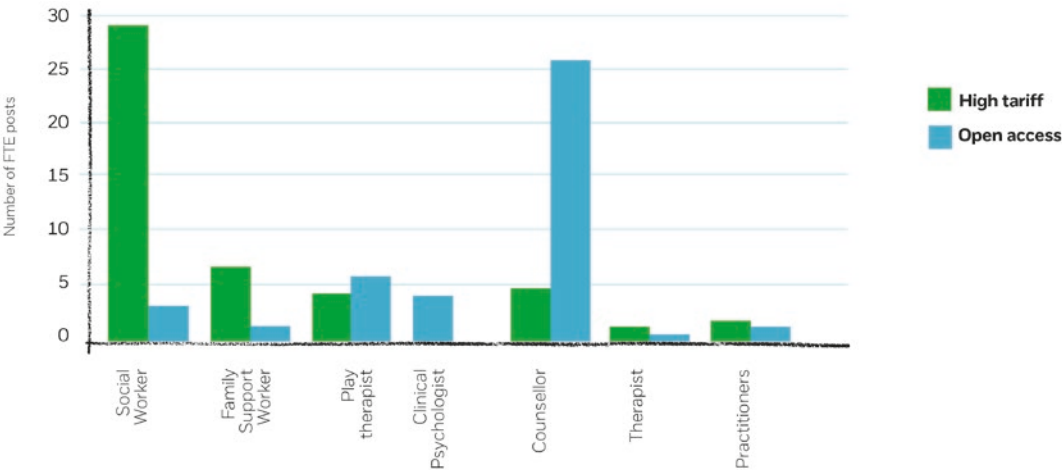
Within these specialist services there are **no** examples of multi-disciplinary work combining health and social care occupations.

- The majority of the clinical psychology resource is in one adult-focused statutory health service.
- Of the 2 nurse posts, one is in a voluntary sector children's service, the other in a statutory service.

Occupations within generalist services

A similar occupational segregation is found within generalist services, with social work posts concentrated in high tariff intensive services and counsellors within the open access services, which include schools counselling services and community-based counselling services. The majority of family support roles are in just one statutory service.

Figure 12. Occupations within services, by type of service



Multi-disciplinary working is a particular feature of the 9 high tariff generalist services, although not necessarily in the form of posts within the services.

- Two of the nine services have both mental health and social care specialisms within their staff team. Both are intensive services for highly vulnerable children.
- One is a social care service which is co-located with CAMHS.
- Other services have a close relationship and do team work with CAMHS colleagues, including Forensic CAMHS, and also draw on support from colleagues in sexual health and educational psychology in their work with children.

### Creative therapies

There is a growing evidence base to support the effectiveness of creative therapies in therapeutic work with children.<sup>87,88</sup> Almost two thirds of services (25 out of 39, or 64%) provide creative therapies to children. The majority of these are in the third sector (n=18, 72%).

The creative intervention most commonly cited by services is play therapy. The rationale for this type of therapy is that it enables children to “use play materials to project their inner worlds and provide ‘a sort of camouflage’ to provide distance and psychological safety.”<sup>89</sup>

Play therapy is the dynamic process between child and Play Therapist in which the child explores at his or her own pace and with his or her own agenda those issues, past and current, conscious and unconscious, that is affecting the child’s life in the present. The child’s inner resources are enabled by the therapeutic alliance to bring about growth and change. Play Therapy is child-centered, in which play is the primary medium and speech is the secondary medium.’ (British Association of Play Therapy)

Practitioners appear to value highly the use of play when working with children and young people who have been sexually abused, especially when working with young children.

Evidence from discussion groups indicates that while the provision of play therapy is limited within the statutory sector, social workers recognise play therapy as being an important form of specialist provision for younger children, and this is something that they would look to access externally for a child, however internal process can make it difficult to access qualified play therapist externally:

*“I’ve had experiences when I’ve been trying to access a play therapist – then that can be much more difficult; in relation to getting funding and getting approval and all that sort of thing- that can take much longer”.*

Whilst play therapy may be the creative intervention most commonly cited, it is clear that many services are incorporating elements of play into their work with children and young people, rather than delivering play therapy. A contributing factor could be that there has not been a fully accredited BAPT Play Therapy course available in Scotland for several years. Steps have been taken to rectify this and a three year part-time Masters Course in Play Therapy, accredited by BAPT, commenced at Queen Margaret University in September 2017.<sup>90</sup>

Two services (one specialist, one generalist) have staff with accredited qualifications in Filial Therapy, a specific form of play therapy which directly involves the child and their parent/carer and is designed to improve parent/child relationships. Filial Therapy is used to help infants under the age of 3 and children up to the age 14 years.

<sup>87</sup> See Play Therapy UK <http://playtherapy.org.uk/Research/Research1>

<sup>88</sup> Hendry, A. and Hasler, J (2017) Creative therapies for complex trauma. Helping children and families in foster care, kinship care or adoption. London: Kingsley.

<sup>89</sup> Play Scotland (2012) Getting It Right for Play. The power of play, an evidence-base. Midlothian: Play Scotland. <http://www.playscotland.org/wp-content/uploads/assets/Power-of-Play.pdf>

<sup>90</sup> [http://www.qmu.ac.uk/courses/PGCourse.cfm?c\\_id=290](http://www.qmu.ac.uk/courses/PGCourse.cfm?c_id=290)

### For how long do children receive help?

The majority of the 39 services offer open ended therapeutic support to meet the needs of the child or young person (n=34, 87%).<sup>91</sup> Therapeutic support is structured but flexible and reviewed in participation with the child at regular intervals.

*“...this is long term work, it’s not a quick fix”.*

“Individuals can be supported for as long as they want or as little as they want. They many choose to have breaks in their support. They may also choose to dip in and out of support sessions”.

The remaining services (n=5, 13 %) offer a time limited service. Whilst it can be argued that some of these services can also provide a longer term therapeutic intervention, they are distinct from the first category in having a pre-defined end point. Four of the five services with a pre-defined end point are in the statutory sector.

The strength of the therapeutic relationship between child and their key worker, and the child’s investment in the relationship, is critical. A common theme or issue for services of all types is that of dependency. Building resilience in children and in their support systems is a key part of the work of many services. Another common theme is the need for carefully planned phased exit work with children.

*“We go on as far as we can go with a young person, and that doesn’t necessarily mean that everything will be ‘fixed’ or ‘all right’ at the conclusion. The door is left open for the YP to come back. It may not be the right time for them”.*

*“We have an open door policy for children where they can re-access the service if they are in need of further support. On completion of intervention, service also offers a pop in session where they can come to a support group on a weekly basis”.*

### Child centred: where and when?

A high priority is placed by services on ensuring that the therapeutic environment and location, and the organisation and timing of support enable children’s needs to be met to the very best of their ability. In some cases this involved overcoming considerable barriers including those of geography and distance and the negotiation of appropriate outreach settings.

It is clear that services are flexible to meet the individual needs of children and place the upmost importance on finding a secure environment where the young person feels comfortable. The question of where and when is a sensitive issue related to the needs of the individuals or population whom the service seeks to support. For a few services outreach work including street work is critical to their work in identifying and engaging with vulnerable children.

The vast majority of services (n=32, 82%) currently provide outreach to children in terms of offering support in local community settings, with educational establishments being the most commonly cited locations. In 27 services outreach is a core part of provision (69%) and in 4 services only offered under certain circumstances.

Seven of the thirty nine services explained why they do not offer outreach. For one service the privacy and anonymity offered by a central location is vital; a community-based location would present a barrier to access. In the case of six services this is because they are child focused services which operate from their own premises, where resources have been invested in providing a purpose-built comfortable therapeutic environment suitable for children and young people. These services have been designed with children and young people at the heart of service delivery.

