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Sexual abuse and therapeutic services for children and young people

The gap between provision and need

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with Lisa Bunting, Avril Price, Natalie Morgan-Klein, Jane Ellis, Lorraine Radford and Anne Stafford

June 2009

www.nspcc.org.uk/inform

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Introduction

Working Together to Safeguard Children (HM Government, 2006) defines sexual abuse in the following way:

“Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways”

(HM Government, 2006)

Worldwide it has been estimated that 160 million girls and 73 million boys under 18 years of age have experienced forced sexual intercourse or other forms of sexual violence involving physical contact (Pinheiro, 2006, p12). In the UK the true prevalence of sexual violence against children and young people is not known, but a recent review published in *The Lancet* estimated that between 5 and 10 per cent of girls and 5 per cent of boys have experienced penetrative sexual abuse and up to three times this number have been exposed to other forms of sexual violence (Gilbert et al, 2008).

Childhood sexual abuse has been associated with both short- and long-term mental health consequences, such as anxiety, phobic reactions, guilt, substance abuse, difficulty trusting others, low self-esteem and dissociation (Walker, 1988), and depression and suicide (Briere and Runtz, 1987). *The Corston Report* (Home Office, 2007) highlighted criminality as a very real potential consequence, revealing that a high proportion of female inmates had a history of sexual abuse. Research also suggests that individuals with a history of sexual abuse and victimisation are at a greater risk of re-victimisation (Messman and Long, 1996; Roodman and Clum, 2001). More recent research by Finkelhor et al (2007) found that there are a significant number of children experiencing more than one type of violence (referred to as “poly-victims”). Therapeutic services aim to address the mental health issues arising from such abuse that may ultimately lead to these consequences.

We know that there is a range of services where children can go to receive help if they have experienced sexual abuse, including the 58 community-based services provided by the NSPCC to help children and young people overcome the harmful consequences of such abuse. However, it is widely believed that the services available do not match the actual need. Services provided by the NSPCC underpin the organisation's commitment to campaigning to ensure that national levels of service provision are adequate. Article 39 of the UNCRC sets out the state's obligation to ensure that child victims of neglect, maltreatment, torture, exploitation or armed conflict receive appropriate treatment for their recovery and social integration. Providing adequate services for children and young people who have experienced sexual abuse is one of the obligations of meeting Article 39. The English government has also recently stressed the need to build capacity, especially in the voluntary sector and in the NHS, to provide adequate services to support children and young people who have been sexually abused (Home Office, 2007). This research, generously funded by the Private Equity Foundation and the Children's Charity, aimed to address a gap in our knowledge by mapping the availability of therapeutic services to support children and young people who have experienced sexual abuse across the United Kingdom.

The aims of the project were to:

1. Map the current availability of therapeutic services for children and young people who have been sexually abused, raped or sexually exploited, which may include services for those who display sexually harmful behaviour.
2. Review the provision of services in relation to the identifiable demand and need.
3. Evaluate the accessibility and approachability of services to children and young people.
4. Consult with young people about the services that exist and the types of services they want.
5. Consult with professionals working in therapeutic services about the accessibility of services, interagency working, and how to deal with any areas of unmet need.

We hope that findings from this study will inform future service development by providing information about the availability of services and gaps that exist. The research also provides a context for a forthcoming NSPCC study, which will investigate what methods of support and therapeutic interventions are helpful in the longer term to bring better outcomes for children and young people who have experienced sexual abuse.

Structure of the report

This is a UK-wide study covering England, Wales, Northern Ireland and Scotland. The data in this report is aggregated to give an overall picture of services across all four nations. Individual reports will subsequently be published focusing on the specific issues relevant to the policy context and the services in Northern Ireland and in Scotland. Differences in policy and service provision across the four nations that make up the UK are only mentioned in this report where they are relevant to the overall analysis.

The report sets out in detail the policy context, rationale for and aims of the research, how the data was collected and analysed and, most importantly, the key findings and their implications for those working with children and young people who have experienced sexual abuse. The executive summary is available as a separate online publication from www.nspcc.org.uk/research. Chapter 1 reviews the literature around the development of service provision in the UK; current research on service provision; and the gap between prevalence and identification. It also covers accessibility and availability of services; views of children and young people and what they want; and a brief commentary on the effectiveness of interventions. Chapter 2 presents the methodology and overview of the participating services. Chapter 3 provides an estimation of need, alongside a geographic presentation of existing services. Chapter 4 examines service demand and accessibility. Chapter 5 describes what services were on offer, who was providing them, and issues related to training and supervision of staff. Chapter 6 presents findings on joint working arrangements, funding structures and the commissioning process. Chapter 7 presents data on young people's knowledge and views around services for sexual abuse. Finally, chapter 8 provides key recommendations for policy. The data is organised so as to maximise the integration of both the quantitative and qualitative data from the questionnaire, as well as the in-depth responses from the semi-structured interviews with managers and commissioners.

1 Literature review

In the UK the true prevalence of sexual violence against children and young people is not known, but a recent review published in *The Lancet* estimated that between 5 and 10 per cent of girls and 5 per cent boys have experienced penetrative sexual abuse and up to three times this number have been exposed to other forms of sexual violence (Gilbert et al, 2008). Retrospective research conducted by the NSPCC with 2,869 young people aged 18 to 24 years found that 16 per cent of young women and 7 per cent of young men reported having experienced sexual violence involving physical contact before they reached the age of 16 (Cawson et al, 2000). The impact of sexual abuse on the health and wellbeing of children and the lasting consequences into adulthood are increasingly recognised. The immediate and longer-term impacts include: detriment to physical health through sexually transmitted infections, physical injury and unwanted pregnancy, post-traumatic stress disorder, anxiety and panic attacks, depression, higher risk of substance abuse, obesity, eating disorders, self-harm and suicide, increased risk of re-victimisation, experiencing domestic violence as an adult and, in some cases, an increased risk of offending behaviour (WHO, 2002). In this first chapter we set out the framework for the provision of adequate services to support children and young people who have experienced sexual abuse as set down by the United Nations Convention on the Rights of Children (UNCRC), which is an important focus of the cross-departmental *Sexual Violence and Abuse Action Plan 2007* (Home Office, 2007) and the *Violent Crime Action Plan 2008–11* (HM Government, 2008). The bulk of this chapter is a review of the research literature on therapeutic services for children and young people. We consider this literature and explore two themes: availability (whether services match needs); and impact (the effectiveness of services in helping children and young people to overcome the consequences of abuse and in bringing improved outcomes).

1.1 Therapeutic services and children's rights

Our approach to the mapping of services for children and young people affected by sexual abuse has been guided by the responsibilities of states under the UNCRC (UNCRC, 1989), which the UK government ratified in 1991. There are many aspects of the Convention relevant to the rights of children and young people who have experienced sexual abuse but the most pertinent are:

- Article 19 (Para. 2), which requires states to take all necessary steps to prevent and protect children from violence, abuse and neglect. “Protective measures should... include...treatment and follow-up of instances of child maltreatment...”.
- Article 34, which refers specifically to sexual violence and places a duty on states to “protect children from all forms of sexual exploitation and sexual abuse”, including prostitution and pornography.
- Article 35, which sets out responsibilities of states to protect children and young people from abduction, sale and trafficking.
- Article 39, which obliges states to take all appropriate measures to promote the physical and psychological recovery and social reintegration of child victims of violence.

The Convention’s provisions set baseline standards against which all policy, legislation and services for children and young people should be measured. The Convention goes beyond child protection and includes state responsibilities for provision as well as for children’s participation (Article 12). The report of the UN Committee on the Rights of the Child (2002 and 2008), which detailed the extent to which the UK was meeting its obligations to the Convention, praised a number of the UK government’s intentions and initiatives in areas such as education, child poverty and child welfare generally, but was critical of the UK’s record in some aspects of prevention of violence against children and provision of services for children (sections 4.37 and 4.38). A strong commitment to implement a children’s rights approach provides an opportunity to plan for and to deliver interventions, which are not only effective at preventing and protecting children from sexual abuse and helping them overcome the harm that may result, but also respect their rights to have a say in the types of services that exist.

1.2 Development of therapeutic services in the UK

There has been some level of state action against the sexual abuse of children since at least the 19th century, when the Punishment of Incest Act 1908 was passed. Historical research suggests that professionals working with children have long been aware of the existence of sexual abuse, but it was only relatively recently, with the advent of second-wave feminism and the “rediscovery” of sexual abuse that occurred with the Cleveland cases, that the harm of sexual abuse was recognised as a child protection matter (Smart, 2000). Voluntary sector child protection agencies, such as Barnardo’s and the NSPCC, have been providing direct

services to vulnerable and abused children since the 19th century. The types of services delivered have changed over time, moving away from an early focus on “child rescue” and sexual abuse as moral depravity towards providing therapeutic support in the community to reform or to aid recovery, and to support non-abusive parents to provide care (Corby, 2006; NSPCC, 2006). Most services to support children and young people affected by sexual abuse developed post-Cleveland (ie since the late 1980s) and the impetus for their development have come from three areas: adult services for people affected by recent and past sexual violence, which have been mostly feminist sexual violence services developed within the voluntary sector (Rape Crisis centres, incest survivors groups, childhood sexual abuse survivors self-help services, male abuse survivors, and most recently the Home Office funded sexual assault referral centres – SARCs); children’s voluntary sector services (eg NSPCC and Barnardo’s services, including court support and assessment services); statutory services developed in local authority specialist residential services, and NHS mental health and treatment services.

The history of service development has been largely uncoordinated and until quite recently there has been little evidence of a strategic approach to match national or local provision with identified needs, even though joint planning to address local needs has been an increasingly important feature of the last decade’s child protection, public health and crime control policies. It is beyond the scope of this short report to consider the history of service development comprehensively, but it is nevertheless important to consider the unique policy developments across the UK that have impacted on the shape of services in Wales, England, Northern Ireland and Scotland. We have outlined below the most important policy developments in each of the four nations, limiting the review to the most relevant developments in the past 10 years of government policy on supporting children and young people affected by sexual abuse in each of these three policy areas.

1.2.1 Children’s services developments towards safeguarding and responsive services

State responsibility to provide welfare services changed radically in the 1980s with the introduction of an increasingly “mixed economy of care” and of care in the community (Parton, 2006). Child protection services, largely the preserve of local authority social services departments, were probably least affected by the trends towards community care as only local authority social workers and the NSPCC have statutory capacity for child protection. However, the general pattern of change to develop local authorities as commissioners of care, to reduce their role as direct providers and to foster improved working

together has had an impact on all aspects of social care. Voluntary sector agency relationships with local authorities have moved towards contractual relationships to provide commissioned care and community support. Since the 1970s the NSPCC has decreased its role in direct child protection and increased its support work with children and their families (NSPCC, 2006).

1.2.1.1 England

A central piece of legislation relating to child welfare and protection in England is the Children Act 1989, in which two important principles are enshrined. These are that: first, the welfare of the child is the paramount consideration in making decisions about children; and, second, wherever possible, interventions should focus on prevention and voluntary work with parents and others, in order to support children and families in the community. Alongside the Children Act 1989, semi-statutory guidance was issued on how agencies should cooperate to safeguard and promote the welfare of children, entitled *Working Together Under the Children Act* (DH, 1991). Following concerns that local authorities were concentrating most of their resources on investigating allegations of abuse, a third edition of *Working Together* (DH, 1999) was issued in 1999, together with an associated document *Framework for the Assessment of Children in Need and their Families* (DH, 2000), which sought to rebalance the focus on child welfare work. Agencies were required to focus their efforts on supporting children in need and their families through the provision of flexible and non-stigmatising services.

There has been a raft of legislative and consequent organisational changes relating to the welfare of children and young people since 2000 under the British Labour government's *Quality Protects* programme (Fawcett, Featherstone and Goddard, 2004). Primary care trusts (PCTs) have been established in health areas and legislation relating to children leaving care (Children Leaving Care Act 2000) and the Care Standards Act 2000 have been implemented. Children's trusts have also been established. In addition, responsibility for children's services was transferred from the Department of Health (DH) to the Department for Education and Skills (DfES) and is now with the Department for Children, Families and Schools (DCFS). *Every Child Matters* (Chief Secretary to the Treasury, 2003) proposed a broad range of strategies to improve services for vulnerable children and young people, comprising the five outcomes: be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic wellbeing. This was followed by *Every Child Matters: Next Steps* (DfES, 2004) leading to the Children Act 2004. The principal provisions of the Children Act 2004 are designed to encourage improved partnership and clearer accountability, by placing a new

duty on agencies and other local providers to cooperate to improve the wellbeing of children and young people, so that all work to five common outcomes.

A fourth edition of *Working Together to Safeguard Children* (DfES, 2006a), which includes regulations in relation to local safeguarding children boards (LSCBs), was published in 2006. The document is one of five giving guidance on children's trust governance and strategic planning, and on the issue of safeguarding and promoting the welfare of children. The underpinning statutory framework of the new guidance comprises the Children Act 1989, the Education Act 2002 and the Children Act 2004. This new guidance stresses the importance of "the duty on all agencies to make arrangements to safeguard and promote the welfare of children" (DfES, 2006a, p10), including the police and youth justice personnel, along with education, health and social care personnel in the statutory sector. Likewise the same "duty" is accorded to those in the voluntary sector and in faith communities.

The only obviously specific reference to child sexual abuse in the new guidance is contained in chapter 6, in relation to children abused through prostitution (6.2); female genital mutilation (6.11); and forced marriage (6.17). Chapter 11 refers to children who may be particularly vulnerable to abuse and includes some mention of sexual abuse. A key principle in working with children and young people who abuse others, including those who sexually abuse/offend, is that "there should be a co-ordinated approach on the part of youth justice, children's social care, education (including educational psychology) and health (including child and adolescent mental health) agencies" (DfES, 2006a, p200).

Although the guidance sets out the ways in which organisations and individuals should work together to safeguard and promote the welfare of children and, in so doing, refers to the appropriateness of good practice and training for those who work with children and young people who have been subjected to abuse, there is no specific reference to the actual provision of services in terms of who should provide what for whom, and where such children and young people might seek and receive the help they require to overcome the trauma of sexual abuse.

The *National Service Framework for Children, Young People and Maternity Services* (DH and DfES, 2004) sets out the key elements of a child and adolescent mental health service (CAMHS) that "works". It states that services need seven factors including "...a commitment to consulting with and acting on children's and families' views;...the integration of the service within the CAMHS tiered framework;...Links with other services and initiatives outside CAMHS...; An ability to attract new sources of funding; Retention of a stable, multi-

disciplinary staff group with opportunities for training and development...and; [a] balance between providing a direct service to users and influencing the broader network.” (DH, 2004, p36).

The *Cross Government Action Plan on Sexual Violence and Abuse* (2007) and the associated *Sexual Violence and Abuse Action Plan Implementation Guide* (2007) address sexual violence against adults but also give equal weight to tackling child sexual abuse. The plan and guide present a coherent strategy to prevent sexual violence across the lifespan and to support and protect victims/survivors. One of three key objectives of the plan is “to increase access to support and health services for victims of...childhood sexual abuse” (p2). There is explicit recognition that low levels of disclosure result in victims/survivors not receiving the support needed to deal with their experiences of abuse and, “where victims do try and access support, it hasn’t always been available. We need to increase the capacity in support services to deliver services for those who need them.” (piii). The implementation guide lays out the responsibilities of statutory and voluntary delivery agencies and partnerships at a local level with indicators to measure success in meeting the plan. The plan is an important step towards planning and providing resources that match the needs of those who have experienced sexual violence and abuse. Guidance is to be provided for PCTs on commissioning services from the voluntary sector. The main focus of provision is by expanding the number of Home Office funded sexual assault referral centres (SARCs) to 40 by the end of 2008. SARCs provide one-stop-shop support to adult and increasingly child victims of sexual violence and are set up to allow self-referrals. SARCs also work with other services, including independent sexual violence advisors (ISVAs), who support victims in the community and through the court and prosecution process. A trial is to be set up in three projects to evaluate the relevance of ISVAs for children and young people who experience sexual violence. However, the plan has to be realised within existing resources. Another relevant piece of legislation, the Female Genital Mutilation Act 2003, seeks to protect girls from genital mutilation, which is still practised within some migrant communities.