*“...a lot of thought and commitment has been put into the integrity of the therapeutic space. This kind of work demands a safe, consistent and protected environment, usually in the same space once a week.”*

<sup>91</sup> There was some ambiguity within the survey responses in terms of the length of time interventions are provided, for example, some respondents referred to the typical length of intervention offered in weeks, while other services referred to the typical number of sessions without specifying whether sessions were held weekly or fortnightly.

### When is support available?

A majority of services (n=30, 83%) offer core provision on weekdays between 8.45am and 5.30pm. Most can also work with children in the evenings but mainly on a need only basis. Others have set evening provision programmed into their standard working week i.e. pre-defined late nights or shift patterns. The latter approach is taken by only five services, four of which are specialist sexual abuse services.

*“Counsellors manage appointments with the family and will work evening sessions if that is needed. There is a lot of pressure on the after school period”.*

Weekend support is very limited; only five services are currently able to offer weekend support in addition to core weekday provision, and this is not available in all local authority areas. The flexible working arrangement of four services (only one of which is a specialist service) means that practitioners are able to work therapeutically with children and young people over the weekend, if required. In addition to these services, an intensive social work service operates a restricted shift pattern with two members of social work staff every Saturday and Sunday.

### What does therapeutic work look like?

#### Key points:

- Building safety and security and a trusting relationship with children is the foundation of therapeutic work
- Services dedicated to engaging with highly vulnerable children at risk of/experiencing CSE do not exist in every area.
- The types of therapeutic intervention offered by the 39 services fits with the UK-wide picture of post-CSA support, with counselling, CBT and creative therapies the most common.
- Multi-disciplinary work combining health and social care is not evident within specialist services.
- The majority of services offer long term open-ended support tailored to each child's specific needs. In just 5 of the 39 services is support time-limited.
- Outreach work is offered by the majority of services.



## 6: The landscape of service provision

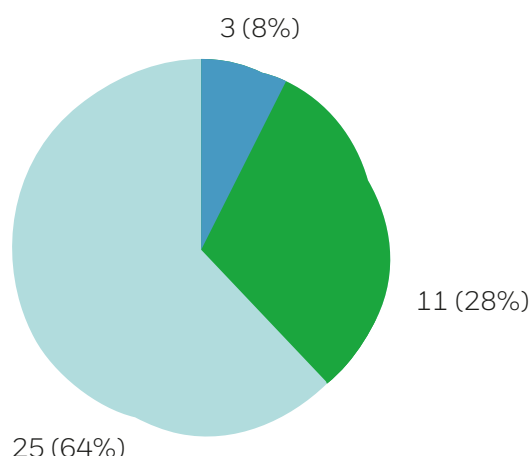
While the main contribution of the third sector is usually perceived as community based early intervention (Tier 2 within a stepped care model of service provision) it is clear that the sector is also a key provider of Tier 3 therapeutic services for children following sexual abuse. It is also important to note that some third sector services span several tiers of prevention work, undertaking universal and primary prevention work with children in addition to tertiary prevention, supporting children who have already experienced abuse.

As can be seen from **Figure 10** the majority of the responsive help available to children following sexual abuse is in the third sector:

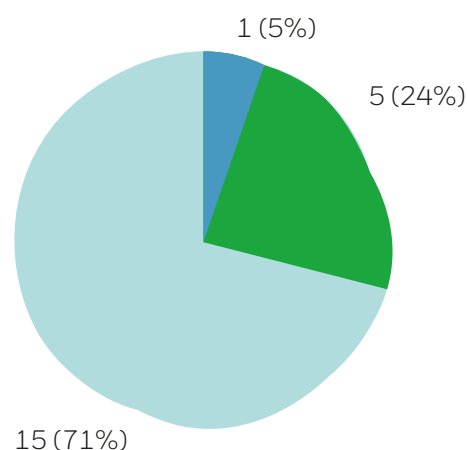
- Sixty-four per cent of all services are in the third sector (25 of 39 services)
- Seventy-one per cent of all specialist services (15 of 21 services) and more than fifty percent of generalist services (10 of 18 services) are voluntary organisations or social enterprises.

**Figure 13. Services by sector**

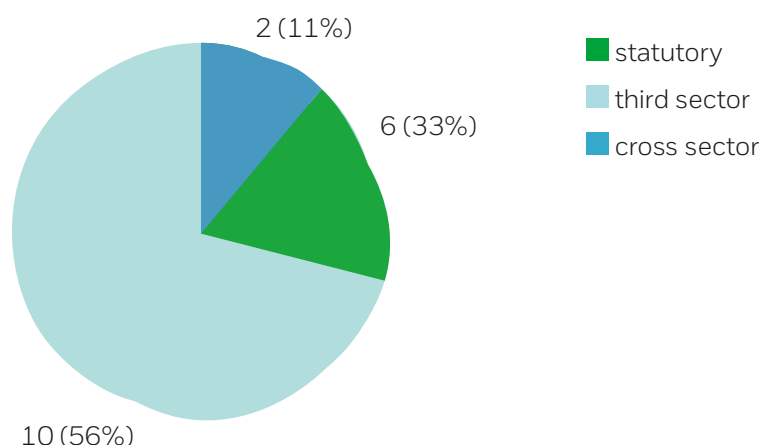
**i All services by sector (specialist & generalist)**



**ii Specialist services by sector**



**iii Generalist services by sector**



statutory  
third sector  
cross sector

The third sector therefore forms a significant part of the landscape of support for children's emotional and mental health following sexual abuse.

However most of the third sector services are dependent upon short term, fragmented and insecure sources of funding.<sup>92</sup>

- In over half of the third sector services (56%, 14 out of 25) the main source of funding is due to end in 2018 or before;
- In 44% of third sector services the main source of funding is due to end in 2017 or earlier.

A main funder in this context means the major or single largest source of funding a service has. However where services have a main funder, they tend to also have a number of other funding sources. A typical picture is for services to piece together support from different funders for different aspects of their service and as a consequence.<sup>93</sup>

*"This is a mixed picture. Some funding sources have come and gone, new ones have come on stream."*

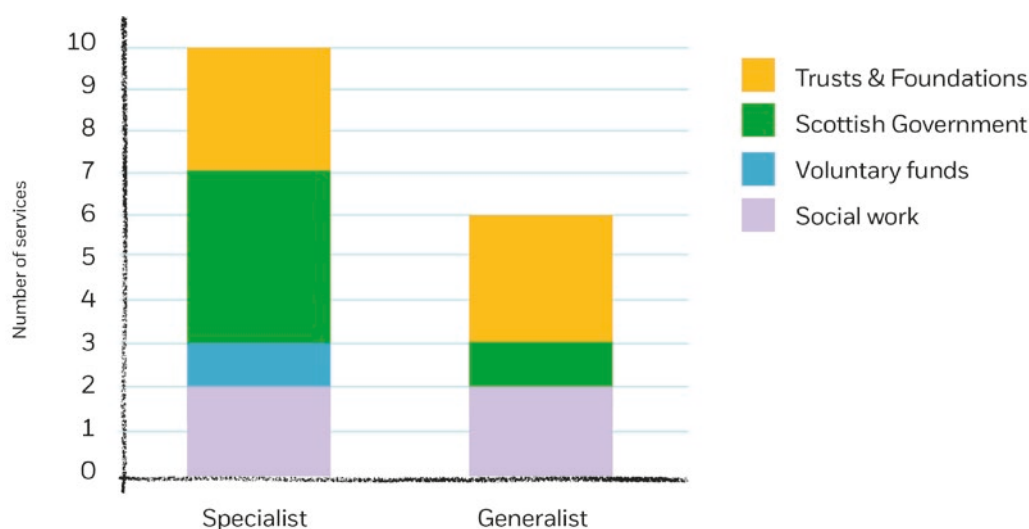
This funding picture is unchanged since the last Scotland-wide study of post-sexual abuse services conducted in 2008 by the University of Edinburgh.<sup>94</sup> This described the negative impact of short term and insecure funding on the provision of services and the concerns held, at that time, about the consequences of a reduction in ring-fencing following the funding concordat between central and local government.

Despite this insecurity, just under half of non-statutory services say they are quite or very confident about securing further funding and this confidence is often due to a certainty in the value of the work and the lack of other provision in the area.<sup>95</sup>

However the majority feel uncertain about the future and concerns are expressed about the impact of the fragility and insecurity of service provision on practice.

## Main Funding Sources

**Figure 14. Origin of main source of funding (non-statutory services only)**



<sup>92</sup> The funding data here relates specifically to face to face therapeutic services for children 18 years and under and not to the core funding of the parent organisation. Funding information was available for all specialist services and all but 2 generalist services.

<sup>93</sup> For social enterprises this includes contracts.

<sup>94</sup> Stafford, A., Morgan Klein, N., and Kelly, S. (2009) Mapping Therapeutic Services to Children and Young People who have been sexually abused. Services in Scotland. University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection.

<sup>95</sup> Information relates to the time of data collection, in summer-autumn 2016.

Of the third sector specialist sexual trauma services for children, 10 have a single main source of funding (see **Figure 14**).<sup>96</sup>

It is clear that the Scottish Government and Trusts & Foundations are the most common major funders of these specialist services. Where services have one main funder:

- 7 of 10 non-statutory specialist services receive their current main funding from either national government or a Trust or Foundation.
- 4 of 6 non-statutory generalist services receive their current main funding from these sources.

These main sources are supplemented by other smaller sources of income:

- 6 specialist services also receive funding from local authorities, either from social work services or health & social care partnerships.
- Charitable fundraising (voluntary funds) is an important part of the picture for most services.

Scottish Government funding streams supporting this work include the Early Intervention Fund, Equally Safe strategy, Violence against Women partnership, and Survivor Scotland.

The most common Trusts & Foundations referred to are the Big Lottery Fund in Scotland, Comic Relief, Children in Need, The Robertson Trust, and Lloyds TSB.

The funding picture clearly reflects some strategic priorities of national government and to some extent the mirroring of these in the funding priorities of key Trusts.

However it is also clear from the funding information of specialist services that:

- Awards from national (and local) government have been frozen or cut over the past 5 years;
- There is heightened competition for funding from Trusts & Foundations as services piece together the resources to provide a service to children.

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- There is heightened competition for funding from Trusts & Foundations as services piece together the resources to provide a service to children.

### Resource trends within specialist services

As might be expected, specialist services for children in the statutory sector have experienced pressures over the past five years. In such labour intensive services, finance equates to staffing, and the most commonly experienced expression of financial constraints for statutory services has been the non-filling of staff vacancies. This has an associated impact on caseloads and therefore waiting times for children. One of the five services had recently been reprieved from closure following a spending review.

While the specialist staff resource in the statutory sector has contracted slightly overall, the majority of third sector specialist services have experienced an increase in funding over the past 5 years, accompanied by an increase in staff resource over the same time period.

In both instances the scale of these changes is small; in some cases it relates to an additional half post, or additional clinical hours per week. However given the small scale of these services, one post left vacant, or half a post gained, can make a substantial difference to provision.

Some of the increases reported by third sector specialist services do not relate exclusively to therapeutic staffing. Some relates to posts for advocacy and prevention work, while therapeutic staffing has remained the same.

<sup>96</sup> Because of the complexity of the funding picture it is easiest to focus on the single main sources of funding for the 28 non-statutory services.

*“This is a problem, as the prevention work we now do is producing more disclosures, which we don’t have capacity to support.”*

Just two specialist services said they had experienced a considerable increase in staff resource over the past five years and they associated this with the high policy priority accorded CSA nationally and for one, the impact of Savile:

*“The staff increase over the last few years has been driven very much by the fact that referrals have increased so much over the past 5 years. The Savile revelations definitely impacted: referrals rose by 47% in the wake of Jimmy Savile, and the continuing media coverage of high profile cases has also had an effect.”*

The quality of support provided to children is contingent on more than the number of staff; it is about investment in the secure, strong base needed for the development of practice skills, and staff who feel valued.

*“Stability and consistency and having the same people in post is highly important for this type of work....it’s so important to have a stable workforce whose skills you invest in year on year.”*

*“The outcome of this is that the staff have gone 8-9 years so far without a cost of living increase in their pay, and no increments.”*

### Comparative trends in generalist services

In contrast to specialist services in the statutory sector, most of the statutory generalist services (four social work and two NHS services) had experienced investment and a growth in staffing over the past five years. With one exception the generalist services are high tariff services working with the most vulnerable and high risk young people. This is also true of two of the specialist services in the statutory sector, but the specialist statutory services also include open access services.

*“It [the staffing level] is currently the highest it has ever been. We have been very fortunate. However we’re still not able to meet all the demand. We could do with an additional full time staff member.”*

In the context of very hard financial challenges, this may reflect a shift away from early intervention and towards a consolidation of resources around populations for whom public agencies have statutory duties.

Generalist services in the third sector share the same funding issues as specialist services; it is a complex picture of fragmented short term funding with half of all services having no single main source of funding.

- In contrast with specialist services, generalist services in the third sector do not benefit from any Scottish Government funding streams.
- Where services have increased their funding over the past five years it is through securing additional funds from Trusts and Foundations with the Big Lottery in Scotland and Children in Need mentioned most frequently.

### The role of Child and Adolescent Mental Health Services

Engaging CAMHS services in the present survey was considered important in order to understand the extent to which services at different Tiers are working with children who have experienced child sexual abuse, as well as identifying referral pathways into CAMHS and out of CAMHS to wider support services.

There were considerable challenges, however, both in contacting and engaging CAMHS teams in the survey of therapeutic services, which are fully detailed

in Appendix 1. This brief overview is based on a small number of partially completed surveys returned from individual CAMH teams (n=7) from individual CAMHS teams/specialisms. A deeper understanding of the role of CAMHS in relation to therapeutic provision for children who have experienced sexual abuse is important going forward, with further research required to look at this. Discussion groups suggest a lack of shared understanding of CAMHS role in relation to the provision for children who have experienced sexual abuse and at times high levels of frustration where children referred to CAMHS do not meet the thresholds and/or are rejected for reasons around stability. Better understanding of the role of CAMHS is particularly important as the Government has identified investment in CAMHS as the main vehicle for improving access to support services for sexually abused children. The updated National Action Plan on CSE reports<sup>97</sup>:

*Since 2009/10, the Scottish Government has invested over £19.8 million to increase the number of psychologists working in specialist Children and Adolescent Mental Health Services by 70%. An additional £15 million is being made available through the Mental Health Innovation Fund during 2015-18, to support better access to Child and Adolescent Mental Health Services and to develop innovative approaches to delivering mental health services. The innovation element of the funding covers all ages and is aimed at supporting people in distress including those who have experienced trauma. £1 million is also being provided to NHS Education for Scotland to deliver a three year programme of Child and Adolescent Mental Health Services workforce development.*

NHS Child and Adolescent Mental Health services are not provided uniformly across health boards and can be complex to understand. Structures, team set-ups and referral criteria can vary widely between and within NHS Board areas. Outpatient CAMHS teams are defined and organised in a variety of different ways, for example by geographical area covered, by presenting condition, by severity of condition (Tier 3/4), age, other co-morbidities; and particular social circumstances such as looked after and accommodated children, or living with a parent with mental health difficulties.<sup>98,99</sup>

There are some specialist CAMH services specifically for children and young people experiencing emotional problems following sexual trauma in Scotland. For example, the Child Sexual Abuse Team, a CAMHS service at the Royal Hospital for Sick Children in Edinburgh, provides therapeutic support for children up to 18 and their parents who are experiencing emotional/behavioural/mental health difficulties secondary to a history of sexual abuse or assault. Until recently an NHS Lothian CAMH service (The Meadows team) provided a multi-disciplinary approach to children and young people and their families who are experiencing emotional, behavioural and mental health difficulties following sexual abuse, as well as a service for children who display problematic sexual behaviour.<sup>100</sup> However specialist child sexual trauma services are not provided across NHS Board areas, and appear to be extremely rare in Scotland.