The recently published DCSF *Staying Safe Action Plan* (2008) has increased the focus of policy on prevention, early intervention and safeguarding as being everybody’s responsibility. *Staying Safe* defined safeguarding at three levels: universal services provided for all children and young people; targeted services for children and young people who are vulnerable to abuse or exploitation; and responsive services for children who have already been harmed. Responsive services include the listening service ChildLine, which is undergoing a government-funded expansion to increase the reach of this important source of confidential support for children and young people. The action plan, promising guidance on

therapeutic and preventive interventions, and on levels of service provision, was intended to be published in summer 2008 by the Department of Health Victims of Violence and Abuse Prevention Programme (VVAPP). However, this programme has now closed and the guidance has yet to appear.

Most recently, the Home Office has initiated a wide-ranging consultation on violence against women and girls, intending to raise awareness of the scale and nature of this violence and to generate national debate and discussion on what more could be done to end it. The consultation paper *Together we can end violence against women and girls* (HM Government, 2009) sets out the consultation strategy and aims, the progress made so far and the challenges that remain. A key aim of the consultation is to consider how best to deliver the strategy that develops from the debate, and ensure that it will be effectively implemented and monitored.

1.2.1.2 Wales

For the most part, legislation in relation to children and young people in England and Wales is identical. The establishment of the National Assembly for Wales in 1999 devolved responsibility for guidance, regulation and budgets around matters relating to health (including child and adolescent mental health services), social welfare and child protection to Wales. This has led to the development of specific Welsh guidance for professionals and commissioners and also the adoption of different approaches.

The overarching strategy in Wales in relation to children and young people is *Children and Young People: Rights to Action* (WAG, 2004), which sets out the Welsh Assembly Government's seven core aims for children and young people: these core aims relate directly to articles in the United Nations Convention on the Rights of the Child, core aim 3 of which states that every child has the right to "enjoy the best possible health" and be "free from abuse, victimisation and exploitation".

As in England, the Children Act 1989 and the Children Act 2004 are the crucial central pieces of legislation relating to child welfare and protection. As it was created before devolution, the Children Act 1989 has few specific references to Wales. The Children Act 2004 has a specific section relating to Wales (part 3), which outlines similar duties to England in terms of the role of agencies in promoting welfare and safeguarding children and young people. The guidance relating to the delivery of the 2004 Act is *Safeguarding Children: Working Together Under the Children Act 2004* (WAG, 2006), which replaced the previous guidance relating to the Children Act 1989 *Working Together to Safeguard Children* (NAW, 2000).

The new guidance set out arrangements for safeguarding children and young people for agencies named within sections 28 and 31 of the Children Act 2004, including the role child and adolescent mental health services (CAMHS) were to play in these arrangements (2.131). The guidance also contained a definition of sexual abuse and had specific sections relating to sexual exploitation and abuse by children and young people. A revised version of the *All Wales Child Protection Procedures*, including the revisions within the new guidance, was published in 2008 to be used alongside *Working Together to Safeguarding Children*.

In September 2001, the Welsh Assembly published *Everybody's Business*, its 10-year strategy for CAMHS. This all-Wales strategy was aimed at establishing comprehensive, effective and high-quality services. Its strategic vision was based on a multi-agency, four-tier concept, which sought partnerships between children, young people, their families and professionals. The strategy envisaged a "joint endeavour" to tackle mental health problems, meaning that "no sector or component of a sector should be absolved from playing its full part in CAMHS". A four-tier strategic framework was outlined to help commissioners develop a strategic approach to CAMHS and was established as a basic tool for planning and delivering services in Wales, with the planning and commissioning of more specialist tier 3 and tier 4 services to be carried out on an all-Wales basis.

Within the strategy, the Welsh Assembly Government highlighted that certain children and young people do provide some particular challenges due to their circumstances, including children and young people who experience abuse and services for children who are in the care system.

In September 2005 the Welsh Assembly Government published the *National Service Framework for Children, Young People and Maternity Services in Wales* (NSF), to be implemented over a 10-year period. The NSF detailed the quality of services that children, young people and their families have a right to expect and receive. In chapter 1, there was a section relating specifically to children and young people with mental health problems and disorders, which focused on two standards covering access to and quality of such services. A range of specific issues was addressed, which coincided with the *Everybody's Business* four-tier and multi-agency context. Twenty-two key actions were detailed with reference to the organisation(s) responsible for their delivery, five of which were "flagged" to identify those core key actions for early delivery. These flagged actions included the development of primary mental health workers (PMHWs); out-of-area referrals; the offer assessment; risk assessments for those who may pose a risk to others or place them at risk of harm from others and themselves; and liaison agreements for risk management.

The Welsh Assembly Government has also recently established a task and finish group to look at the provision of services to children and young people who display sexually harmful behaviour. The task group has reported with a series of recommendations for consideration by the Minister for Health and Social Services.

1.2.1.3 Scotland

Scotland has taken a more strategic approach to domestic and sexual violence of adults, and to providing services for children affected by domestic violence, which has inevitably had an impact on the development of services there. The Scottish Executive (known as the Scottish Government since 2007) and the Scottish Parliament were established in 1999. The Scottish Government has the power to make and implement policy; propose primary and secondary legislation; and allocate finance to areas in which it has responsibility (Smith, 2008). These include health, social welfare, education, local government and public bodies, as well as much civil and criminal law (Smith, 2008). As such, they include the key areas of relevance to this study.

The guidance accompanying the Children (Scotland) Act 1995 outlined the main categories of needs for which services were required. These included children who are looked after by the local authority; children who need protection; and children who “have emotional, behavioural and mental health problems” (Scottish Office, 1997, p15). The guidance also set out categories of services to meet needs. These included counselling services and psychological/psychiatric services (Scottish Office, 1997, p17).

The Children (Scotland) Act 1995 was followed by a number of national guidance documents aimed at promoting interagency cooperation in child protection and setting out the roles of professionals in the various agencies in an increasingly specific way.

Protecting Children – A Shared Responsibility: Guidance on Inter-agency Co-Operation was issued by the Scottish Office in 1998. Agency-specific guidance exists for health professionals (Scottish Executive, 2000) and education professionals (Scottish Executive, 2005).

Following devolution in 1999, the Scottish Executive made children and young people a key policy priority, making explicit reference to the UN Convention on the Rights of the Child. As a result, there have been significant policy developments in this area in recent years. The overarching *Vision of Scotland's Ministers for all Scottish children* (Scottish Executive, undated) set out intended outcomes for all policies and services concerning children and

families – namely, that children are safe, healthy, achieving, nurtured, active, respected, responsible and included. With regard to health, the aspiration was that children and young people in Scotland have “the highest attainable standards of physical and mental health, access to suitable healthcare, and support in learning to make healthy and safe choices” (Scottish Executive, undated). Specific policies of relevance to the study are set out below.

Protecting Children and Young People: The Charter

Based on a consultation with children and young people with experience of the child protection system in Scotland, this document set out what children themselves wanted to see from services and what they could expect from professionals. This included the pledge to children that “you will get the help you need, when you need it” (Scottish Executive, 2004a).

Protecting Children and Young People: Framework for Standards

This document set out eight overarching standards for professionals working in child protection, based on the above charter. This included the objective that: “In addition to meeting immediate need, professionals identify and provide the help needed to enable children to overcome the longer-term effects of abuse or neglect. The provision of necessary help will not be delayed pending legal or other processes” (Scottish Executive, 2004b).

Mental Health of Children and Young People: a Framework for Promotion, Prevention and Care

The Scottish Government’s National Programme for Improving Mental Health and Well-being identified children and young people as a key priority. Based on a needs assessment of the mental health of Scotland’s children and young people commissioned by the Scottish Executive Health Department in 2000 – which identified “a significant mismatch between the level of mental health need and the capacity to work with that need” and in particular a lack of capacity in the specialist sector – the document *Mental Health of Children and Young People: a Framework for Promotion, Prevention and Care* set out the following key principles:

- Mental health promotion for children and young people should be an underpinning principle for all who come into contact with children and young people, whether they are well or unwell.
- Work on prevention of mental ill-health, treatment and care for children’s and young people’s mental health should be needs led.
- Mental health promotion, illness prevention, treatment and care for children and young people should have the rights of children and young people as a core value.

- Mental health should be mainstreamed within children's services.
- Improving the mental health of children and young people requires a coordinated and coherent combination of health promotion, prevention work, and intervention and care services.
- Children's services should operate as intelligent networks – that is, services engaged with one another in ways that encourage development and adaptation to changing need, circumstance and evidence.

The document also prioritised the involvement of service users in service planning and evaluation. The Scottish Government is committed to implementing the framework by 2015, acknowledging in 2007 the findings of a strategic review of the CAMHS workforce, *Getting the Right Workforce – Getting the Workforce Right* (Scottish Executive, 2005b) that the specialist mental health workforce in Scotland was less than half the size required to achieve this, it has committed to annual increases in NHS specialist CAMHS workforce capacity to the required level by 2015.

1.2.1.4 Northern Ireland

Northern Ireland differs from other health structures in the UK in that it has an integrated health and social care system. This integrated system has recently undergone significant changes under the review of public administration (RPA). Under RPA the trust structure changed in April 2007 from 19 trusts to five health and social care trusts. The four HSSBs are currently still in operation, although it is intended that they will be replaced by one health and social care authority and seven local commissioning groups (LCGs) in 2008. Under these new arrangements the five HSCTs are responsible for the provision of therapeutic services, which are currently commissioned by the four HSSBs. These reforms have entailed a period of huge structural change and flux for HSCTs, which are still very much in a transitional phase in Northern Ireland.

Policy context

A central piece of legislation relating to child welfare and protection in Northern Ireland is the Children Order (NI) 1995, in which two important principles are enshrined. These are, first, that in making decisions about children, the welfare of the child is the paramount consideration and, second, that wherever possible, interventions should focus on prevention and voluntary work with parents and others, in order to support children and families in the community. Alongside this legislation, the Department of Health, Children's Services and Public Safety (DHSSPS) has published guidance entitled *Co-operating to Safeguard Children*

detailing how agencies should cooperate to promote the welfare of and to safeguard children, which was last issued in 2003. This defines sexual abuse and outlines child protection processes to be followed if a child is suspected to be at risk of significant harm.

More recently the government strategy on *Tackling Sexual Violence and Abuse 2008–2012* (2008) has outlined plans to develop a more strategic approach to supporting victims, identifying the need to “to provide and deliver easily accessible, coordinated, quality support services for victims/survivors and their families” as a key objective. A major element of the support component of the strategy was to provide a sexual assault referral centre (SARC) for NI, with an associated performance indicator being the “number of children accessing services through a SARC” (2008, p115).

The strategy recognises that children who have been sexually abused or who display sexually harmful behaviour are often found among those who have the worst predicted life outcomes and that, given the very specific nature of child sexual abuse, therapeutic services should be provided by a specialist service, rather than by general children’s counselling services. It gives a commitment to:

- support counselling services in schools to ensure that children and young people who are victims of sexual abuse are identified and referred for appropriate support in line with the regional procedures on child protection;
- make available therapeutic support not just for children and young people, but also their carers;
- develop and publish guidance for professionals on therapeutic support, to assist in ensuring that children and young people are not denied assistance in advance of a court case.

The strategy also stresses that the ways in which victims/survivors of sexual violence and abuse access services is dependent upon their own individual circumstances; formal pathways usually beginning with the police; and informal pathways with friends and family. As such HSCTs are required to develop clear care pathways for child victims and to support services that are offered to, and taken up by, all identified children. This information, together with a directory of services, is to be made available in a variety of settings to which the public has access and in a number of formats and languages, to ensure wide accessibility. DHSSPS is also tasked with ensuring that trusts: “put in place measures to support all victims/survivors of sexual violence

and abuse, that is, child and adult victims/survivors and their families, as part of their Service Delivery Plans and Service Level Agreements with other providers” (2008, p101).

The development of service frameworks is also a major element of the service reform programme in Northern Ireland aimed at setting specific, measurable standards for health and social care.

The sexual violence prevention strategy stipulates that each trust must ensure that any such child identified as engaging in sexually harmful behaviour is considered as a child in need and any assessed risks are managed through the child protection process with the child and their carer(s) offered therapeutic counselling. The strategy also gives an undertaking to examine existing models of assessment in order to put in place the best and most appropriate uniform method for assessing the risks of children and young people who present with sexually harmful behaviour.

Implications for findings and recommendations

Section 1.2 has identified the key pieces of legislation that have shaped service provision in England, Wales, Scotland and Northern Ireland. It has been important to highlight the unique developments across nations. While some of the findings and recommendations will have relevance across all nations, it is inevitable, given nation-specific developments, that some findings in this report will have specific implications, leading to separate and nation-specific recommendations.

1.3 Research on service provision

In this section we consider the research literature relevant to services for children and young people who have experienced sexual abuse. We consider the gap between the prevalence of child sexual abuse and the numbers of children and young people who come to the attention of services. We consider the challenges posed in providing services that are accessible and are relevant to need in the context of low and delayed disclosure. We also consider research on the availability and effectiveness of services.

1.3.1 Do services match need? The gap between prevalence and identification

The best estimate of the prevalence of child sexual abuse in the UK comes from an NSPCC study conducted 10 years ago. This research used computer-assisted self-interview (CASI) methods to survey a randomised probability sample of 2,869 young people aged 18 to 24 years retrospectively about their experiences of child maltreatment, including childhood sexual abuse. Sixteen per cent of those surveyed (11 per cent males and 21 per cent females) reported experiences of sexual abuse in childhood. Eleven per cent (7 per cent of boys and 16 per cent of girls) reported that they had experienced sexual abuse in childhood involving physical contact (defined as intercourse, oral sex, touching and fondling, sexual hugging or kissing against their will before the age of 13). An additional 6 per cent (4 per cent of boys and 8 per cent of girls) had experienced non-contact abuse (defined as using the child to make pornographic photographs or videos, showing the child pornography, forcing or encouraging the child to watch sexual live acts, exposing sex organs to excite themselves or shock the child before the age of 13) (Cawson et al, 2000). An additional “borderline” group was defined within the study, in which 6 per cent of those aged 13–15 reported involvement in sexual experiences with someone aged five years older or more, to which they had consented, despite this being illegal when it involved vaginal or anal intercourse. A prevalence rate of 16 per cent reflected a mid-point between figures obtained in a range of types of earlier UK studies and was close to the level identified by Creighton and Russell (1995). The findings were also similar to those in a subsequent American study using similar definitions of abuse, which found that approximately 12 per cent of children in the USA had been the victims of sexual abuse (Renk et al, 2002), and to those of a national US survey looking at the victimisation of children and young people, showing that one in 12 children in America had experienced some form of sexual victimisation (Finkelhor et al, 2005).

Cawson et al (2000) noted that their research confirmed findings from previous studies that girls and young women are more likely to be victims of sexual abuse, and that abusers are most likely to be known to the child, but not necessarily a relative. Abusers were overwhelmingly men or boys, as most other studies show (Finkelhor, 2007). However, Bunting noted the small proportion of women and girls who sexually abuse: “current understanding suggests that females may account for up to five per cent of all sexual offences against children.” (2005, p14)

Beyond gender there is little reliable data on the different groups of children who are sexually abused. In respect of age, recorded cases of abuse show that it begins for some children when they are very young and for others the onset may be in later childhood or when they are

young people. There is no accurate data in relation to ethnicity or socio-economic status, although there is some evidence that disabled children are more likely to be abused than non-disabled children (Miller, 2002). Finkelhor (2007) suggested that any child could experience sexual abuse but it is distributed unequally across social groups.

There has been some debate about whether or not the prevalence of child sexual abuse is declining in rich industrialised nations (Jones and Finkelhor, 2004). If sexual abuse is declining, it could be reasonable to conclude that there might be a corresponding decline in demand for services. However, there currently seems to be little evidence to support this conclusion. Child protection register statistics, collected nationwide across the four countries of the UK, offer the only other source of recent statistical information regarding child sexual abuse. The figures represent the number of reported and recorded cases of children for whom there was a need for a child protection plan under the category of sexual abuse; this however did not reflect all those children who had experienced sexual abuse. Child protection data shows that sexual abuse is the least frequent reason for registration, with neglect being the most frequent reason recorded for registration (Gilbert et al, 2008). Registrations in England for all forms of child abuse and neglect have declined in the past 10 years, although this pattern of decline is not matched in Wales.