Access to CAMH services in general for children experiencing emotional and mental health problems following sexual abuse may be difficult, depending on team structures and referral criteria. Thresholds for intervention at Tier 3 and 4 CAMHS are generally high. General guidance produced by the Scottish Government CAMHS delivery board in 2009 specifies that referrals are appropriate when a) a child or young person meets a basic condition of having, or suspected as having, a mental disorder or other condition that results in persistent symptoms of psychological distress and b) there is also the existence of at least one of the following: an associated persistent impairment of their day to day social functioning and/or an associated risk that the child may cause serious harm to themselves or others.

Thresholds at Tier 2 are lower with potentially greater access for children, perhaps especially where these are delivered as Tier 2 counselling services. Tier 2 services also may play an important role in the assessment and referral of children 'up' to higher Tier CAMH services or on to other services where referrals to CAMHS are rejected.

<sup>97</sup> Scottish Government (2016) Scotland's national plan to prevent and tackle child sexual exploitation updated. Edinburgh: Scottish Government, p.16.

<sup>98</sup> Murphy, R., (2016) SPICe Briefing Child and Adolescent Mental Health – Trends and Key Issues. Edinburgh: The Scottish Parliament.

<sup>99</sup> Royal College of Psychiatrists (2013) Building and sustaining specialist CAMHS to improve outcomes for children and young people, London: Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/files/pdfversion/CR182x.pdf>

<sup>100</sup> The Meadows team recently merged with The Rivers Centre an NHS specialist trauma service for people of all ages, dedicated to addressing the health, social and welfare needs of people affected by psychological trauma, including people who have experienced traumatic events such as childhood abuse and neglect and rape and sexual assault.

There can be significant variation in the referral criteria for CAMHS across NHS board areas and in the Tiers at which young people will be seen and assessed for a service.<sup>101</sup> There may also be variation in how referral criteria are interpreted.

In discussion, CAMHS professionals identified a range of issues around CAMHS structures, referral criteria and processes which may impact particularly on access to CAMHS for children experiencing sexual abuse and/or other childhood abuse or trauma, particularly where they may have complex behavioural presentations. It is important to point out that several of the CAMHS professionals who took part in the discussion were LAAC specialists: discussions were at times framed in relation to children who have experienced sexual abuse as part of a wider complex range of adverse childhood experiences.

#### Team structure/set up

Professionals described contrasting referral systems operating in different localities. One professional described an 'open' system, encouraging referrers with any concerns about (LAAC) children's mental/ emotional health to refer and where initial referral involves in-depth consultation between specialist CAMHS and the referrer, usually social work. In contrast, a more common 'closed' referral system was described, where all children and young people who are referred to CAMHS are initially assessed within a generalist/ locality team. According to professionals, 'closed' systems may lead to significant variations in how children who have experienced CSA and other complex childhood trauma will be assessed and whether they will be accepted for a service.

*"We have shifted a bit recently; there was a looked after children team that would be more dedicated to meeting the needs of the population and what these are, rather than putting these barriers. But recently we have shifted to all referrals coming through the locality teams – and I think the... demands that are facing teams, people's experience of working with trauma; their ability to recognise trauma – then a layer before they can get up (to specialist CAMHS services)".*

#### Staff skills, experience and training

There was some concern that CAMHS staff in generalist/ locality teams may lack skills and experience in recognising behavioural symptoms of trauma – including sexual trauma. Children who present with externalising problem behaviour, symptomatic of abuse and trauma, may be less likely to be assessed as meeting the criteria for a CAMHS service.

Participant 1: *"I think whether children who have been sexually abused are offered a service depends on the symptoms they are presenting with and the symptoms that are noticed. That is a real worry for me".*

Participant 2: *"I think in our team things have progressed a lot over the years, certainly not just with these difficulties but with other problems. But it can sometime depend on who is on duty on the day – who sees the referral as it comes in the door – as to whether or not that young person is accepted. That is improving – we are trying to improve consistency there but it is still an issue".*

Some groups of children may be particularly affected, for example children where sexual abuse is not formally identified and children who are not looked after. In some areas, for example, all looked after and accommodated children referred to generalist CAMHS teams for initial assessment will be assessed by specialist CAMHS, whilst children referred from home backgrounds will be assessed within generalist/ locality teams.

Potential referrers may also lack skills and experience in recognising behavioural symptoms or more specifically, carrying out routine enquiry with children where sexual abuse is a concern, meaning some children are not referred into CAMHS in the first place.

*"Part of the difficulty is the referrer – usually social work – don't feel skilled enough to do things like routine enquiry or ask about basic psychological functioning, for example like asking about more traditional symptoms like flash backs. It worries me that referrals (to CAMHS) can be batted off before they even arrive".*

<sup>101</sup> Murphy, R.,(2016) SPICe Briefing Child and Adolescent Mental Health – Trends and Key Issues. Edinburgh: The Scottish Parliament.



### Interpretation of CAMHS referral criteria

Interpretation of CAMHS referral criteria may vary across teams/ services in response to resource constraints and pressure on teams. This was seen to carry particular risks for children with externalising behavioural presentations, which may be a common presentation in some children who have suffered sexual abuse as part of a complex range of adverse childhood experiences.

*“It’s the kids that come in with the behavioural (presentations). . . . Now, there is a criteria for CAMHS – severe, enduring problems – but it depends on what CAMHS team you come in to. It’s like social work: their tariff goes up and up and up, the less and less staff they have. I think if you are a very stressed CAMHS team it’s how you interpret ‘severe and enduring’ and behavioural – so I would suggest it depends which CAMHS team you go to, as to whether that case would be accepted. And I find that very worrying”.*

### Wider systems work

Working with wider systems around a child is considered an integral aspect of CAMHS role with children experiencing sexual abuse and trauma. Multi-agency working and training and support for wider systems is essential both to equip those most closely involved with the child with skills in recognising and responding to trauma, and to facilitate children’s access to CAMH services for therapeutic intervention.

Participant 1: *“actually if I was going to do it again (set up a specialist team), I would probably say we would not do any direct work with the referrals we would just do training. Because we are rolling out basic introductions to attachment, to trauma: what it looks like, how it presents, what does it mean, what can you do if you are worried – that sort of stuff. Then we do much more intensive work with foster carers and with social workers”.*

Participant 2: *“This is the foundation that lets you build the rest on top all that”.*

Participant 1: *“Yes! Then you have the shared understanding, the shared language: you have the relationships with the other incredible but stressed professionals-social work-you know, you give them a platform. Actually I am already seeing a difference because they have a language to talk to people like children’s hearing system...or to talk to CAMHS even if the child isn’t looked after: they have language and they can speak to CAMHS – ‘here’s why I am worried’...and they are more likely to get them through the door”.*(CAMHS Discussion Group)

Professionals identified a range of pressures as ‘squeezing’ their capacity to work systemically, given its very time consuming nature. These included lack of staffing, pressure of workloads, the necessity to meet targets and the fact that much systemic work – such as extensive multi-agency working and attendance at children’s panels – is not included in CAMHS targets.

Overall, increasing pressure on Tier 3 and 4 CAMH services is regarded as driving stricter referral criteria in some services/ areas, again potentially impacting more heavily on children who may not be presenting with a clearly defined mental health problem.

The very low numbers returned from CAMH services, almost exclusively from one NHS board area, meant that no meaningful analysis could be undertaken. A few points are worth noting from the 7 returns:

- 6 of the 7 teams/specialisms record information about child sexual abuse in all cases. No figures were provided; one service reported that although they collected information, there was no separate system for retrieving this.
- 4 of the 7 teams/specialisms reported frequently working with children who have experienced sexual abuse, describing this as a ‘significant component’ or ‘regular part’ of their clinical work. One Tier 4 service estimated that 50% of their case load was made up of children who had experienced sexual abuse.
- 2 teams/specialisms reported infrequently working with children who have experienced sexual trauma, describing this work as of ‘very low frequency’ and ‘very small numbers’.

- 2 'comparable' Tier 3/4 CAMH locality services reported very different levels of work with children who have experienced sexual abuse, with one reporting high frequency and the other low. This may reflect differences in the way referral criteria are interpreted by the individual service and/or wider provision of therapeutic support services in the local authority area:

*"Many of the referrals for children/young people that have experienced sexual trauma get redirected to community services such as [service name] and [service name]. Children/Young People with experiences of sexual trauma would get accepted into our service if they were also presenting with a moderate to severe mental health difficulty".*

CAMH services are a source of incoming referrals, although not a main source, for many of the 39 services accessible to children following sexual abuse in the West of Scotland. This includes specialist post-CSA services both for younger and older children. This picture of CAMHS referring children on to appropriate specialist services locally fits with an understanding of the range of CAMHS referral criteria.

The 18 generalist services which offer therapeutic support to children after sexual abuse, have varied origins and orientations but many were created to fill an identified gap in emotional and mental health support for children and young people who do not meet Tier 3 CAMHS criteria. These include intensive statutory services for children with a history of neglect and abuse, who for a variety of reasons may not receive a service from CAMHS. They also include a number of third sector services established by experienced professionals with a background in statutory agencies, with a motivation to fill a known gap in emotional and mental health provision for children within a particular community or locality.

### Issues arising

Some fundamental questions arise from this overview of the landscape of provision for children. They relate to the extent of provision within the third sector and the implications this has for a child-centred response. First and foremost is the ethics of accepting children for intensive long-term support and treatment in circumstances in which the security and sustainability of the service is in doubt. This question was raised by practitioners in both the statutory and third sectors, and is most pressing in relation to children who do not meet the criteria or high thresholds of targeted statutory services at Tier 3-4.

*"Usually we have waited until the end of the financial year in March to find out that we will have funding for another year. It has been a source of continual anxiety for practitioners that they may not be able to provide ongoing support to children whose referrals they accept late on in the financial year. There are a lot of issues of safety and security around the work we do. We have excellent committed staff. But they have concerns about the lack of understanding of how important it is for staff to have a secure base to work from, when involved in such demanding and intensive long term work with children."*

The 2008 study of therapeutic support for children following sexual abuse found that while the need for specialist services had been accepted, the necessary funding was not there. It concluded there was "little evidence of a strategic approach to meeting the needs of children and young people who have been sexually abused."<sup>102</sup> The funding information presented here indicates the Scottish Government, and some key Trusts and Foundations are, through aligning funding with national priorities, taking a strategic approach to the provision of therapeutic support to children following sexual abuse. However it has not in itself resolved the underlying issues of patchy provision, under-capacity and insecurity.

<sup>102</sup> Stafford, A. , Morgan Klein, N. and Kelly, S. (2009) Mapping Therapeutic Services to Children and Young People who have been sexually abused. Services in Scotland. University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection.

The second, given the third sector are the major provider of therapeutic support for children post-sexual abuse, concerns the integration of third sector and statutory services within a clear pathway for children's emotional and mental health, so that they receive the right kind of help, at the right time.

Responses from services also indicate local variation in practical relations between third sector services, Child and Adolescent Mental Health Services, statutory social work services and the police, including how closely they work together as a system, the factor which at local level develops the child centred-ness of responsive help. In some areas third sector services are commissioned or co-commissioned by statutory services and, in a small number of cases, these were co-located or delivered in partnership with statutory agencies. Other services are provided following a competitive tendering process. In other areas third sector services, while receiving large numbers of referral from statutory agencies, have neither a contractual or funding relationship with local statutory agencies

The responses received from CAMHs teams/specialities came from three areas within the West of Scotland. Of these three areas, one is known to have in place an integrated pathway for children with emotional and mental health difficulties of all ages and this was independently referenced by CAMH services and other services in the area, together with the multiagency process by which each child is assessed and directed to the most appropriate care. A limitation of this study is that it cannot confirm whether a similar pathway exists in every other local area. A vital enabler of integrated local pathways may be a common framework for governance and quality assurance, to complement the National Trauma Knowledge and Skills Framework.<sup>103</sup>

## The landscape of service provision.

### Key points:

- The majority of generalist and specialist provision is in the third sector and is dependent upon short term, fragmented and insecure sources of funding.
- In over half of the third sector services (56%, 14 out of 25) the main source of funding is due to end in 2018 or before.
- This picture of provision is unchanged since the last Scotland-wide study of post-sexual abuse services conducted in 2008
- The Scottish Government and Trusts & Foundations are the most common major funders, where specialist services have one major source of funding.
- There is a great deal of local variability in practical relationships between third sector services, Child and Adolescent Mental Health Services, statutory social work services and the police, including how closely they work together as a system
- The ethics of accepting children for intensive long-term support and treatment in circumstances in which the security and sustainability of the service is in doubt was raised by practitioners in both the statutory and third sectors.

<sup>103</sup> NHS Education Scotland (2017) Transforming psychological trauma: a knowledge and skills framework for the Scottish workforce. Edinburgh: NES <http://www.nes.scot.nhs.uk/media/3806664/nationaltraumatrainingframework3.pdf>

## 7: Discussion and recommendations

These findings suggest there is still work to do to meet the emotional and mental health needs, even of the small number of children – the tip of the iceberg – whose experiences of sexual abuse come to light during childhood.

For those agencies currently endeavouring to develop a truly joined-up, child-focused health and justice response to sexual abuse, this overview provides part of the evidence base needed to inform the planning of therapeutic and social care provision for children.

There have been major improvements in the response to CSA since the 1980s, including better access for children to specialist services based on the efforts of adult sexual violence organisations; a transformation in policy and practice by the police in relation to sexual crimes including the introduction of Sexual Offence Liaison Officers; the development of primary prevention programmes in schools; and initiatives such as Stop to Listen, which aims to give children greater control over what happens following disclosure of abuse. All of this has been enhanced by the GIRFEC approach, which recognises the importance of a child's wider network in promoting their recovery.

Today there is arguably a greater national policy focus on CSA than at any other time, across issues such as online grooming and abuse, CSE, and HSB. However, while the detail of current provision may differ, the broad picture of therapeutic services has not changed since the Scottish mapping study of 2008. Indeed in very many areas and for some groups of children, *'patchy, inadequate and haphazard'*, the description of services made by Lord Justice Butler Sloss in 1992, equally applies today.

The overall picture of specialist support for children who have experienced sexual abuse is still one of extremely insecure provision. The majority of specialist provision is in the third sector and in over half of these services the main source of funding was due to end in 2018 or earlier.<sup>104</sup> A quarter of provision in the statutory sector is also insecure.

Across an area with a child population of over half a million there are 8 open access specialist sexual abuse services designed specifically for children. Three of these services also support children affected by domestic abuse, which means there are 5 open access specialist children's services in the West of Scotland solely dedicated to sexual abuse.

We have seen that these are very small services and the majority do not have capacity to meet demand. Where it is safe for services to have a waiting list, waiting times for services can be lengthy, varying from a few weeks to up to a year. Consequently the aspiration of GIRFEC, to provide 'the right help at the right time' is not being met for children following sexual abuse.

We must bear in mind that the current lack of capacity relates to a situation in which disclosure rates are low. As few as 1 in 8 children who experience sexual abuse are estimated to come to the attention of statutory agencies.<sup>105</sup> Those services that undertake primary, secondary prevention work with children and young people point to increased disclosures and growing pressures on therapeutic support services. A joined up ethical approach to prevention must also involve planning to ensure support is available for children's recovery.

<sup>104</sup> This relates to the point of data collection.

<sup>105</sup> Children's Commissioner for England (2015) Protecting children from harm: a critical assessment of child sexual abuse in the family network in England and priorities for action. London: Children's Commissioner for England.