The child protection register statistics show that a large gap exists between the estimated prevalence of sexual abuse and the cases subject to child protection orders.

In England, 2,000 children and young people were registered under the specific category of sexual abuse (DCSF, 2008). In Wales, 160 children and young people were registered under the specific category of sexual abuse, with an additional 50 being included in other categories of multiple abuse, alongside neglect and physical abuse (Local Government Data Unit – Wales, 2008). In Northern Ireland in 2008, 244 children were registered under the specific category of sexual abuse, with additional victims being included in other categories of multiple abuse, alongside neglect and physical abuse (Northern Ireland DHSSPS, 2006). In Scotland, 240 children were registered under the specific category of sexual abuse (Scottish Government, 2007). The methods of collection and presentation of these statistics differ across regions and countries, and whether or not they accurately reflect levels of detected cases of child sexual abuse is open to question. However, looking at the statistics for the whole of the UK, we can see that child protection registrations for sexual abuse are made for approximately 0.02 per cent of the child population¹, while the (lifetime) prevalence of

¹ Calculated as 2,000 registrations England, 160 plus 50 Wales, 226 Northern Ireland, 240 Scotland and 13 million UK child population.

sexual abuse involving contact is, as we noted earlier, 16 per cent (Cawson et al, 2000). We do not have prevalence data in the UK that allows us to estimate the percentage of children who may currently be experiencing sexual abuse.

Increased calls to ChildLine² indicate a gap between officially recorded cases of sexual abuse and children affected, as well as an indication of increased demand for services, although this will be influenced by ChildLine's increased capacity to take calls as a result of its merger with the NSPCC in 2006 to secure its financial future. A recent ChildLine report (ChildLine, 2007)³ stated that a total of 11,976 children spoke to ChildLine about sexual abuse in 2005/06, this being the equivalent of more than one full classroom of children per day, every day of the year. Sexual abuse is the fourth highest of 48 categories of issues about which children call. Of the 11,976 children, 94 per cent knew her or his abuser. Fifty-nine per cent of abusers were said to be family members, 35 per cent were said to be acquaintances and 5 per cent were said to be strangers. It was also reported that children who call ChildLine about sexual abuse now do so much sooner after the abuse begins than previously.

Data from the SARCs indicates a growing use of services by sexually abused and raped girls, although this may similarly be because awareness of the services has grown. Kelly et al (2005), drawing on historical data from one SARC, reported an 18 per cent increase in the proportion of service users aged under 20 between 1988 (25 per cent) and 2002 (43 per cent). An evaluation of the STAR (Surviving Trauma After Rape) project, a West Yorkshire service specifically for 14 to 16-year-olds who have experienced rape and sexual assault, reported 185 cases in the two-year period of evaluation. All were young women, 75 per cent of whom were referred by the police (Skinner and Taylor, 2005). Figures from the 2004/05 annual report of the Manchester SARC showed that the average age of the 861 service users was 23.5 years, while the most common age was 16 years and the youngest was two (St Mary's SARC, 2005). It may be the case that, because they allow self-referral, the SARCs are responding to the needs of young people who would be unlikely to contact services for children affected by sexual abuse, as referral tends to come through children's services.

It cannot be assumed that all children and young people who have been sexually abused will want or need to have support from a service. The short-term and lasting consequences of sexual abuse have already been mentioned, but not all children and young people will be affected in the same ways. Some abuse may be short-lived; in some cases it may continue for years; the impact on each individual may range from apparently minimal to extremely

² ChildLine is delivered from bases in each nation.

³ The report *Calls to ChildLine about sexual abuse* (2007) is available from www.nspcc.org.uk/inform

damaging. It is not possible to predict the outcomes for any one individual precisely, although a number of factors have been identified that may compound or mitigate the impact. Factors that compound the impact include the duration of the abuse (Bagley, 1996) and its coexistence with other forms of abuse and victimisation (Finklehor, Ormrod and Turner, 2007). Adams-Tucker (1982) suggested that the experience is more traumatic the closer the relationship is to the offender, while the most important intervening factor is support.

Identified effects of childhood sexual abuse include academic failure, low self-esteem, alcohol and drug dependency (Bergen et al, 2004), eating disorders (Wonderlich et al, 2001), poor parenting skills, mental ill-health and post-traumatic stress disorder (Briere and Elliott, 1994, and MacIntyre and Carr, 1999, offer comprehensive commentaries). Bannister (2003) and Howe (2005) noted attachment damage, especially that occurring in the family during a child's early years. Some of the other known negative consequences of childhood sexual abuse include sexually transmitted diseases, teenage pregnancy, self-harm and re-victimisation (see Classen et al, 2005; Filipas and Ullman, 2006; Gidycz et al, 1995; Messman-Moore and Long, 2003; and Sanders and Moore, 1999, regarding re-victimisation). However, there is no single trajectory and some children do well academically. Furthermore, many of these studies were with clinical samples of children/adults who had the most difficulties.

In addition to the manifestations described above, wide-ranging behavioural problems may develop, including violence, inappropriate sexualised conduct, or sexually explicit behaviour, play or conversation. These and other ensuing antisocial behaviours can also become pathways into criminal activity (Boswell, 1996; and Falshaw, 2005). While the evidence on the extent to which children and young people committing sexual abuse have themselves been sexually abused remains incomplete, Vizard noted that: "Most UK studies of sexually abusive children show high levels of family dysfunction." (Vizard, 2006a, p77). Consequences are complicated where children adopt negative coping strategies and do not receive timely help and support.

An early model still widely used to explain the traumatic effects of sexual abuse is the traumagenic dynamics model proposed by Finkelhor and Browne (1985), who argued that sexual abuse traumatises children through four distinctive mechanisms, which in turn account for the variety of outcomes experienced by victims. These are: 1) traumatic sexualisation, or experience of developmentally inappropriate sexual behaviours; 2) powerlessness, or feelings resulting from the contravention of the child's will and domination by the abuser; 3) stigmatisation, or the shame, self-blame and negative connotations of the abuse, which the

victim internalises; and 4) betrayal, or the shattering of the child's belief that trusted adults will protect and not harm them. The authors asserted that these key dynamics alter a child's cognitive or emotional orientation to the world and distort that child's self-concept, leading to the psychological and behavioural problems characteristic of child victims and adult survivors of sexual abuse. These problems may well require systematic treatment from one or more services, including those that may be described as "therapeutic".

1.3.2 Disclosure of child sexual abuse

Disclosing sexual abuse and the response to a disclosure are important factors in the process of stopping the abuse, reducing the impacts and meeting the needs of children, including those accessing appropriate services. The presentation of need and its recognition are the first stages in the process of obtaining support and/or access to services (Goldberg and Huxley, 1992).

Of the total sample in Cawson et al's study, 72 per cent had not told anyone at the time of the abuse, 27 per cent had told someone (usually a friend) later, and 31 per cent had not told anyone by early adulthood. Other studies show that disclosure is a complex phenomenon, which rarely happens immediately after abuse occurs (Goodman-Brown et al, 2003). Many adults report never disclosing their abuse during childhood (Finkelhor et al, 1990; and Lamb and Edgar-Smith, 1994), and indeed, it is thought that some never disclose these experiences at all even in prevalence research (Jensen, 2005).

Alaggia's (2004) qualitative study of children's disclosure sought to identify individual, familial and environmental influences that inhibit or promote the disclosure of child sexual abuse. Her findings suggested that victims of childhood sexual abuse disclose in varied and complex ways. Purposeful, accidental and elicited/prompted disclosure (Paine and Hansen, 2002; and Sorenson and Snow, 1991) accounted for some of the findings. However, further "types" of disclosure were also revealed. "Behavioural disclosure" was described as the non-verbal cues used to convey a message that something was amiss, behaviours which include temper tantrums, angry outbursts, withdrawal, avoiding being at home or running away. These could also include indirect verbal hints that were not detected as disclosure attempts. "Disclosure intentionally withheld" accounted for some of the children studied. Children who chose not to disclose did so because they felt that they would not be believed or they would hurt the feelings of others and/or they were experiencing feelings of self-blame, shame and fear. Non-disclosure of this type could go well into adulthood, where, among other factors, negative reactions from family were still a high likelihood. "Triggered disclosure" tended to

occur much later in life, when children begin to recover their memories or re-think their experiences in adulthood.

Delayed disclosure is common, which highlights the difficulty in bringing services to those who may most be in need of them. Research shows that children typically delay disclosure by three to 18 years (Lamb and Edgar-Smith, 1994) and Goodman-Brown et al (2003) suggested that children under the age of six are least likely to disclose. Delayed disclosures can be associated with repressed, recovered or delayed memories (Flathman, 1999; and Pope and Brown, 1996). However, delays can also be attributed to children's sensitivity to adult's thoughts and feelings (Jensen et al, 2005). Jensen et al's (2005) research supports the idea that children use adult reactions as a barometer for disclosing certain types of things (Nettleton, 2001; and Prout, 2001). A child's perceptions about how the confidante is dealing with what the child is telling can affect what the child chooses to disclose. Concern on the part of a child about potentially negative consequences of disclosure is also linked to delayed disclosure (Hershkowitz et al, 2007; Goodman-Brown et al, 2003; and Jensen et al, 2005). In addition, abusers' threats as to what will happen also silence children. However, there is some evidence that early disclosure to an adult moderates the impacts and reduces the likelihood of further victimisation (Kogan, 2005), so equipping all adults to understand the processes of disclosure and to respond positively is important.

A study of calls to ChildLine Scotland revealed that a large number of callers indicated that they had disclosed to someone apart from the helpline counsellor, "the most common person being their mother followed by a friend" (Backett-Millburn et al, 2006, p22). Disclosure appeared to be proportionally more common among girls than boys. Boys are less likely to disclose for various reasons, including fear of stigmatisation and being labelled homosexual, which prevents them from telling in a homophobic society (Goodman-Brown et al, 2003) and not viewing what happened as abuse/victimisation (Kelly et al, 1991). Studies by DeVoe and Faller (1999), and O'Leary and Barber (2008) support this claim, both showing that girls are more likely to disclose than boys, and boys are more likely to delay disclosure. Gordon and Grant (1997), and Briere and Elliott (1994) found that girls are also almost twice as likely to talk to their friends and their mothers as boys. Finally, cultural issues may act as deterrents. Disclosure may be inhibited in cultures that hold negative attitudes and taboos about sexuality (Gilligan and Akhtar, 2006).

Researchers have identified some circumstances that support children to disclose abuse. DeVoe and Faller (1999) found that a sensitive environment for talking is a prerequisite. Children need to feel listened to and believed (Jensen et al, 2005). They need to see the

person they are telling as trustworthy, good at listening, non-judgmental, and providing reassurance and emotional support (Balding, 1997; Gordon and Grant, 1997; and Mudaly and Goddard, 2006). Hartwig and Wilson (2002) found that a child is more likely to disclose abuse when they feel that their interviewer is already aware and it is therefore no longer a secret. Also, the advent of ChildLine has had some positive affect on children disclosing abuse. However, Jonzon and Lindblad's (2004) study concluded that childhood disclosure, when it happens, results in unpredictable consequences, constituting a challenge to child protection professionals. They argued a need for further knowledge around strategies of seeking support and the underlying considerations, thoughts and emotions during different stages of overcoming abuse.

1.3.3 Availability of services: mapping children's service and CAMHS

Reviews of children's services in Scotland (Scottish Executive, 2002a) and of CAMHS in Scotland (Public Health Institute of Scotland, 2003, pp11–23), Northern Ireland, (Bamford Review of Mental Health and Learning Disability, 2006) and Wales⁴ (NSPCC Cymru/Wales, 2007) have revealed significant gaps in the availability of responsive safeguarding services and lack of information on services specifically targeted at the needs of sexually abused young people.

In England in 2002, the Department of Health (DH) instigated an annual mapping exercise for the collection of data on specialist child and adolescent mental health (CAMH) tier 2 to 4 services (Barnes et al, 2006). This annual mapping is carried out for the DH and Department for Education and Skills (DfES) (now DCSF) by the University of Durham, but data specifically related to the need for therapeutic or support services for children and young people who have been sexually abused is not collected. There are also gaps in data relating to voluntary sector therapeutic treatment provision and services relevant to young people.

In 2006, the YoungMinds Stressed Out and Struggling (SOS) Project, which highlights the mental health needs of 16 to 25-year-olds and campaigns to improve access to and acceptability of mental health services for this group, carried out a qualitative mapping survey to determine how well primary care trusts (PCTs) in England and Scotland considered they were meeting the mental health needs of these young people (Pugh and Meir, 2006). The report was aimed at commissioners and providers of CAMHS and adult mental health services (AMHS) to assist them in comparing how well they were meeting the needs of young adults. Although the particular needs of children and young people who have been

⁴ A review of CAMHS is currently being undertaken in Wales by the Welsh Audit Office with results expected in late 2009.

sexually abused were not specifically addressed in this research, the findings are relevant with regard to the availability generally of support for distressed young people.

The study found that only 60 per cent of CAMHS commissioners and 34 per cent of AMHS commissioners had completed, or were undertaking, needs assessments. Forty per cent of CAMHS commissioners and 25 per cent of AMHS commissioners expressed a wish to develop new services for young adults. Eighteen per cent of CAMHS commissioners and 16 per cent of AMHS commissioners identified gaps in primary care services. Twenty-six per cent of CAMHS and 30 per cent of AMHS commissioners identified gaps in secondary care services. A wide variation in the level of choice was recorded, with some areas having more choice in the voluntary as opposed to the statutory sector, and other areas having a wide range of specific and generic statutory and voluntary sector providers.

1.3.4 Access issues

The research literature suggests that barriers to accessing child sexual abuse therapeutic services include:

- the need for a medical diagnosis, so that a service may not be provided until a young person has diagnosable mental health or behavioural problems (Fonagy et al, 2002);
- the need for younger children to access services through adult gatekeepers;
- lack of knowledge about what services exist and how to find them;
- long waiting times to get a service (Audit Commission, 1999; and DH and DfES, 2006);
- stigma and difficulty in accessing services that are culturally relevant to young people from ethnic minority backgrounds (Bradby et al, 2007);
- lack of access for young people with disabilities (Miller, 2002); and
- difficulty in getting to a service in rural areas (Pugh and Meir, 2006).

We do not know enough about the accessibility of support and therapeutic services for children who have been sexually abused, although reports by children themselves to confidential services such as ChildLine (2007) suggest there are gaps in services (Featherstone and Evans, 2004). Studies also show children have unequal access to existing services relating to many factors, including perceptions of services and, in the case of mental health services, of mental health *per se* (Sayal, 2006). Children's access to services is often dependent on the concerns of parents/carers and other adults such as social workers and police, so adults' knowledge and understanding of services is crucial.

Fonagy et al (2002) maintained that access to services adopting the medical model is restricted since access is “based on measurement disorders at the level of symptoms and syndromes” (2002, p14). Gaining access to some services is therefore difficult for some sexually abused children who are filtered out due to not meeting these narrow criteria.

Waiting time, after referral, is an important indicator of the accessibility of services. While NICE recommends trauma-focused cognitive behavioural therapy (TF-CBT) should be “offered to older children with severe post-traumatic symptoms or with severe PTSD [post-traumatic stress disorder] in the first month after the traumatic event” (NICE, 2005, p4), several studies show significant waiting times for services. There is evidence that early intervention, between two days and four weeks following traumatic events, is effective particularly for stress disorders (Bryant et al, 1999).

In England and Wales⁵ an Audit Commission review of CAMHS showed the median waiting time was 10 to 15 weeks, with children having to wait over six months in 10 per cent of NHS trusts/healthcare trusts (Audit Commission, 1999). In England, a 2006 report (DH and DfES) indicated that, although greater numbers of children had received a service in 2003/04, there were still issues with waiting times. These varied:

“...depending on the type of service being accessed and the location. At Tier 2–3, for example, 32 per cent of those waiting had waited for up to 3 months, a further 15 per cent had waited between 3 and 6 months, and a further 18 per cent had waited over six months. Almost all SHAs had some cases that fell into the longest wait category.”