Therapeutic provision and pathways need to reflect the complexity of children's experiences of CSA. There are key gaps in provision in six areas:

First, in tailored provision for children with disabilities including learning disability and communication difficulties, a population of children at heightened risk of sexual abuse. There is one 0.5FTE dedicated therapeutic post for children with learning disability for which funding has run out. There are no dedicated therapeutic posts for children with learning disabilities under 12 years of age.

Second, there is a very significant gap in provision for younger children. The vast majority of children aged 12 years and under have no access to specialist services in their local authority area. The gap in provision is greatest for children aged 5 and under, and for this youngest age group what is required is support for the child within the context of their caregiving relationships, which is work with their non-abusing parents/carers.

Third, half of local authority areas do not have a service offering a sexually harmful behaviour intervention. The gap is greatest for younger children; 12 out of 17 areas have no service. Professionals in discussion groups expressed concerns about the lack of early intervention support where there were concerns about a child's sexualised behaviour.

Fourth, a gap exists in child-focused services for older children. 9 out of 10 young people aged 13 years + have access to specialist service in their local authority area, but mainly from *adult-focused* sexual violence or survivor organisations. A majority of all specialist provision accessible to children (57%) is delivered by this sector.

The benefit of tailored provision for children and young people has already been recognised by adult sexual violence and survivor services, as evidenced by the development of child-focused services since around 2007-08. However there are still too few of these services, and those that exist require greater capacity in order to scale up their preventative work to a universal level, and match this with adequate therapeutic staff resource.

Six, for children at risk of or involved in sexual exploitation, professionals express concerns about the gap in many areas of anyone whose responsibility it is to persist, and keep on persisting, in trying to engage highly vulnerable young people. Specialist services dedicated to this task do not exist in every area.

### Therapeutic work with children

We found that there are broad commonalities across specialist and generalist service provision in terms of the psychological therapies used and the core principles of work with children such as needs-based, long-term support.

However, while there is strong evidence for the importance of work with non-abusing parents and carers, resources for carer work are concentrated in tier 4 (higher tariff) services. Resources for carer/family work are more stretched within open access specialist services for children and especially within adult-focused services (where the older age-group of children supported may also alter the nature of their needs).

There are signs of growing pressure on some statutory services to restrict the duration or 'dosage' of support for children in order to meet waiting time targets and manage resources.

Within specialist services there are no examples of inter-disciplinary working combining health and social care occupations. Inter-disciplinary work is found within high tariff generalist services, most but not all of which are in the statutory sector.

### Care pathways

A number of pieces of evidence suggest that a clear integrated care pathway to stepped care provision of support may not always exist in every local area for children following disclosure of sexual abuse.

there is no standard assessment of children's emotional and mental health needs following

disclosure of sexual abuse and no routine follow up of children over time.

a lack of awareness amongst professionals of available therapeutic service provision in their areas combined with uncertainty about the governance and quality of services, including for how long they will exist;

local variance in practical relationships between third sector services, CAMHS, statutory social work and police including how closely they work together as a system;

targeted statutory therapeutic provision for children with ongoing child protection concerns exists in only 6 out of 17 local authority areas;

all professional groups express concern about children assessed as having no ongoing child protection concerns. In these cases no-one is responsible for assisting the child and family, including providing or referring to appropriate therapeutic help and family support.

This overview is limited by the absence of information about CAMH services. Given the emphasis placed on CAMHS within the National Child Sexual Exploitation Action Plan, the extent and nature of the role of local CAMH services in supporting recovery from CSA would benefit from further exploration. Further scoping is required to look at how, in each locality, children of different ages and with different needs, who require help recovering from sexual abuse, fit within local care pathways for children with emotional and mental health difficulties.

Service planning is hindered by the lack of coordinated data gathering. For example, data is not routinely gathered about the numbers of children accepted after referral to specialist and generalist services each year for therapeutic support following experiences of sexual abuse.

Generalist services tend not to record, in a retrievable and reportable manner, the numbers of children with whom they work who are receiving therapeutic help following an experience of sexual abuse. The 2008 UK mapping study by Allnock found this in relation to generalist CAMH services and recommended improved recording. Moreover professionals in discussion groups indicated reasons to believe there is an under-reporting of CSA within official child protection data. We have mentioned the lack of Scottish prevalence data for CSA and the full potential of data about the incidence of CSA, such as police recorded crime, is not being achieved. In sum, improvements are needed in data recording, collation and reporting by all agencies to help improve knowledge and understanding of CSA.



## The way forward

In recent years national government has played a valuable strategic role, through key national initiatives, in directing funding into CSA prevention and therapeutic service provision. This is evident from our analysis of funding information. However this has not been sufficient to resolve the underlying problems of insecure and patchy provision. There are also some common issues of demography, numbers of referrals, rurality and geography which affect all forms of specialist service provision.

The 2017 strategic review of forensic medical services by HMICIS highlights how far Scotland lags behind the rest of the UK in providing healthcare, advocacy and ongoing therapeutic services for victims of sexual abuse, both children and adults. In England these are provided in an integrated model, to set standards, by a network of 43 Sexual Assault Referral Centres (SARCs) with 4 in Wales and 1 in Northern Ireland. However not all of these see paediatric cases. Scotland has one, the Archway at Sandyford in Glasgow, although this only sees children aged 13 years and over.

All roads currently point towards the benefits of the 'Children's House' or *Barnahus*, a model which originated from the United States Child Advocacy Centres and has been carried to countries around the world including Iceland and South Africa.<sup>106</sup> It was one of the models of practice considered by the 2015 report of the Evidence and Procedure Review and according to HMICIS, the model is now being considered by the Scottish Government, Police Scotland and the Scottish Court Service.<sup>107</sup>

This model provides child-centred and integrated justice, healthcare and ongoing therapeutic social care services all under one roof, often in a purpose built child-friendly accommodation, and is already tried and tested in improving justice and therapeutic outcomes for children who have experienced sexual abuse and assault. NHS England is currently funding the establishment of two Children's Houses in London.

Whilst this holds the potential to improve criminal justice outcomes for children, the emphasis must be on the health, wellbeing and recovery of all children and families affected by child sexual abuse. Whether the model adopted is a Children's House, or a SARC, some form of regionalised coordinated service provision tailored to the needs of children is required, linked to clear pathways of care for children of every age group in each local area, and to existing local specialist services.

A regional specialist centre, a centre of excellence, could perform a number of the functions outlined below. This includes the provision of training, advice and consultancy to support frontline professionals and children's wider systems (including carers and foster carers) across local authority areas, which the current funding model does not enable specialist CSA services to play a full role in.

We have the benefit of being able to learn from developments at a more advanced stage in the rest of the UK. NHS England has already published a toolkit for assessing local need and planning recovery services for children following sexual abuse, based on experience in London.<sup>108</sup> We can also draw on the evidence-base for effective practice with children and young people and their families, which now includes RCT findings.<sup>109</sup>

<sup>106</sup> Children's Commissioner for England (2016) *Barnahus: Improving the response to child sexual abuse in England*. London: Children's Commissioner for England. <http://www.childrenscommissioner.gov.uk/publications/barnahus-improving-response-child-sexual-abuse-england>

<sup>107</sup> HM Inspectorate of Constabulary in Scotland (2017) Strategic overview of provision of forensic medical services to victims of sexual crime. Edinburgh: HMICIS para 278. [www.hmics.org.uk](http://www.hmics.org.uk)

<sup>108</sup> Harewood, E. (2017) Child sexual abuse hub toolkit. London: NHS England. <https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2017/04/Child-Sexual-Abuse-Hub-Toolkit-March-2017.pdf>

<sup>109</sup> Carpenter, J., Jessiman, T., Patsios D. et al (2016) Letting the future in. An evaluation of impact and implementation. London: NSPCC. <https://www.nspcc.org.uk/services-and-resources/research-and-resources/2016/letting-the-future-in-evaluation/>

## Recommendations

1. Following a disclosure of sexual abuse, *every child* should receive an expert assessment of their emotional and mental health needs and, in line with GIRFEC, this should consider the support needs of the child's non-abusing parents and carers (see point 3).