(DH et al, 2006, p28)

A qualitative Scottish study (Bradby et al, 2007) found that families of South Asian origin were under-represented as service users in CAMHS and that stigma, shame and anxiety about gossip were strong deterrents from taking up services. Families reported that discrimination accentuated their children’s difficulties, as services were seen as “culturally inappropriate” with limited treatment options through a lack of common language and different interpretations of children’s conduct. The authors argued that “the under-use of CAMHS by some ethnic groups indicates unmet need cannot be dismissed” (2007, p2415). Earlier studies have similar findings, (Angold et al, 1998; and Street et al, 2005), as do studies into access to social care, for example Weeks (2004). All highlight the need for ethnically and culturally sensitive services (for example, see Kurtz et al, 2005). More generally, socially excluded and

⁵ Before devolution.

marginalised children, such as asylum seekers (Sinha et al, 2006) and children with disabilities (Miller, 2002), are particularly vulnerable and can experience significant difficulties accessing services.

The YoungMinds research discussed above found that rural services struggled to develop many of the new services detailed in the Department of Health (2001) *Mental Health Policy Implementation Guide*, and teams servicing rural populations spread across a wide geographical area were not always resourced to take account of travelling time and isolation issues. Ease of access to all services was variable and only 16 per cent of CAMHS and 14 per cent of AMHS commissioners had initiatives in place to provide age-specific services (Pugh and Meir, 2006).

1.3.5 Mapping studies of therapeutic services for sexually abused children

Since 2000, only two substantive exercises have been carried out to map the extent of services for children who have been sexually abused. The first was a study of provision in Italy, the Netherlands and the United Kingdom of counselling and support services for young people aged 12–16 who had experienced sexual abuse (Baginsky, 2001). The second was a scoping review of the availability of sexual abuse treatment services across London commissioned in 2005 by the (then) London Child Protection Committee, now known as the London Safeguarding Children Board (LSCB, 2007). Service provision was found to be variable in both studies.

A study of the counselling and support services provision for young people aged 12–16, based on interviews with service providers and with young people in Italy, the Netherlands and the UK was carried out by the NSPCC and partner researchers (Baginsky, 2001). In all three countries it was difficult to determine precisely what services there were and what they offered. Aside from the inevitable structural differences of approach to how services for children, young people and their families were organised in the three countries, there were however some striking similarities in the findings for each nation. One that emerged very clearly was that not one of the three countries had adopted a holistic approach to the welfare of sexually abused children and young people, offering a range of provision to meet their varied needs. Services were described as being “patchy” across all nations and gaps in provision existed especially for children from ethnic minorities, children with disabilities and for young people who displayed sexually harmful behaviour. Another key finding was that many of the young people interviewed said they did not trust adults to respond appropriately

to concerns about sexual abuse, especially adults from social care professions. Schools and educators were seen to have a key role to play in identifying and helping to prevent child sexual abuse, but the proactive work in schools was variable and hard to map. Appropriate training, support and supervision were deemed essential for all professionals involved in this field of work and multi-agency working, and more holistic provision and evaluation of the effectiveness of services, especially in the voluntary sector, were recommended.

The most recent mapping exercise of therapeutic services for sexually abused children and young people was commissioned by the London Safeguarding Children Board (2007) in order to obtain an overview of the availability of sexual abuse treatment services for children in London. Despite a rather limited response from those invited to participate, the exercise suggested that knowledge, availability and range of services for children and young people who had experienced sexual abuse were variable, both in terms of initial access to services and especially in the longer term. Information about the quality and effectiveness of services was not available. Four centres specifically dealing with child sexual abuse were identified, three of which were SARCs, where experienced professionals offered immediate short-term medical advice and help, counselling and practical/emotional support. The three SARCs were open to children and young people under 16, plus adults, but because of the criminal justice system orientation of the SARCs, they only offered services to those who had experienced recent abuse. All four SARCs offered relevant and appropriate services to children immediately following sexual abuse, but it was unclear as to *whether* or *how* children who were victims of child sexual abuse became users of the centres. The research team was of the opinion that referral to other specialist services after contact with the SARCs was not necessarily the norm, nor likely to take place.

The rather limited feedback obtained in this research nevertheless indicated that children and families, as well as practitioners, would like services to be easily and locally accessible. It was also established that practitioners found it difficult to obtain help for families. Gaps in services, systems and processes were identified, as well as a need to explore further the training provided for those likely to come into contact with children who had been sexually abused. The research team recommended:

- There was a need for a clearer understanding of the gaps in treatment services across London.

- The knowledge and understanding of designated and named professionals in the area of child sexual abuse needed to be increased, alongside the knowledge and understanding of all adults involved with children and young people who experience sexual abuse.
- Collaboration and partnership between professionals and agencies likely to be involved in child sexual abuse work should be encouraged.
- Further work was needed with CAMHS, especially where child sexual abuse is detected when a child has been referred for other reasons.
- Agreement on appropriate levels of education, training and knowledge was needed for those working with children and young people in these services.
- It is important for agencies to provide an appropriate atmosphere in which a child or young person can be interviewed and examined, and where they can comfortably share their experiences.

A further study to mention is the *Map of Gaps*, undertaken by Coy, Kelly and Foord in 2007 to map the location and comparative availability of “violence against women” (VAW) services across the UK, demonstrating that “women in the UK face a postcode lottery in their access to basic support services” (p4). Although the focus of the study was on services for adult women, some of the services they included in fact offered provision to young people under the age of 18, making their availability and scope relevant to this study. Findings included: a third of local authorities across the UK had no specialised VAW support services; most women in the UK had no access to a Rape Crisis centre and fewer than one-quarter of local authorities had any sexual violence service whatsoever; and fewer than one in 10 local authorities had specialised services for BME groups to address forced marriage, female genital mutilation and crimes in the name of honour, as well as other forms of violence. One year on, the *Map of Gaps* was repeated to see if the picture of support had changed for women who had experienced violence (Coy, Kelly and Foord, 2009). Findings showed that, again, there remained a postcode lottery for these services: one in four local authorities had no specialised support in place. Other findings indicated that ethnic women were most poorly served; a majority of these services were statutorily provided, not accounting for those women who chose not to report the violence to the police; and voluntary provision remained static, although was under threat of closures in the next few years due to lack of funding. The new “violence against women” consultation can perhaps contribute to the reversal of some of these trends described by Coy et al (2009).

All of the aforementioned studies, despite limitations and differences in focus, identified serious gaps in supportive services for children and young people who had experienced sexual abuse.

1.3.6 Mapping services for children and young people with sexually harmful behaviour

A substantial body of international literature now exists on children with sexually harmful behaviour (for a review, see Hickey et al, 2006). It is beyond the scope of this report to review this literature. However, there is one research project on the provision of services in the UK published in the past decade that we will consider briefly, as this gives information on services that provide therapies for young people who have themselves been victims and who subsequently display sexually harmful behaviour. A two-year research project to map and explore services for young people who have sexually abused others was undertaken by Hackett et al (2003), jointly funded by the Youth Justice Board (YJB), the NSPCC and the National Organisation for the Treatment of Abusers (NOTA). This was the most comprehensive review of the field ever undertaken in the geographical areas of England, Wales, Scotland, Northern Ireland and the Republic of Ireland. The research involved a five-step mapping covering two Delphi consultations with 78 key providers and 65 managers to explore services available and their organisation; a mapping of 186 services (111 YOTs and 58 voluntary sector, 30 statutory sector and seven private sector providers); policy document analysis; and interviews with 23 young service users. The full report was published by the Youth Justice Board in 2005. The results of the study suggested that services for children and young people who had sexually abused have developed substantially in England and Wales since a benchmark report by the National Children's Home (1992). The data gathered on services in Northern Ireland, the Republic of Ireland and Scotland also provided evidence of important initiatives. The research revealed that the range of statutory, voluntary and private sector services varied in size and in the makeup of their staff, and were often multi-agency organisations with complex funding arrangements. Some growth in services over the past 10 years was detected, but long-term funding remained a problem. Despite evidence that a significant proportion of young people with sexually abusive behaviour had some degree of learning disability, almost none of the local areas examined had policies that explicitly referred to this group of people, or that gave advice about the particular needs and difficulties of such young people. Work with parents of children displaying sexually abusive behaviour was felt to be important, as it helped them to gain insight into the nature of sexual abuse, as well as to address their own feelings about their problems. It was recognised that parents often needed help and support in getting young people back into schools, from where the

response following the identification of abuse by young people was often poor. A substantial minority of informants expressed dissatisfaction with the overall availability and quality of services, noting problems with funding, distance and location of specialist services, and the length of waiting lists, especially for the most problematic young people. Although indicating considerable progress in service availability, the research echoes findings from other research discussed so far, in that there are concerns about the availability and quality of services, their accessibility in terms of location and referral routes, and their accessibility to specific groups of marginalised and socially excluded young people.

1.4 What support and services do children and young people want?

It is increasingly apparent that very little research has previously sought the views of children about their experiences of sexual abuse or asked them what services they might find supportive. Clearly this is crucial in gaining an accurate picture of the way in which their needs can best be met.

In 1989, NCH Action for Children set up the Child Sexual Abuse (CSA) Initiative, the object of which was to establish a national network of projects providing a range of treatment services for children who had been sexually abused, their families, and carers, and services focusing on work with children and young people who had sexually abused other children. Integral to setting up the new services was a commitment to evaluate them. The NCH Action for Children Newcomer Research Project was one of the first projects to be set up within the CSA Initiative and its role was to provide an evaluation of the (then) professional response to child sexual abuse, in particular from the child's perspective. Thus, in 1994 a revealing report containing "messages from children" was published (NCH Action for Children, 1994). In summary, it suggested that children needed honesty; they especially needed to hear that it was not their fault; they needed information; and they needed to participate in decision-making. The children said that they appreciated the services that were offered to them. It was acknowledged that therapy must be available to children. There was recognition of long-term need for services and for resources to be preserved and enhanced. The difficulties and dilemmas surrounding children's involvement in the Criminal Justice System and the post-disclosure experience of children needed to be addressed. In a nutshell, what the children told the researchers was that they wanted "justice and therapy". More recent work illustrates that little has changed since these two studies were conducted.

A 2007 report from the ChildLine Casenotes series entitled *Calls to ChildLine about Sexual Abuse*, which analysed the work of ChildLine between April 2005 and March 2006, found the common features of those reporting sexual abuse included: self-blame; fear of the consequences of disclosure; fear of not being believed; suicidal feelings; negative coping mechanisms, including self-harm, drink, drugs and sexually risky behaviour; lack of help for those admitting they were actual or potential abusers; insufficient recognition that females (mothers, aunts) could also be abusers (see also Bunting, 2005); and the fact that child protection and court systems were frequently neither child-friendly nor effective. Based on evidence that most children disclosed to their friends or members of their family and were reluctant to approach authority figures and statutory services (see also Featherstone and Evans, 2004), the need for confidential, accessible and responsive services that give children and young people someone they can trust for advice, support and protection was emphasised. The ChildLine report contained recommendations for the UK government and the devolved administrations in Wales and Scotland, urging them to establish a fully funded delivery plan at national and local levels to ensure that children who are abused receive child-centred therapeutic services. The availability of comprehensive access to therapeutic services in all areas was also advocated. It was further recommended that local children and young people's plans must ensure that CAMHS and other therapeutic services are commissioned in such a way as to ensure that, at the absolute minimum, there is at least one such service in every children's trust in England; in every HSS trust in Northern Ireland; a locally accessible service in every NHS trust in Wales; and sufficient services within Scottish health boards to help children overcome the effects of abuse. It was suggested that relevant government departments in each jurisdiction should consider either funding a new delivery model for providing therapeutic services through the voluntary sector, or maximising the experience and knowledge of the voluntary sector in delivering services. The report also recommended exploring the potential of SARCs to provide therapeutic support to children and young people.

A small study of a post-abuse service with 25 children aged six to 17 years in a South Wales CAMHS (Potter et al, 2002) highlighted the importance of listening to what each individual child wanted from a service with referrers or therapists not making assumptions. Children were able to express their needs and the addressing of these needs was central to their progress in dealing with the abuse.

These publications contain clear messages regarding the need for confidential, accessible and responsive services for sexually abused children and young people; proper and consistent assessment, referral and treatment services for children and young people engaging in

sexually harmful behaviour; preventive treatment for potential abusers; and support for carers of abused children.

1.5 Research on service impact and effectiveness

There is a substantial body of research literature on therapeutic interventions with children and young people, but there are relatively few systematic reviews on interventions that are effective in bringing improved outcomes. A recent comprehensive review of effective interventions to prevent child maltreatment (Macmillan et al, 2008) noted the poor quality of the research literature in this area. It is difficult to draw conclusions about effective interventions because:

- Research studies focus on different age groups of children, ranging from two to 17 years and the impact of the abuse and the treatment may vary with age.
- Some studies focus on interventions with the child alone, whereas others focus on the child or parent, or on group work.
- The samples may not reflect the typical experiences of sexually abused children and young people; they tend to be clinical samples; many studies have “convenience” samples; and attrition or drop out from a programme may not always be considered.
- There are few randomised controlled trials; and few but more before-and-after control comparison studies.
- The harm or trauma to children from the abuse is not consistently defined nor measured, either before or after an intervention programme.
- Many studies contain only limited information on what the intervention programme involved.
- There are few studies that take a longer-term view on outcomes for children over time.
- Possible compounding factors such as poly-victimisation or other psychological problems may not have been considered.

Many different therapeutic interventions exist for supporting sexually abused children and young people including individual counselling, child-centred play therapy, art therapies, narrative therapies, cognitive behavioural therapies and family systems approaches. Some

interventions may employ a variety of different approaches in a specific programme of intervention. Perhaps the best evaluated treatment interventions are those that employ cognitive behavioural therapy approaches to work with the child and sometimes also the non-abusive carer to address the harm to victims (Macdonald et al, 2006). A recent review concluded that there is some evidence that CBT-based approaches can improve the mental health outcomes for sexually abused children with symptoms of post-traumatic stress disorder or with anxiety or depression. However, there is conflicting evidence on the effectiveness of CBT treatments in reducing child behavioural problems (Macmillan et al, 2008). The research evidence clearly points towards the need for us to question why certain approaches are used and to explore ways to improve our knowledge about what works, especially taking into account young people's own views about the services they receive and the support they would like to have.

1.6 Conclusion

It is apparent from this review that there has been, and doubtless will continue to be, an increasing public and professional awareness of the complex effects of childhood sexual abuse. As this process of recognition has developed, those who have chosen to work in this field have had to confront the difficult tasks of understanding abuse dynamics and addressing the consequences in their attempts to provide effective therapeutic remedies. A range of imaginative yet largely untested treatment approaches has been adopted (and adapted) within health, social work and specialist post-abuse services.

In terms of therapeutic service provision, the literature does not offer a clear picture of existing services and their accessibility for children and young people who have been sexually abused. The various surveys and mapping exercises that have been considered in this review suggest there are gaps in provision, and patchy, inconsistent resources across the UK.

Messages from children who have experienced sexual abuse, and the agencies they approach in their distress, underline the urgency for responsive, needs-appropriate and effective service provision. It is essential, however, to determine from a national perspective what the actual availability of such services is, to hear from commissioners, professionals, carers and children themselves about what services and forms of access to them will most help to overcome the effects of sexual abuse, so that the children who have been abused can achieve their potential. This evidence can then be presented to policy-makers to aid the continuing development of sufficient effective therapeutic services.

2 Overview of the methodology

A multi-methodological approach was adopted to map therapeutic services by looking at their location, availability, scope and coverage across the four nations of England, Wales, Northern Ireland and Scotland. There were five components to the data collection strategy, including:

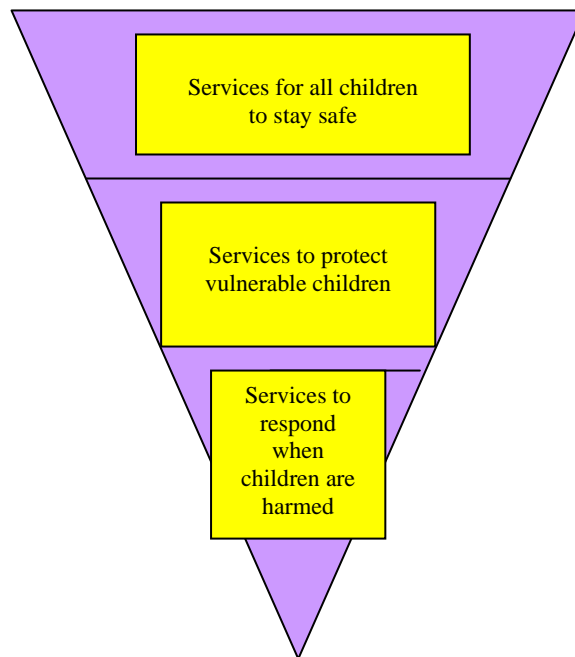
- 1) a geographical mapping exercise to plot the location of 508 therapeutic services identified
- 2) a structured questionnaire collecting data on 195 services
- 3) semi-structured interviews by telephone with 21 service managers/practitioners
- 4) semi-structured interviews by telephone with 11 service commissioners
- 5) focus groups with 10 young people about their views on services.

In this section of the report we explain the definition of a “therapeutic service” used in the research; strategies used to identify services; how we determined eligibility (our inclusion/exclusion criteria for services we mapped); the five methodological approaches to mapping; the ethical issues; other challenges we faced in doing the research; and our approach to data analysis. We also describe the services that participated.

2.1 Defining “therapeutic services”

Figure 1 below shows the approach to safeguarding children from harm outlined in England’s *Staying Safe* (DCSF, 2008, p6). Services need to be available to all children to prevent sexual abuse from happening, to protect children who are vulnerable to harm and to respond to the needs of children who have been harmed by helping them to overcome the consequences. The focus of the mapping study was on the responsive services for children and young people harmed by sexual abuse. In all four nations, these services fall within tiers 3 and 4 covering specialist and residential therapeutic services for children⁶ (in England see DH, 2004; in Wales see WAG, 2005). ChildLine provides a confidential listening service for all children and young people, including those concerned about sexual abuse. The mapping however did not include ChildLine services, which are available to children and young people across all four nations of the UK.

⁶ At the time of writing, service frameworks were being developed through extensive consultation in Northern Ireland.

Figure 1 Levels of service for safeguarding children from sexual abuse

Initially, services were defined as providing a “therapeutic service” if:

- they had developed a recognised specialism working with children/young people in relation to sexual abuse

and/or

- they spent a substantial proportion of their working time providing a service to children/young people who had experienced sexual abuse.

Managers were asked to self-classify as a therapeutic service. The reason for allowing this self-classification was to understand the range of therapeutic work being undertaken in the UK, of which little is known to date. However, during the course of identifying services, it became clear that there was a subset of services that provided therapeutic work in relation to sexual abuse, which did not fit the above definition in respect of the second criterion. There were a significant number of “generic” services, which undertook therapeutic work but did not necessarily spend a *substantial* proportion of their time doing so. Much of the child sexual abuse work undertaken in the statutory sector is carried out in CAMHS settings (if it is not commissioned out), but few would consider themselves to be a “specialist” sexual abuse service⁷. Some CAMH services will offer therapy to address the harm caused by sexual abuse

⁷ There are a small number of CAMH services which have developed “specialist” sexual abuse services; however, the majority of children receiving a service in relation to sexual abuse will be seen within a context of wider mental health issues.

if this emerges as an issue for a child or young person, but they do not automatically accept sexually abused children for treatment.

2.2 Identifying relevant services for participation

The strategies for identifying services for inclusion were systematic across nations, although they differed slightly across Northern Ireland, Scotland, England and Wales due to variations in local circumstances. Northern Ireland and Scotland are geographically smaller with fewer services than England, and were therefore in a better position to identify, contact and engage most/all of the services within the timetable of the project. In Northern Ireland, researchers had closer and better established relationships with services, which eased the difficulties in contacting relevant informants within services. Table 1 summarises the approach taken to both identify services.

Table 1 Methods used for identifying services for inclusion in the study⁸

Strategy for identifying services	
Northern Ireland	<ul style="list-style-type: none"> a) Potentially relevant services were first identified through contact with NSPCC services, as well as directories of services provided on health and social care trust (HSCT) websites. b) The director of children's services (or equivalent) in each HSCT was contacted in relation to the mapping and each appointed a HSCT link person to assist with further development of the service list. c) Relevant managers/practitioners in each HSCT were also contacted to confirm service locations and details within their catchment area.
Scotland	<ul style="list-style-type: none"> a) Services were identified by contacting key informants at a range of levels in health, social work and the voluntary sector, including practitioners, managers and senior managers. This incorporated a "snowball" approach, in which practitioners/managers in relevant services were asked to identify others locally. b) Local authority online children's services directories and health board online service listings were consulted, as were other sources of published information on services.
England and Wales	<ul style="list-style-type: none"> a) NSPCC service directories were initially consulted, as well as a range of directories of services, including the CAMHS Directory. b) A general internet search was undertaken, using terms identified through CAMHS mapping, the DABS Directory and the Community Care Purchasing Directory. c) Some services were identified via word of mouth during interviews with other service managers.

⁸ Greater detail about these approaches can be found in appendix A.

Table 2 presents the numbers of services identified as potentially relevant to the study.

	Potentially eligible services
England	503
Wales	15
Scotland	Missing data
Northern Ireland	67
Total number of identified services	585^a

^a This number excludes the initial number of services identified in Scotland.

2.3 Eligibility for the study

In all of the research areas, each service that had been identified was then contacted by telephone and included in the mapping if the manager (or another staff member) confirmed that the service fitted our criteria; or provided some level of therapeutic work. Table 3 shows the numbers of services identified for inclusion in the study. If it was possible at the time of contact to invite services to complete the questionnaire and take part in an interview, then this was done. In many cases however, repeated calls had to be made to find a time that was suitable for participants to complete the questionnaire.

	Statutory sector	Voluntary sector	Private sector	Total number
England	268	61	34	363 ^a
Wales	6	4	5	15
Scotland	41	41	0	83 ^{bc}
Northern Ireland	32	16	0	47
Total number of identified services	347	122	39	508

^a There were 14 services in England that could not be assessed for inclusion in the study, as relevant information about the nature of the service could not be obtained. These were therefore excluded.

^b This number excludes two sets of services in Scotland: 1) SHB services with a child sexual abuse component in Scotland, which the researchers were unable to assess fully within the project deadline; 2) a further 52 services were identified as eligible *after* the project deadline. These services have been excluded from the analysis in this report (including the GIS mapping). However, they will be included in the analysis in the forthcoming separate Scottish report.

^c This number includes the 41 statutory services and the 41 voluntary services, with one additional service that is joint statutory/voluntary provision.

2.4 Services included in the study

Statutory, voluntary and private sector services were all included in the study. The statutory sector provides services that must be granted by law, such as children's, health and education services. The types of statutory services included in this study are, for example, CAMHS, social work departments in children's services, secure units and family centres funded by government.

Voluntary sector services differ in that they are independent of government, not for profit and are value-driven in that they exist for the good of the community. Voluntary sector organisations vary enormously in size, from small local groups run entirely by volunteers to large national charities with complex infrastructures and many hundreds of staff. Although the voluntary sector is independent from government, it may provide statutory services on behalf of the local and national government. All the voluntary sector services participating in the study provided therapeutic work for children and young people who had experienced sexual abuse. Some of them provided independently of government; others were commissioned by statutory services. Although some of the voluntary services included in the study were small (some very small, offering only five places), they all employed trained and specialist staff. Only a small minority of services were found to employ non-professionally qualified staff or volunteers.

Private sector services are those that provide services for profit. A small number of the services in the study were private. All were providing services commissioned by the statutory sector. Therapeutic services are very expensive and private sector services do not rely on a "core" pot of funding, as some statutory and voluntary sector services do. However, none of the private services charged families for the service. They were wholly dependent upon their status as a commissioned service for their income.

Not all the users of services for young people with sexually harmful behaviour are young people who have experienced sexual abuse themselves. Research based on case records in one service found that 71 per cent of the service users had experienced child sexual abuse themselves, as well as a range of other adversities (Hickey et al, 2005). Services for children and young people who had displayed sexually harmful behaviour (SHB) towards others were included in this study provided that, where a child or young person had previously been a victim of sexual abuse, the service worked therapeutically with him or her in relation to this experience as well as addressing the harmful behaviour. These criteria were applied in order to avoid duplication of a previous mapping study of SHB services (Hackett et al, 2003). The

services provided by the youth offending teams (YOTs) and criminal justice system were not included in this study, as these had already been mapped in the research by Hackett et al (2003). This should be taken into consideration when viewing the maps on service provision.

The following categories of services were included:

- specialist post-sexual abuse services
- specialist post-abuse services of any kind (including emotional and physical abuse and neglect; sexual exploitation; rape)
- services for children and young people who had displayed sexually harmful behaviour and which also provided a therapeutic component where sexual abuse had been experienced
- therapeutic services addressing emotional/mental health issues more generally (eg CAMHS).

Within these categories, services were mapped that were open to any child or young person, as well as services with more restricted eligibility, such as services for looked-after and accommodated children. Both residential and non-residential therapeutic services were included in the study. Eight per cent of the sample that returned completed questionnaires were residential services from Northern Ireland, England and Scotland.

In England and Wales, private, voluntary and statutory sectors were systematically identified and mapped. In Scotland and Northern Ireland, priority was given to identifying services provided within health, social work and the voluntary sector, as resources would not permit further investigation of the private sector. However, in Scotland, researchers did not readily encounter private sector services (eg where the statutory sector commissions services, they are by and large within the voluntary sector); therefore it was believed that the private sector did not contribute a very large proportion of therapeutic work in this area.

2.5 Methodological approaches

2.5.1 Geographical mapping

We wanted to map the geographical location of the identified services across the UK against a broad estimate of need based upon prevalence in different area populations of children and young people. In order to meet this aim, the researchers required that the locations of therapeutic services for children and young people who had been sexually abused in the UK

(and which had been positively identified as relevant – see above) be mapped by type and in the context of the number of children aged 0–17, to provide evidence of gaps in provision across the country. Five hundred and eight services were listed by postcode and by service type: statutory, private and voluntary. To be able to map the locations of these services, the postcodes were used to geo-reference each record by assigning the “x” and “y” coordinate for that postcode. These coordinates allowed each service to be represented as a point on a map in GIS software, accurate to the resolution of each unit postcode. Each of the three service types was represented by a different colour on the map. For background mapping, local authority boundaries for the UK were used and census data from 2001 was applied for the number of children aged 0–17. This information was represented in two ways: shaded by local authority as the size of the child population aged 0–17, and shaded as a ratio for the number of services per 10,000 children aged 0–17. Maps were also split into statutory service types, and private and voluntary service types. UK-wide maps were produced, as were individual maps for Scotland, Northern Ireland, England and Wales.

Five hundred and eight services were mapped in total (see table 4 below). This number excluded 52 services in Scotland that were unable to be contacted by the project deadline; and 14 services in England with which contact was not possible.

Table 4 Number of services mapped geographically in the GIS component of the study

	Mapped services
England	363
Wales	15
Scotland	83
Northern Ireland	47
Total number of identified services	508

2.5.2 Structured questionnaire and follow-up telephone interview with managers

A 30-page questionnaire (47 questions in total), participant information sheet and consent form were distributed via email to service managers, inviting them to take part in the study. Questions aimed to collect descriptive information about the service including characteristics of the service (eg type of service and catchment areas); accessibility of the service (eg eligibility criteria, waiting times, demand for services and referral rates); staffing levels, training and supervision; what was on offer (eg therapeutic provision; family support; targeted support for specific groups with particular needs); strategies for reviewing the

service and user involvement; funding sources; and joint working and commissioning. The questionnaire was designed on the basis of the significant knowledge of service provision and previous experience held by members of the research team.

The researchers followed this up with a telephone call to arrange an interview, ahead of which managers were asked to complete the questionnaire. At the time of the scheduled call (duration approximately 1.5 hours), the researchers went through the questionnaire with the respondents in order to maximise the data collected. A large amount of qualitative data was captured in addition to the quantitative questions. A shortened version of the questionnaire was used in Scotland⁹.

A total of 165¹⁰ questionnaires covering 195 separate services was completed and submitted to the research team, representing a 38 per cent inclusion rate (out of 508 eligible services); 152 telephone interviews were undertaken. The 12 respondents who did not take part in the telephone interview were unable to negotiate a time to talk on the phone, but still submitted a completed questionnaire. Sixty per cent of the services were voluntary; 31 per cent statutory; and 9 per cent private sector. One service categorised itself as “other”, indicating it was joint provision through social care and a voluntary agency. Table 5 shows the breakdown of services that provided information on the questionnaire for the study.

Northern Ireland fared the best of the four nations in respect of response rates. By the deadline for data collection in July 2008, the Scottish researchers were able to collect 49 questionnaires/interviews from all eligible services (n=135)¹¹, representing a 36 per cent response rate. The response rate in England was 27 per cent. Only one Welsh service participated in this component of the research.

⁹ There were two main reasons for using the shorter version of the form in Scotland. First, initial interviews for this phase of the research in Scotland proved extremely lengthy – between 1.5 and 2.5 hours. It was judged that this placed an unrealistic demand on service managers' time. Second, the research team in Scotland drew on the experience of the research team responsible for England and Wales (where the fieldwork began earlier); securing the participation of service managers was proving very challenging. A decision was made to edit out a number of questions to avoid overburdening participants and improve the participation rate. The aim was to be able to elicit limited, key data on all the services identified in Scotland rather than comprehensive, in-depth data on a minority. Using the shorter interview form reduced the duration of interviews to within 40 minutes and just over one hour. It meant that the participation rate was high.

¹⁰ The majority of respondents reported that they only offered one type of service for sexual abuse. However, 30 respondents reported that they provided two or more types of service within their same agency/organisation: those services were counted as *separate services*. Where services were counted as separate, it was on the basis that the services for which the managers provided information *were of different types*. For example, one manager completed a single questionnaire for three different services that they supervised. One was a post-sexual abuse service; one was a post-abuse service working with any type of abuse; and the third was an SHB service. Although all three of these services were offered on the same premises, and managed by the same person, they offered different types of work and other characteristics differed, such as eligibility criteria and waiting times.

¹¹ The Scottish team continued to collect data after the July 2008 cut-off date with the intention of using the additional interviews for their separate forthcoming Scottish report.

Table 5 Number of services providing additional information

	State sector	Voluntary sector	Private sector	Total number
England	24	57	16	97 (98 ^a)
Wales	0	1	0	1
Scotland	6	43	0	49 ^b
Northern Ireland	31	16	0	47
Total number of identified services	61	117	16	194 (195) (100%)

^a One service categorised themselves as “other”. As a joint service between children’s services and a voluntary sector organisation, it has therefore been added to the 97 services in England to make a total of 98 services completing questionnaires.

^b Although researchers in Scotland identified 135 relevant services (see table 1.3) by the deadline for data collection, they were only able to collect data on 49; they continued to collect data after the deadline for inclusion in a separate forthcoming Scottish report.

Despite the low rate of participation in England, completed questionnaires were received from diverse parts of the country, including rural and urban areas. Both Northern Ireland and Scotland had a fair distribution of responses. Identification and engagement of services in Wales was challenging, resulting in a very disappointing response (for further information about this, see 2.8 Limitations of the study).

2.5.3 Semi-structured interviews by telephone with managers/practitioners

Semi-structured interviews with managers were used in the study design in order to capture contextual information that is generally difficult to gather in structured questionnaires. In-depth telephone interviews with 21 service managers/practitioners were undertaken, drawn from the services that participated in the questionnaire element of the study (duration 1.5 hours). Managers interviewed (even those from different sectors) consistently expressed and reflected the key messages reported in the questionnaire component of the study. This led the researchers to believe that “saturation” of the data had been reached, and the relevant and important themes had been identified. Managers had been asked at the end of the questionnaire whether they would be willing to participate in an in-depth interview; for those who agreed, we contacted them and arranged a future interview date with either themselves, or a nominated member of staff. In this component of the research, we developed open-ended questions related to those in the questionnaire, seeking further in-depth and contextual information. The manager/practitioner participants in the in-depth interviews covered both statutory and voluntary services; there were no interviews with managers/practitioners in the private sector. There was one CAMHS manager interviewed in Northern Ireland, England and Scotland; interviews with managers in several large and small voluntary sector services

were obtained; and several “other” types of statutory services were represented. Table 6 shows the number of managers/practitioners who participated.