The expert assessment and the standards around this should be developed, preceded by discussion of who should be involved in developing these, at which point in time the assessment should be undertaken, who should undertake the assessment, and associated training needs.

2. Because the impact of abuse may not be evident immediately, there should be *routine follow up* of each child at set points, to review changes in their needs over time. The evidence base indicates this is necessary, as for a range of reasons, the full impact of abuse often does not affect a child until a later developmental stage, when they are able to understand what has happened to them.

The model for this process could be the assessment and routine follow up which occurs (in some areas) whenever a child is hospitalised following an incident of self-harm.

3. Standard information, advice and support should be available to non-abusing parents and carers following disclosure so that they are equipped to know and understand how their child is likely to be feeling and behaving, and are able to make sense of and respond supportively. A named point of contact for any queries or help down the line should be made available to them.<sup>110</sup>

4. In every local area there should be an integrated therapeutic care pathway for children following disclosure of sexual abuse. This could be specific to sexual abuse, or integrated into a broader local care pathway for children's emotional and mental health needs.
5. Strategic coordinated action at national, regional and local level is needed to ensure that, wherever a child lives, they have access to the right help, in the right place, at the right time from specialist children's services after sexual abuse. Detailed planning work is required giving attention to the following gaps:
  - services for younger children (under 12s) with a particular focus on care-giving relationships;
  - child-focused services for older children (12 years +);
  - tailored provision for disabled children, including learning disability and communication difficulties;
  - Child sexual exploitation: services able to do the arduous, persistent work needed to engage with children identified as at risk, working with police and social work;
  - Intensive therapeutic services for the most vulnerable children.
6. Central collation, routine updating, and dissemination of information about available services to the multi-agency professionals who need this.

<sup>110</sup> The role of the named person could be considered here.

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7. This mapping of service provision, including provision for harmful sexual behaviour, should be carried out for the rest of Scotland, to complete the national picture. It is vital that this includes a thorough exploration of the role of specialist CAMH services throughout Scotland in supporting children with sexual trauma, as the Scottish Government has identified this as the main vehicle for improving access to support services for sexually abused children.
  8. Improvements in data recording, collation and reporting by agencies and services about child sexual abuse should be undertaken. The Scottish Government should investigate how to fill the gaps in knowledge about the population prevalence and incidence of child sexual abuse in Scotland and maximise the potential of existing data sources to help our understanding of the nature of child sexual abuse and the contexts in which it takes place.

# Appendix 1 – Study Methodology

Two types of data collection were undertaken: a mapping exercise and survey of services, and facilitated discussion groups with professionals experienced in supporting children and their families and carers following disclosure of sexual abuse.

Ethics approval was not required for the survey work due to it being essentially an audit of service provision, and non-sensitive in nature. However good practice guidelines were followed to ensure that informed consent was sought from services and the data was stored, used, and reported in a manner that protects the anonymity of participants. Ethics approval was obtained for the expert discussion groups because of the sensitive nature of the issues discussed.

## Mapping of Therapeutic Services

### Parameters

Services were included which offer ongoing *face to face* therapeutic support or intervention to children and/ or young people, who have experienced sexual abuse, at any point in their childhood.

This includes services for children up to and including the age of 18, who:

- have experienced any form of sexual abuse, including child sexual exploitation;
- have been identified as being at risk of sexual abuse/ exploitation;
- may have displayed sexually worrying or harmful behaviour.

The aim was to capture both specialist and generalist services providing therapeutic recovery services to children following sexual abuse.

Specialist services are those which have developed a specialism in working with children who have experienced sexual abuse or who present harmful sexual behaviour and who spend all of their time, or a large proportion of it, doing so.

Generalist services are those which help children with a range of difficulties and adversities. These services undertake work with children who have experienced sexual abuse or present harmful sexual behaviour, but as part of what they do, and they do not necessarily spend a substantial proportion of their time doing so. Both types of service can be either adult or child-specific.

For resource reasons decisions were made to exclude some specific types of generalist service and these are described below. The following were *excluded* from the study:

- Health and social work professionals e.g. LAAC nurses, area team social workers, who provide therapeutic support to children as part of their general practice. These were excluded because of the focus on services.
- Internal specialist resources within statutory services, for example specialist posts or teams within social work departments who provide consultancy and support to area team social workers.
- Private sector services including freelance therapists and consultants are excluded because the focus is on services available to children *free at the point of use*. Their services may be 'bought in' by statutory agencies to work with individual children and also accessed on a paid basis by children and young people.
- Services whose primary focus is on domestic abuse, or substance or alcohol misuse. There are well-evidenced associations between these issues and sexual abuse. Similarly services such as street work with young people, sexual health services and youth offending are also likely to come in contact with children at risk of, or who have experienced sexual abuse. However for capacity reasons these types of services were excluded from the study. The only exception to this was harmful sexual behaviour services or interventions located within youth justice. These services were included because they met this specific criteria.
- Victim Support Scotland services available to children aged 12 and over, again for capacity reasons. These provide face to face emotional support to all victims of crime including sexual abuse but do not provide counselling and tend to refer on for longer term therapeutic trauma recovery work. Children under the age of 12 are referred to Childline.

## Identification of services

A database of every existing service located within the geographic area of interest was developed using diverse lines of investigation. The initial core of the database consisted of services known to Rape Crisis and to Childline in Scotland and was assembled by the West of Scotland Child Protection Managed Clinical Network. This was cross checked against the Survivor Scotland, the Women's Support Project and Roshni directories and with the database of services developed by the University of Bedfordshire for a mapping exercise conducted in 2015. In addition the following additional lines of inquiry were explored:

- Third sector children's organisations were asked to identify relevant services, including Children 1st, Barnardo's, Action for Children, Aberlour, and Quarriers.
- Stop to Listen Pathfinder local authority leads via their stakeholder groups were asked for help in identifying services in their areas.
- Requests for details of relevant services were circulated through the following networks:

The Child Protection Committees Lead Officer Group  
(via WithScotland)

The National Violence Against Women network

Rape Crisis Scotland Prevention Worker network

Zero Tolerance distribution lists

National Children and Young People Prevention Network

The database was supplemented and refined further through desk research and online searches of local authority and NHS service websites, Children's Service Plans and web searches with the following search terms:

- [Child sexual abuse services + 'location']
- [ 'Sexually harmful behaviour children + 'location']
- [Child sexual abuse + location]
- [Sexual trauma children + location]

Snowball technique was also used; as services were identified and screened, they were asked for details of any other relevant services they were aware of in their areas.

## Survey Protocol

Following identification, initial contact was made with each service by email, followed up by telephone contact, and a screening question asked:

*"Does your service offer any kind of therapeutic support for children and/or young people who have experienced sexual abuse including child sexual exploitation, or who present harmful sexual behaviour?"*

A negative response resulted in the service being screened out of the study. Where services met the criteria, arrangements were made to conduct the survey by telephone or in person at a convenient time with the most appropriate person in the organisation, usually the service manager. An information sheet outlining the purpose of the study and the intended outputs was provided in advance, to ensure informed consent to participation.

The data collection tool was a survey questionnaire. The questionnaire was administered mainly via telephone interviews and in some cases in face to face interviews. In a minority of cases where time constraints were overwhelming, the questionnaire was self-completed and returned by services. The majority of data collection activity was conducted over summer and autumn 2016. Most survey respondents were service managers or team leaders (33 out of 39). It was common for managers or team leaders to also spend a portion of their time on face to face practice.

To provide consistency the questions were based upon the survey developed and administered by Debra Allnock at the University of Bedfordshire for a UK-wide mapping of therapeutic services in 2015, commissioned by the NSPCC. Some additional questions were developed and piloted. The main areas for data collection included:

- service type, origins and history
- geographic area covered
- service criteria and referral pathways
- types of therapeutic intervention offered to children, and safe carers
- duration of support offered
- staffing and occupations
- funding sources and trends
- waiting times
- demographic information about the children accepted after referral in the most recent year.