2.5.4 Semi-structured interviews by telephone with commissioners

Semi-structured interviews were built into the design of the study to capture a different perspective – that of organisations buying in therapeutic services for children and young people who had experienced sexual abuse. In-depth, semi-structured telephone interviews of 1.5 hours duration were carried out with 12 services commissioners. Commissioners in England and Wales were identified via a snowball sampling technique, after managers responding were asked to provide contacts. In Scotland, a purposive sampling technique was used to identify commissioners in high and low provision areas. Commissioners in Northern Ireland were identified via established contacts. An in-depth, open-ended questionnaire was developed to capture issues related to the commissioning process, such as commissioning strategies, views on commissioned services, how they chose services to commission and how they were reviewed. The commissioners participating represented the following organisations: a city council and PCT, two county councils, a metropolitan borough council, two CAMH services, a statutory sector secure unit, a local authority social work department, two health boards, and two health and social care trusts (HSCTs) .

Table 6 Semi-structured interviews with service managers/practitioners and commissioners

	Number of service manager/practitioners	Number of commissioners
England	7	4
Wales	2	1
Scotland	4	3
Northern Ireland	8	3
Total number	21	11

2.5.5 Focus groups with young people

Focus groups with young people were included in the design of the study to capture the views of young people in terms of their knowledge of services available to them; and how they would go about helping a friend who was in need of a service. Two focus groups with young people (one with girls and one with boys) aged 14–17 were undertaken only in England. Ten participants took part, including young people from a mix of ethnic backgrounds, none of

whom were known to be service users. The young people were identified via a youth service in a location outside of London. The young people were asked a range of open-ended questions about their knowledge of services in the local area; their views on what a sexual abuse service should look like/offer; and what they would do if a friend told them they had been sexually abused. The groups lasted for approximately 1.5 hours. Although it is disappointing that we were unable to get views from service users themselves, the young people who did participate raised some important issues in respect of local services, their own knowledge of sexual abuse and what to do if they found out a friend had been abused.

2.6 Ethical considerations

Ethical approval for the research was granted by the NSPCC's research ethics committee in April 2007. Approval for social care services in England was given by the Association of Directors of Children's Services in November 2007. Health services in all nations required permission from the NHS National Research Ethics Service (NRES) (obtained in November 2007 and March 2008 for different methodological components) and the research and development (R&D) department in every NHS trust area to be included in the study. This was a lengthy and complex process, the result of which meant that we were unable to secure approval for many health services within the project timetable. As a result, health services are underrepresented in the study.

2.7 Data analysis

Data was analysed using SPSS for Windows, producing descriptive statistics using frequency, cross-tabulation and chi-square statistical tests. Qualitative data obtained from the questionnaire component and the two semi-structured interview components was transcribed into Microsoft Word files and analysed thematically using NVivo7, a qualitative data analysis software package. A geographical information system (GIS) was used to analyse and present information on the location of services referenced to local authority boundaries and the population of 0–17 year-olds in each authority using the 2001 census data.

2.8 Limitations of the study

It is difficult in mapping studies to ensure that all eligible services are identified. Despite extensive efforts to capture services across all four countries, it is inevitable that some services have been omitted from the study. This may be more so in Wales where few services were identified, although those service managers to whom we *did* speak suggested that there

were very few services of this type across Wales. The identification of services in Wales, particularly CAMH services, was not an easy task and made difficult by often unhelpful NHS trust processes. Trusts were identified, followed by an analysis of their websites, which provided little information as to the availability of therapeutic services of any type, much less services for children and young people who had experienced sexual abuse. This was followed up with direct telephone calls to children's services and other departments to try to trace the correct service. This exercise often proved futile as researchers were passed from one department to the next with no reply to messages left. Emails also went unanswered.

The difficulties experienced in this mapping study were echoed in *NSPCC Cymru/Wales Experience of CAMHS* (NSPCC, 2007):

“Any information on CAMHS is hard to find, even *Everybody's Business*¹² cannot be accessed easily online. It has been difficult to identify who the key people in the commissioning process are and what services are being commissioned in a local area. We are concerned about the lack of transparency around the commissioning process as information on local structures and delivery is so difficult to obtain.”

(NSPCC policy advisor)

A number of very small services in private and voluntary organisations were found via comprehensive internet searches, leading the researchers to believe that further small organisations may have existed, but were difficult to find. However, it is likely that those identified would be the most established organisations and those that have not been identified would be small services accommodating a low number of users. As it was not possible to identify the full population of therapeutic services, the numbers of eligible services have been reported as only those identified in the research.

Of those services identified, some degree of contact was made with almost every eligible service. However, a second issue was a lack of response to the invitation to complete the questionnaire and take part in an interview, particularly in England and Wales. A significant number of services made no further response to invitations we made by telephone or email. It became clear throughout interviews that *were* secured that time was of a premium to most service managers. Services were under-staffed and had waiting lists, so taking part in a study

¹² Welsh Assembly Government (2001) *Everybody's Business: Child and Adolescent Mental Health Services – Strategy Document*. Cardiff: Welsh Assembly Government.

such this would have been seen as a low priority, despite the fact that the study aimed to investigate these concerns.

Health services were the most difficult to contact and engage in the study. This was not surprising given the amount of research that takes place across the NHS. CAMHS mapping was underway in many of the services we approached, which meant some felt the pressure to do more was too great and potentially burdensome. In some regions, mapping research around domestic violence or other topic areas was underway in addition to CAMHS mapping. The lengthy R&D process considerably frustrated our efforts to include services in the health sector and these are underrepresented in the study.

Another limitation of the study was the scaled down nature of our consultation with young people and the lack of consultation with young service users. We had initially hoped to be able to survey young service users to canvas their views on what services and service improvements were needed. However, the NHS ethics and R&D applications caused serious delays in the research timetable and unfortunately we had to scale down and lose these consultations. A survey of service users will however be addressed in the subsequent research project, which will consider the outcomes of interventions for children and young people affected by sexual abuse.

2.9 Summary

Despite the limitations and the obstacles encountered in carrying out the research, each of the five methodological components have delivered consistent and cross-cutting messages on the shortfall in service provision and the challenges facing services in an environment of scarce resources. The next chapters present our findings.

3 Identifying the gaps in service provision: mapping the services

This chapter provides an estimate of the need for services across the United Kingdom; an overview of the characteristics of services; and their geographical distribution in relation to services identified as eligible for the study across England, Wales, Scotland and Northern Ireland. It concludes with a description of the 195 services that provided information in the questionnaire component.

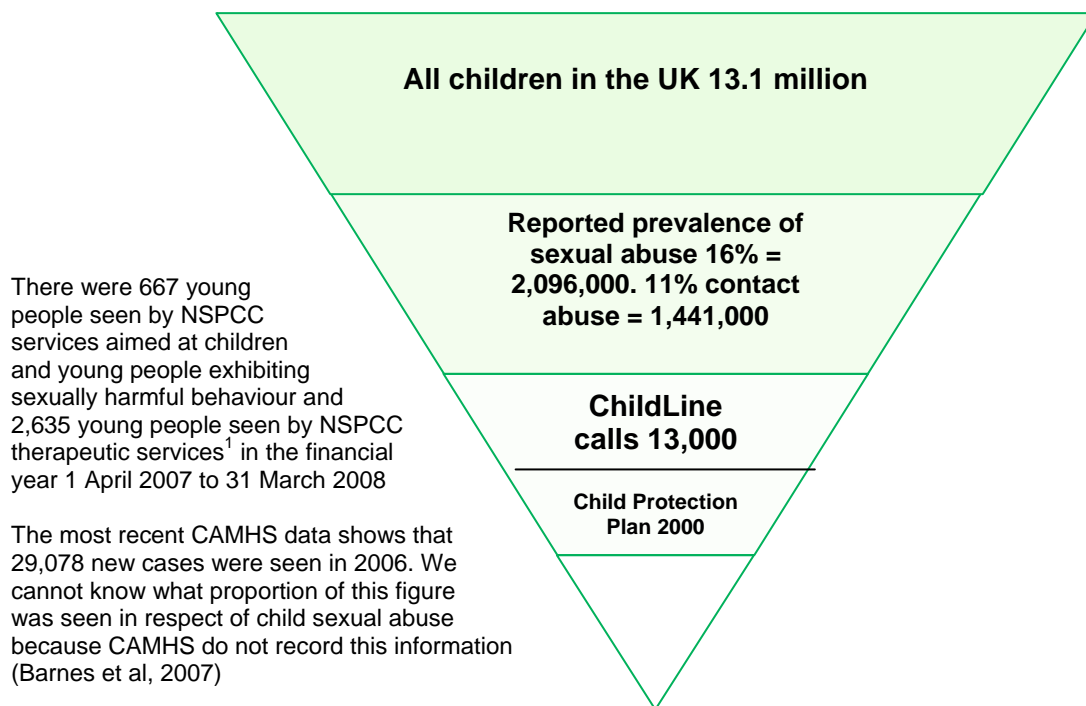
3.1 Estimating the need for services

Before we examine the distribution of services, we should consider what level of service provision might be needed to provide adequate therapeutic support for children and young people who have experienced sexual abuse in the UK.

Figure 2 below shows the known and estimated populations of children and young people who have experienced sexual abuse or who have been in touch with services. The top slice of the triangle is relevant to the universal services shown in the previous chapter. These are the services that should be available to all the 13.1 million children and young people in the UK. These services include responses provided by education, child health, youth services and so forth as part of their general activities to deliver services to promote children's wellbeing. The services targeted at vulnerable children to prevent sexual abuse for which we have no incidence data or prevalence estimates would be within this 13.1 million. For responsive services for children harmed by sexual abuse, we have already noted the gap between estimated prevalence and cases reported to children's social care services. Figure 2 shows our estimates for the number of children in the population affected. The NSPCC prevalence study (Cawson et al, 2000) found that 16 per cent reported sexual abuse in their lifetime, providing an estimated figure of 2,096,000 million children who may have experienced child sexual abuse. Figure 2 also shows that approximately 2,000 children and young people were subject to a child protection plan in 2007 under the category of sexual abuse. The child protection registers do not record all children who have experienced or are likely to experience significant harm, but only those for whom the need for a child protection plan has been identified.

Finally, determining the number of children using tertiary services has always been most difficult because of a lack of consistent and accurate recordkeeping and reporting at a national level. The only figures prior to this mapping study that we have been able to use for calculations are those derived from NSPCC services for children and young people and ChildLine figures for 2007/08, which are also shown in figure 2.

Figure 2 The gaps between need based on prevalence, identified abuse and response



Now, however, we are able to estimate what we believe “adequate” provision should be by using figures for the total population of children and young people under 18 in the UK; figures from the NSPCC prevalence study (Cawson et al, 2000); making assumptions about the numbers of children and young people who would need or want a service; and new data from this mapping study.

Calculations begin with the 13.1 million children in the UK. Using NSPCC prevalence data from 2000 (Cawson et al, 2000), which indicated that 11 per cent of children experienced contact sexual abuse in their childhood, we can estimate that 1,441,000 in the UK have experienced contact sexual abuse. However, the prevalence study asked about lifetime abuse, and therefore it must be assumed that some abuse may have happened some time ago and some will be more recent. Our earlier discussion of the research literature shows that many children will not tell anyone about the abuse until some years later. However, we cannot

assume that, even in a world where all children felt safe to talk about the abuse immediately, that all would necessarily want or need therapeutic support. Applying a conservative estimate that 5 per cent of the young people would want support from a service, we can estimate the need for 72,050 therapeutic spaces for children and young people who have experienced contact sexual abuse each year.

If we include non-contact sexual abuse in our estimate of need, and if 16 per cent of the population had experienced sexual abuse (contact and non-contact) in their childhood, 2,096,000 children will have been affected. Applying the same conservative estimate that 5 per cent of them will want or need a service, there would be a need for 104,800 therapeutic places per year.

3.2 Are there enough services in the United Kingdom?

Using these conservative estimates of overall need for services, we can now draw on information gained in our research about actual services that exist to consider whether or not there is a gap between provision and need.

The mapping study identified 508 therapeutic services for children who had experienced sexual abuse. There would need to be 142 spaces for therapeutic work with a child or young person in each of these services per year to meet the level of estimated need for children affected by contact sexual abuse (72,050) or 206 spaces for therapeutic work per year to meet the level of estimated need for children affected by contact and non-contact sexual abuse (104,800). However, we only have data on referrals (for one year) for 110 services. These services were not based on a representative sample and this should be taken into account when considering the estimates. The average (mean) number of referrals for these 110 services was 32 per year. Applying this figure across all 508 services, it can be estimated that approximately 16,256 children were receiving a service in 2006/07. Subtracting this number of children from the identified need for children affected by contact sexual abuse (72,050), there is a shortfall of 55,794 places. Subtracting 16,256 currently receiving a service from the level of need for children affected by contact and non-contact sexual abuse (104,800) applying our conservative estimates of demand, we have a shortfall of 88,544 places each year.

The following estimate is a conservative calculation but excludes Wales. We are estimating in this way to account for the challenges faced in data collection in Wales – therefore the

calculation applies only across Northern Ireland, Scotland and England. The population of the UK, excluding Wales¹³, is 12.3 million (12,358,400). Applying the 11 per cent contact abuse statistic from the prevalence study (Cawson et al, 2000), 1,359,424 children and young people across England, Northern Ireland and Scotland would have experienced contact abuse in a year. Finally, applying a take-up rate of 5 per cent, we can estimate the need for 67,971 therapeutic spaces for children and young people who have experienced contact sexual abuse each year.

Subtracting 15 services identified in Wales from the 508 services identified across all four nations, there were 493 services identified in England, Northern Ireland and Scotland. There would need to be 137 therapeutic spaces for children and young people in each of the 493 services per year to meet the level of estimated need. Subtracting the 16,256 children receiving a service in 2006/07 from the total number of therapeutic spaces required (67,971), we can estimate a shortfall of 51,715 places.

3.3 Distribution of services across the United Kingdom

The estimates above suggest that there is a shortfall in services across the whole of the United Kingdom. In the following pages, a number of maps are presented, which visually plot the location of statutory, voluntary and private sector services. The maps presented are UK-wide, giving an overall picture of service location, and for this reason may be difficult to read. However, there is no mistaking some very large gaps in provision in numerous geographical areas in all four nations. Following these are maps of the individual nations, providing the opportunity to examine the gaps more closely¹⁴.

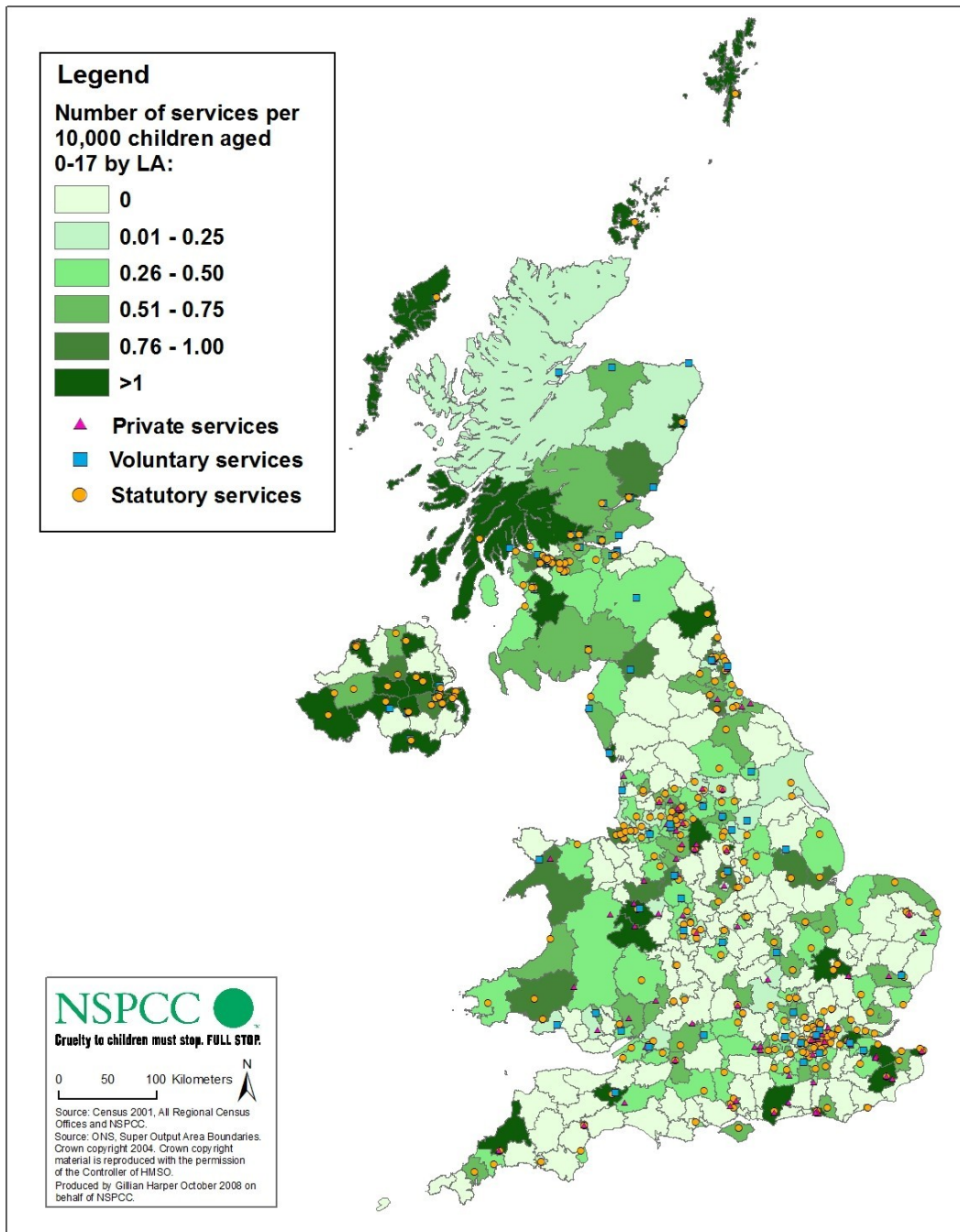
¹³ Population of children and young people in Wales, taken from the 1991 census, is 741,600.