### Response rate

A total of 53 services were initially identified. This included services suggested by other agencies.

The total number of services screened as meeting the criteria was 41. Survey interviews were successfully completed with 39 services, a response rate of 95%

### Data analysis

Data from completed survey responses was entered into SPSS and analysed using SPSS and Microsoft Excel. A thematic analysis of data from open questions was undertaken.

### Limitations

#### Identification of services

Best efforts were made to identify all relevant services. However, it must be acknowledged that the completeness of the mapping exercise is contingent upon the responses received (or not received) from the organisations and networks with whom we made contact and the deficiencies of online directories in terms of being regularly maintained. It is therefore possible that some eligible services have been overlooked. Provision by statutory social work services was included where we were made aware of this. From enquiries we are also aware that not all local authority social work services have developed this type of provision in their areas.

In the course of mapping the West of Scotland services, the research team produced tailored mapping reports for the Stop to Listen Pathfinder local authorities: Glasgow City, Renfrewshire, North Ayrshire and also Perth and Kinross. This provided the opportunity to check for completeness the outcomes of the mapping exercise at local authority level, tested against the knowledge of local stakeholders. The feedback received indicated that all specialist CSA recovery services meeting the criteria had been identified. Any services initially overlooked were generalist services, and in some cases there were doubts about their eligibility.

It is worth noting that if a research team was unable to detect a service using a systematic approach and with a dedicated resource then how difficult must it be for children, young people and their families, or indeed professionals, to source help.<sup>111</sup>

### Child and Adolescent Mental Health Services

Very few survey responses (n=7) were received from individual CAMH teams/ specialities. The responses came from 2 out of the 6 full NHS Board areas in the study area.<sup>112</sup> Because of the low response rate and the incomplete nature of the responses received, the decision was taken to exclude CAMH services from the main analysis.

Considerable challenges were experienced in attempting to contact and engage with CAMHs teams during the fieldwork. Obtaining contact details for CAMHS in each area proved extremely difficult as did identifying the most appropriate individual to speak to, as contact information for CAMH services, and details of the structure of services in each area of Scotland is not consistently available online. Where contact details were available and contact was made, it proved difficult to identify the appropriate person to speak to, and be connected with them. Given the pressures on CAMH professionals unsurprisingly email contact tended not to be acknowledged or responded to.

Central support from the West of Scotland Programme Manager and a senior manager at one NHS Board level resulted in a number of CAMH teams within one NHS Board area responding to the survey. However survey questionnaires were fielded electronically and many returns were incomplete.

Initial contact and assistance from a single CAMH team in a second area enabled responses to be obtained from other relevant teams in the same area.

<sup>111</sup> Allnock, D., Sneddon, H. and Ackerley, E. (2015) Mapping therapeutic services for sexual abuse and exploitation. London: The University of Bedfordshire and the NSPCC. [www.beds.ac.uk/\\_data/assets/pdf\\_file/0004/504283/mapping-therapeutic-services-sexual-abuse-uk-2015.pdf](http://www.beds.ac.uk/_data/assets/pdf_file/0004/504283/mapping-therapeutic-services-sexual-abuse-uk-2015.pdf)

<sup>112</sup> The study area also includes a part of NHS Highland (Argyll & Bute Council area only).



### Flaws in data collection tool

Despite initial piloting of the questionnaire, some survey questions proved ambiguous and produced an inconsistent response, compromising the quality of the data collected. Where this was the case the findings are not reported. For example, the survey sought to identify services specifically targeting/tailored to the needs of specific high risk or vulnerable populations. The survey questionnaire asked if services 'provide tailored support' to a number of different groups. However the wording of the question was interpreted in a variety of ways: either as the service is specifically designed for this population; proactive measures are in place to meet the needs of this specific population; or the service is inclusive by nature/ staff are responsive to every child's specific needs as a matter of course.

### Professional Discussion Groups

Facilitated discussion groups were held with 5 groups of professionals who may work closely with children at different stages following sexual abuse. Health Professionals (n = 1); Social Workers (n = 1); Police (n = 1), CAMHS (n = 1) and Social Workers (n = 2). Discussions ranged in length from between one and a half hours to three hours; all groups were facilitated by members of the research team. With the written consent of participants, four of the group discussions were recorded and transcribed for analysis. In the case of the 2nd social work group, (held at a seminar exploring community responses to child sexual abuse) a full note was taken of the discussion with the verbal consent of participants, and written up immediately after the event. A thematic analysis of the transcriptions was undertaken manually by two members of the research team.

The discussion groups were exploratory in nature. They were convened to investigate professionals' views and experiences around the issue of therapeutic support for children, rather than a comprehensive picture of knowledge and practice. Very small numbers of professionals were involved in each discussion group and not all local authority areas across the West of Scotland were represented at every group.

### Child and Adolescent Mental Health Services

Seven CAMHS professionals from four NHS Board areas participated in the CAMHS discussion group. The group comprised of clinical psychologists and family therapists, some within LAAC teams or services. Participants were recruited through the West of Scotland CAMHS Network, which facilitated contact with the clinical directors for CAMHS in each of the five NHS Boards which fall within the geography of this study. Invitations were passed to appropriate colleagues within CAMHS teams with experience and interest in working with children who had experienced sexual abuse. Broadly, the discussion explored the role of CAMH services in working with children and young people experiencing sexual abuse, children and young people's access to CAMHS services and professional's around barriers to access.

### Health Professionals

Five health practitioners from three NHS Board areas participated in a facilitated discussion. The group was recruited via the West of Scotland Child Protection Managed Clinical Network and included a consultant paediatrician, a nurse consultant, a CAMH service manager, a senior staff nurse in an emergency department, and a child protection nurse advisor. Broadly, the discussion explored health professional's roles in supporting young people who had experienced sexual assault; health involvement in the assessment and referral of children to therapeutic support; perceptions of therapeutic service provision for children and young people in their local area and areas for improvement.

### Police Officers

Four police professionals from four Police Scotland divisions participated in a facilitated discussion group. Participants were recruited with the assistance of the Stop to Listen Pathfinder Steering Groups in the West of Scotland and Police Scotland. Broadly, the discussion explored the police role in working with children and young people who have experienced any kind of sexual trauma, including any role in facilitating access to services, perceptions of children's needs and the availability of therapeutic recovery services for children in their local areas.

### Social Workers (2 groups)

Nine social work professionals participated in two separate discussion groups held to gather experiences from both statutory and third sector social work practice. The first group involved three social workers from three local authority areas all working within Children and Families teams, who were recruited through the Stop to Listen Pathfinder Steering Groups. A second 'opportunistic' group was recruited with the assistance of the Centre for Family and Relationships Research at Edinburgh University from mixed participants attending a CRFR seminar on community responses to child sexual abuse. Participants included four social workers working within statutory sector one social worker working within a 3rd sector therapeutic organisation and a counsellor working with children and young people. The two groups explored processes locally and social workers' role in the assessment and referral of children to therapeutic support services; social workers' own potential role in working therapeutically with children and young people following sexual abuse; professionals' impressions of local service provision and potential barriers to children accessing services.

## Appendix 2 – Study Geography

The West of Scotland Managed Clinical Network in Child Protection covers the following NHS boards and local authority areas:

NHS Greater Glasgow & Clyde – Glasgow City, Renfrewshire, East Renfrewshire, East Dumbartonshire, West Dumbartonshire, Inverclyde.

NHS Lanarkshire – North & South Lanarkshire councils

NHS Forth Valley – Clackmannan, Falkirk & Stirling councils.

NHS Dumfries & Galloway – co-terminous with D&G Council

NHS Ayrshire & Arran – South Ayrshire, North Ayrshire, East Ayrshire Councils

NHS Highland – Argyll & Bute Council area only

NHS Eileanan Siar/Western Isles – co-terminous with Comhairle nan Eileanan Siar/Western Isles Council.



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