¹⁴ A limitation to the maps presented below and in appendix 1 is that they show the location of the central "offices" of the services identified. The catchment area or "reach" of many of these services will be contained within a strategic health authority or within a local authority. However, some are in fact national or regional, which means they can accept children from outside the local authority within which the service resides. For example, the main headquarters of one voluntary service in the south-east of England covers Bromley, Bexley and Greenwich in London and Ashford, Dartford, Gravesham, Maidstone, Medway and Swale, Sevenoaks, Tonbridge and Malling, and Tunbridge Wells. On the maps, some of these areas (eg Maidstone, Sevenoaks, Tonbridge and Malling, Tunbridge Wells and East Surrey) appear to have no services, but this voluntary organisation accepts children from these areas. Certain policies within the service (for example, waiting times between acceptance of referral and the start of therapeutic work) will apply to all of those areas. There are no extra "places" for example because of the wider catchment area; all referrals from those areas will be subject to the same eligibility criteria and waiting periods as children in the immediate locality of the headquarters.

We do not have data on the percentage of referrals coming from areas that are far from the service venue where therapeutic work takes place; however, interviews undertaken with managers uniformly highlight difficulties in providing services to children who live far away. Distance will inevitably impact on the potentiality of children living far away of being able to access the service. Travel costs and separation from family may prove to be too big a cost in accessing the service.

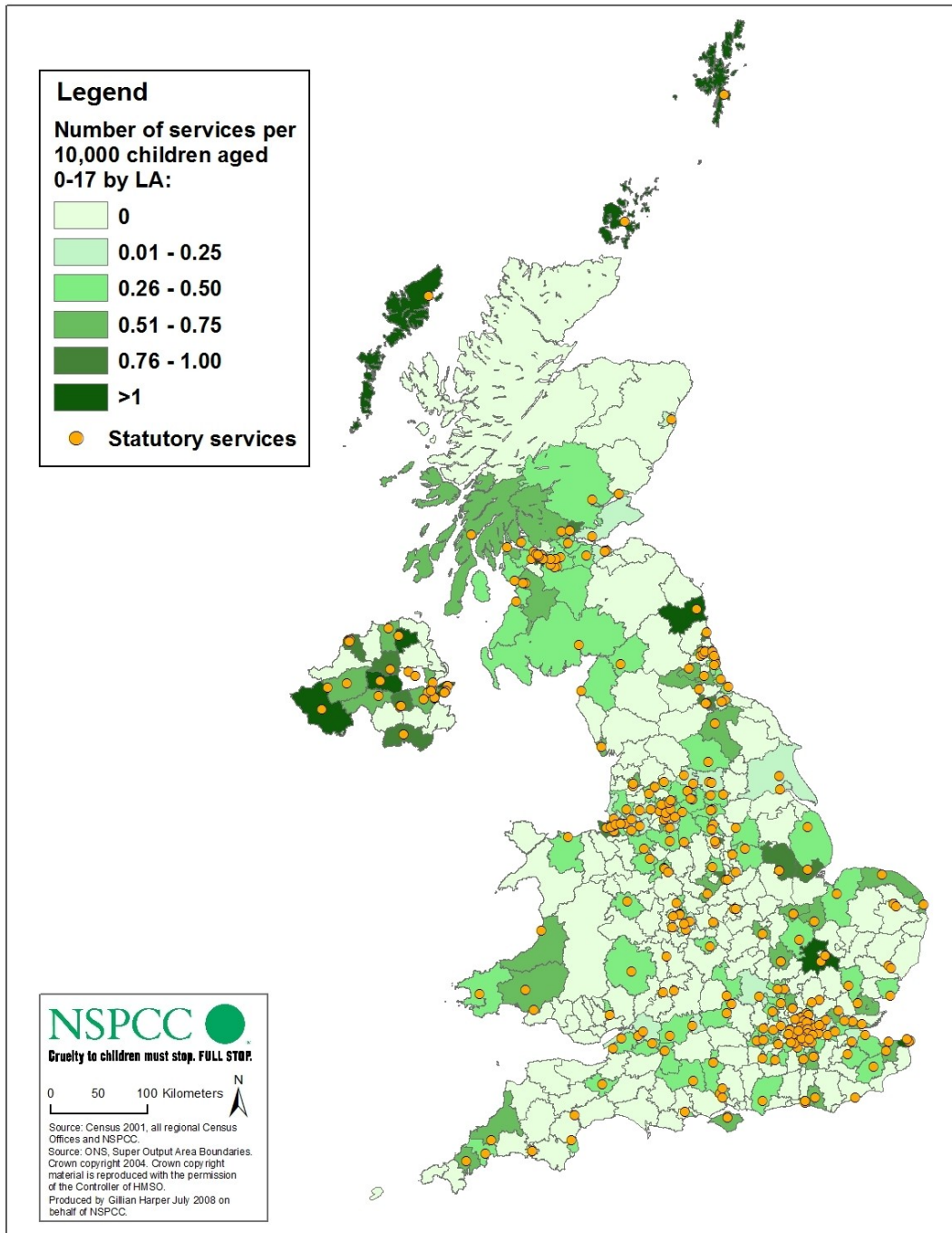
Map 1 shows the distribution of statutory, voluntary and private services across the United Kingdom according to the number of services per 10,000 children aged 0–17 by local authority. These services include areas of provision as diverse as health, social care and youth and children’s services. It reveals startling gaps in service provision by statutory services, with particularly substantial pockets in Scotland, the north of England, East Anglia, the south west and Wales lacking services. It also shows gaps in Northern Ireland, but provision appears more evenly and consistently spread across the country.

Map 1 Location of private, voluntary and statutory therapeutic services in the UK by number of services per 10,000 children aged 10–17

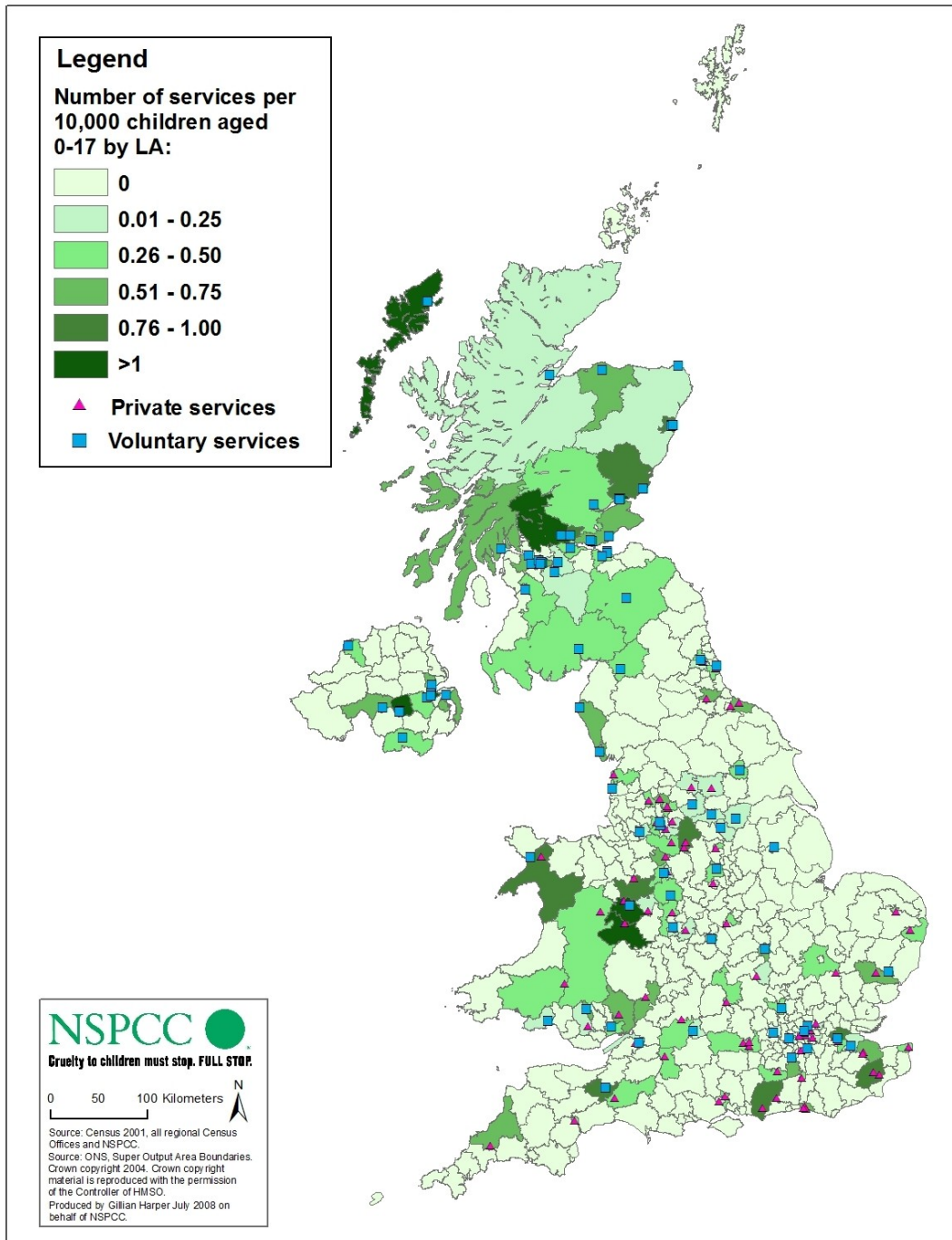


Map 2 covers statutory sector provision only, while map 3 presents voluntary and private sector provision. The maps should be read simultaneously with map 1 (UK-wide) to observe the overlay. For example, when reading map 2, there may appear to be no provision of statutory sector services at all, but a voluntary or private sector service may have been located there.

Map 2 Location of statutory therapeutic services in the UK, by number of services per 10,000 children aged 0–17



Map 3 Map of private and voluntary sector therapeutic services in the UK, by number of services per 10,000 children aged 0–17



The maps provide complicated reading when also accounting for the number of services available per 10,000 children aged 0–17. For example, there are no statutory services

providing therapeutic work in the Scottish Borders, but map 3 shows a voluntary sector service. Capacity is low, providing less than half a service per 10,000 children aged 0–17¹⁵.

There are no voluntary sector services shown in North Norfolk, and King’s Lynn and West Norfolk, but there is a statutory service providing therapeutic work. As in the Scottish Borders, there is less than half a service for every 10,000 children aged 0–17 in North Norfolk; and in King’s Lynn and West Norfolk, there is less than three-quarters of a service per 10,000 children.

3.4 Scarcity of services as reported by managers

Managers were asked, via open-ended questions in both the questionnaires and the semi-structured interviews, to tell us about any gaps in provision¹⁶. Fifty-six managers (in the questionnaire) and 14 (in the interviews), pointed out considerable shortages of therapeutic services for children who had experienced sexual abuse in many areas across the UK. Managers reported local shortfalls, identifying specific geographical areas without any services or with very few. One specific quote from a manager of a voluntary service in England exemplified the situation in which many services found themselves: “We are the only service within a 50-mile radius, but the majority of children we provide a service to are in close proximity of the service.”

Twelve managers also reported that rural areas were particularly lacking services and that they did not have the capacity to provide outreach; distance, a lack of time and low staff capacity confounded attempts to provide services further afield, even when rural areas may still have been in the service’s catchment area. A manager of a voluntary sector service in Scotland described attempts by the service to assist children in rural areas by introducing overnight accommodation for families to access services. However, not all services had the resources to solve the problem of long distance travel, which could take up a considerable amount of the working day, reduce the number of children seen and produce fatigue and frustration for workers.

¹⁵ The figure was calculated by adding together the number of statutory services per 10,000 children and the number of voluntary services per 10,000 children.

¹⁶ They were asked a very general question about the gaps without prompts from the researchers; therefore their responses reflect the most important gaps in provision, as understood from their experiences.

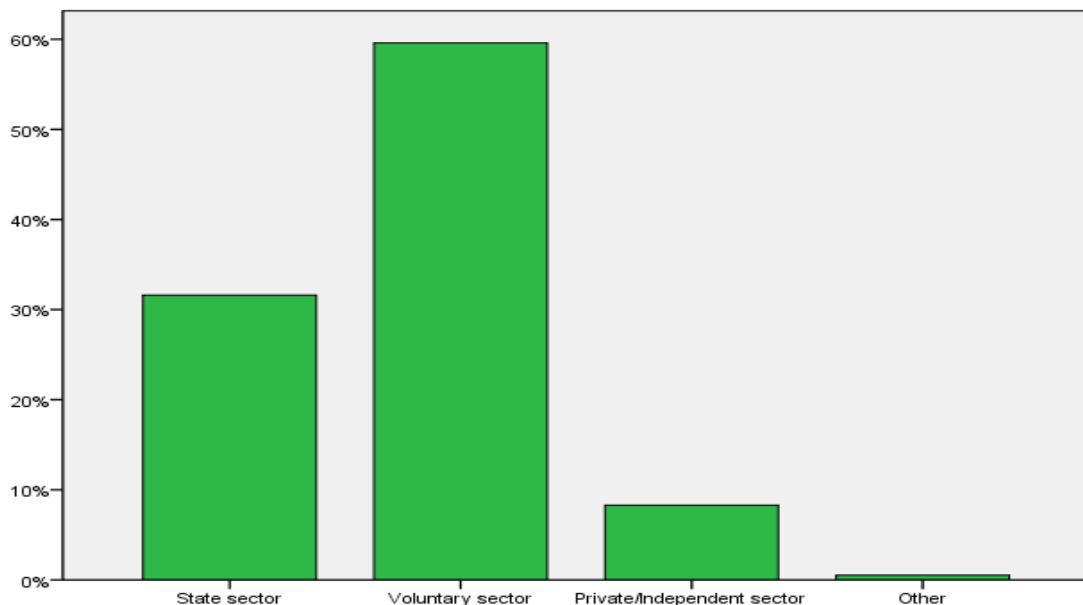
3.5 Characteristics of services

This final section presents an overview of the characteristics of services from information in the questionnaires. For the remainder of this report, data will be drawn from the 195 services that completed a questionnaire and telephone interview, and from information given in the semi-structured follow-up interviews.

3.5.1 Sector, area of provision and type of service

Therapeutic services for children who have experienced sexual abuse are typically provided through one of three sectors: statutory, voluntary or private. Participation in the mapping study was skewed toward voluntary sector provision due to a) a lower response rate than expected among services in England; b) difficulties in contacting services in Wales; and c) difficulties in progressing R&D applications in the health sector services in England, Wales and Scotland in time to meet the project deadline. This is especially regretful, since the GIS maps presented in this chapter indicate that a significant proportion of services (67 per cent of identified eligible services) are offered within the statutory sector. Figure 3 below shows the sectors of the services that completed questionnaires. Nearly 60 per cent were operating in the voluntary sector. Over a third of these were from the statutory sector, the majority being CAMH services.

Figure 3 Sector in which the service operates



3.5.2 Area of provision

Across all sectors, services may be categorised as health or social care-based services, children’s services, and criminal justice services, with a small minority operating within a multi-agency framework. Table 7 below describes the participant services in terms of their type of provision.

Table 7 Percentage of services working within different types of provision

Type of provision	% (n=144) ^a
Social care services	38
Health services	34
Youth and children’s services	11
Other	8
Multi-agency initiative	7
Criminal justice services	1
Education services	1

^a Information for Scotland was not available.

Nearly three-quarters of the services were provided within a social care setting (38 per cent) or health-based setting (34 per cent). Smaller numbers of services operated within youth and children’s services (11 per cent); “other” types of services (8 per cent); multi-agency initiatives (7 per cent); criminal justice services (1 per cent) and education services (1 per cent). Managers who described their services as operating in an “other” area of provision tended to depict jointly funded services. For example, one manager of a statutory service in England stated: “We are funded by health, social services and education, all of which came together...after a countywide restructure of children’s services.” Others classified themselves as a counselling service (such as rape and sexual assault centres – SARCS) or rape crisis counselling services (RCCS).

Examining the services by sector shows that the statutory services were primarily health-based (60 per cent); a further quarter were social work services; 6 per cent operated within the criminal justice system; 6 per cent were part of a multi-agency initiative; 4 per cent worked within youth and children’s services; and 2 per cent described themselves as “other”. Within the voluntary sector, services operated primarily in the social work sector (51 per cent); 20 per cent were health-based; 11 per cent worked within youth and children’s services; 11 per cent described themselves as “other”; and 7 per cent were part of a multi-agency initiative. The private sector services fitted primarily within youth and children’s

services (38 per cent); 19 per cent were social work services; 13 per cent were health-based; 13 per cent were part of a multi-agency initiative; 13 per cent are described as “other”; and 6 per cent operated within the education system.

3.5.3 Type of service

Service managers were asked to identify the nature of their service as either 1) a post-sexual abuse service; 2) a post-abuse service working with any type of abuse trauma (including emotional and physical abuse, and neglect); 3) a specialist SHB service (working with children displaying sexually harmful behaviour) *also providing* a post-sexual abuse component¹⁷; or 4) “other”. Of the 195 questionnaire respondents, 35 per cent described their service as “other”; 32 per cent as a post-abuse service working with any type of abuse trauma; 21 per cent stated their service was a dedicated specialised service for sexual abuse; and a further 12 per cent characterised their service as specialist SHB with a complementary post-sexual abuse (PSA) component. This data shows that only one in five of the services were specifically dedicated to working with children who had experienced sexual abuse.

Data was next analysed by sector in order to understand if there were differentiated patterns of service types across statutory, voluntary and private sector services. Statutory sector services were most likely to describe their type of service as “other” (57 per cent). This encompassed a range of settings not specifically dedicated to work with children and young people who had experienced abuse, but within which trained staff may have undertaken therapeutic work where sexual abuse may have emerged as an underlying problem. For example, statutory health services included CAMHS and child and adolescent inpatient units. Within the social care area of provision, therapeutic work was offered within some generic counselling settings, family centres, young people’s projects or provided by specialised staff in learning disabilities or looked-after children teams. Therapeutic work was also offered in some criminal justice settings, such as a youth offending setting. Only 13 per cent of statutory sector respondents described their service as a dedicated post-sexual abuse service; 23 per cent as a post-abuse service working with any type of abuse trauma; and 7 per cent as a specialist SHB with a PSA component.

Dedicated post-sexual abuse services were most commonly offered by the voluntary sector (28 per cent); 35 per cent reported that they provided post-abuse services for any type of

¹⁷ Only SHB services providing a therapeutic service for children who had also experienced sexual abuse were included in this study; this was to avoid duplication with a previous mapping study of SHB services undertaken by Hackett et.al (2003).

trauma-related abuse; 23 per cent described their service as “other”, which included settings as diverse as generic counselling services, family centres or psychological trauma services; and a final 15 per cent were classified as specialist SHB with a PSA component. Fifty-six per cent of the private sector respondents said that their service could be categorised as post-abuse working with any type of trauma-related abuse; 31 per cent were “other”; and 13 per cent offered specialist SHB services with a post-sexual abuse element.

Of the SHB services included in this study, 59 per cent were provided through the voluntary sector (primarily in youth and children’s services provision); 29 per cent through the statutory sector (in primarily health settings and youth and children’s services); and 12 per cent were private provision. Two of the SHB services were residential.

3.6 Summary

This chapter has provided estimates of the overall need for services in the United Kingdom; identified gaps in provision; and described the services that took part in the questionnaire component of the study. The maps highlight the inadequacy of therapeutic service provision for children and young people who have experienced sexual abuse.

- The overall number of services per 10,000 children and young people is low. There is a mean average of 0.37 services per 10,000 children and young people across the UK – in other words, there is less than one service available per 10,000 children and young people.
- In some areas, there are no services at all.
- There is a striking paucity of services in Wales; even in the event that the services identified are a conservative estimate.
- Across all four nations, services are particularly scarce in rural areas. Bearing in mind that some children in rural areas may be eligible for services at a distance, information presented in a later section indicates that rural children are at a significant disadvantage in accessing a service.
- Employing the conservative estimate that only 5 per cent of those children who have experienced sexual abuse in their lives will want to access a service in any one year, there is, across the UK (including Wales), a shortfall of 55,794 spaces per year for children and young people who have experienced sexual abuse involving physical contact.

- Employing this same conservative estimate that only 5 per cent of those children who have experienced sexual abuse in their lives will want to access a service in any one year, there is, across the UK (including Wales), a shortfall of 88,544 spaces per year for children and young people who have experienced contact and/or non-contact sexual abuse.
- Excluding Wales (where data collection was impeded by the contemporaneous review of child and adolescent mental health services), the conservative estimate that only 5 per cent of those children who have experienced sexual abuse in their lives will want to access a service in any one year, results in a shortfall of 51,715 spaces per year for children and young people who have experienced sexual abuse involving physical contact.
- Managers' responses during in-depth interviews add further evidence of gaps in services.
- Only a small proportion of services are specialist post-sexual abuse services. A majority of work in relation to child sexual abuse is subsumed within service provision that deals with a wide range of mental health issues.

The following chapters consider other aspects of service delivery, such as accessibility of services, what therapies are on offer, who provides them, and the funding and commissioning processes.

4 Service demand and accessibility

The gap between the estimated need for provision and the reality of services on the ground is significant. In this chapter, a range of topics is explored to examine the impact this gap in provision has, in practice, on service delivery and operation. First, figures for current service use are presented and analysed using data from the questionnaire, followed by an analysis of waiting times as a measurement of demand. Next, manager and commissioner views regarding perceptions of demand are examined. Finally, service eligibility and accessibility for children with particular needs are explored.

4.1 Current service use

Confidently assessing the demand for therapeutic services for children and young people who have been sexually abused is a complex task, when even reporting the numbers of children who are currently receiving a therapeutic service is difficult.

In order to understand current capacity, service managers were asked to provide the numbers of children and young people who had experienced sexual abuse who were accepted after referral in the financial year 2006/07. They were also asked, where possible, to provide a breakdown of their characteristics (eg by age and gender), as well as their primary reason for referral. This question proved to be a complex one and reliable statistics were difficult to obtain, reflecting the fact that recordkeeping in respect of sexual abuse is inconsistent and patchy. Although a number of respondents in this mapping study were able to provide accurate statistics on referrals, other services were not able to quickly and easily locate the data for a variety of reasons. Many questionnaires were returned incomplete, excluding the requested figures, either because of time pressures hampering managers' ability to obtain the numbers, or because, in some cases, services could not identify the numbers of children they worked with who had experienced sexual abuse. This latter reason was particularly the case for CAMH services, where referral statistics were recorded by presenting *disorders*, such as hyperkinetic or emotional disorders. The total number of new cases seen in the year 2006, as reported in the most recently published CAMHS mapping exercise, was 29,078 (Barnes et al, 2007). While sexual abuse may very well have been an underlying cause of the medicalized

behaviour observed in some cases, this was not recorded systematically and therefore it is impossible to know how many of their service users also experienced sexual abuse. Reflecting this recording structure, the CAMHS mapping exercise is of little help in revealing the extent of sexual abuse among service users.

In England, where CAMHS managers provided figures, they reported overall numbers for their service, but could not identify specific referrals where sexual abuse was an underlying factor, and were thus omitted from the analysis. In Scotland and Wales, no CAMH services were interviewed¹⁸. In Northern Ireland, CAMHS managers were able to report more reliable figures, although in some cases the figures may have been higher because they were reported for cases where sexual abuse was present, but they were not necessarily undertaking therapeutic work relating to sexual abuse. These figures were included, although they may have been slightly overestimating the total number of referrals accepted where therapeutic work was being undertaken. The question posed to managers did not account for referrals made but rejected.

The tables in appendix 2 present referral rates by total number, primary reason for referral and ethnicity, showing the mean, median and standard deviation (variation), along with the minimum and maximum number of referrals in each category.

The data shows wide variation (represented by the standard deviation) in these referral rates. Based on figures received from 127 services, the average number of children and young people accepted after referral was 32, although there was wide variation with a maximum of 190 referrals accepted by one service. There were on average more girls (23)¹⁹ accepted after referral than boys (10)²⁰, and, by age, the largest group accepted to a service after referral were children aged 10 to 15 (average of 17 referrals, based on figures from 101 services). The 16 and 17-year-old age group represented the fewest average number of referrals (5.8) and the youngest groups (up to age 9) averaged 6.4 referrals.

The average number of children and young people referred for sexual abuse across 115 services was 21, with a high degree of variation observed (with a maximum number of referrals being 190). A much smaller average number of referrals (7) were evident where the primary reason for referral was an “other” type of abuse such as physical or emotional abuse,

¹⁸ This was because the researchers were unable to secure R&D approval for research in the health sector by the project deadline.

¹⁹ Based on figures from 111 services.

²⁰ Based on figures from 110 services.

or neglect, or some combination of these (but where therapeutic work was being undertaken for sexual abuse as well). The average number of children and young people accepted after referral specifically for SHB (but where therapeutic work was being undertaken for sexual abuse as well) was four.

There are two primary explanations for these figures. First, the wide variation observed can largely be explained by the size of services. Some services have very low capacity; for example, one service could only accept a maximum of five children and young people at any one time due to small premises. Other services were very large residential units, which could accommodate a high number of children and young people. Second, the observed low figures will be a factor of the length of therapeutic work undertaken. There were a number of services that had no – or very low – “turnover”, either because of lengthy therapeutic work, which lasted longer than a year, or because of careful assessment of new placements. “We never know how long we will be working with young people.” (Voluntary sector service, England). Thus, referral turnover can be related to the “appropriateness” of the placement and length of work undertaken, which can be unpredictable.

Of all three sectors, voluntary services reported the highest average number of children accepted after referral (37.6); the statutory sector averaged 24.9; and the private sector averaged 26.0. The average number of children accepted after referral for sexual abuse also differs among the sectors; the voluntary sector reported the highest average number referred for sexual abuse during that time period at 24.5, the statutory sector averaged 15.4 referrals; and the private sector averaged 7.8 referrals for sexual abuse. Where the primary reason for referral was for an “other” reason, the statutory sector had the highest average number of referrals at 35.6; the voluntary sector averaged 9.1; and the private sector reported an average of 3.7 referrals of this type. Where the primary reason for referrals was SHB, the private sector reported the highest average of referrals (5.8); voluntary services averaged 3.7; and the statutory services averaged 2.5 referrals for SHB.

Overwhelmingly, it was White British children who were receiving a service across the United Kingdom (see table 17 in appendix 2). A very small number of children from an “other” White or minority ethnic background or disabled children²¹ were being referred to sexual abuse services. Generally speaking, the primary route of access for most children receiving a service was via another professional, such as a social worker, health worker, the

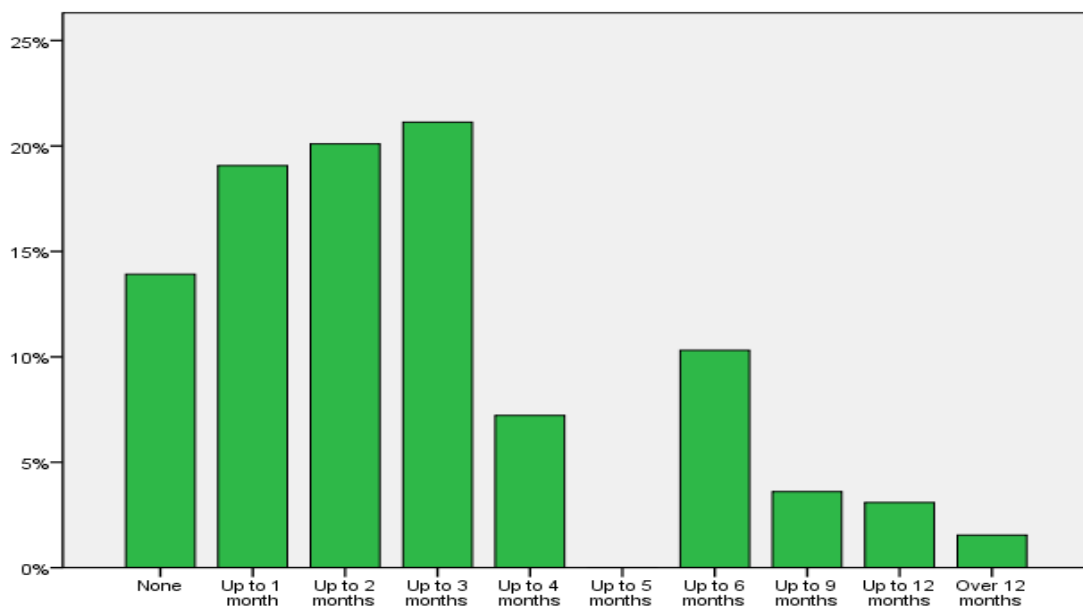
²¹ Numbers of disabled children referred must be interpreted with caution, as “disability” was not defined in the questionnaire for respondents.

police or an education professional. This being the case, it was unclear whether children from a minority ethnic background and disabled children were being referred and not accepted into a service (as the figures above refer only to children accepted after referral); or whether they were potentially not being identified at an earlier stage through another route (for instance, via school, social work or the police) and offered a service. Alternatively, there were significant barriers to the disclosure of child sexual abuse in some communities, leading to an under-reporting of incidents of sexual abuse (Gilligan and Akhtar, 2006). It is difficult to speculate too widely because the statistics are limited; and they may not be representative of BME children and young people who have been identified as sexually abused. This is despite our knowledge that abuse occurs across socio-economic and cultural backgrounds, and also despite our understanding that disabled children are more vulnerable to abuse than non-disabled children (Miller, 2002).

4.2 How long do children wait to receive a service?

In order to try empirically to assess demand for services, managers were asked to tell us about their waiting times for a service. Figure 4 below shows the distribution of the responses.

Figure 4 Estimate of typical waiting time between referral and commencement of therapy



The mean average waiting time between acceptance of referral and therapy was three months. However, nearly 20 per cent of services reported waiting lists of six months to one year²². Waiting times must, however, be interpreted with caution. Various strategies for managing demand (eg prioritising children; targets) may have artificially deflated the actual waiting times. Manager's responses in the semi-structured interviews revealed mixed feelings about the length of waiting times. There were only a few managers who felt that a three-month waiting period was an acceptable time period for receiving a service. Others felt that such waiting times were unacceptable for children who had been traumatised by sexual abuse, which could potentially have negative impacts on the child. For example, parents may struggle to cope with the impact of abuse on the child. Problematic patterns of behaviour by a child can become entrenched; or it may not be in the child's best interests to bring up the events and relive them so long after they occurred, as suggested by a manager in Northern Ireland: "If you had a three-year-old who was referred for investigation of sexual abuse and they waited until they were three and a half, that would nearly be pointless interviewing them about something that happened six months ago so yes, it [long waiting times] could have big implications". Finally, denying access to a service when it is needed may reinforce a child's negative self-feelings, potentially compounding already existing feelings of worthlessness:

"We believe that the longer they wait, the more unhelpful behaviours and dynamics in the family can develop...so a child's view of themselves and their place in the world, if that's still staying in a very negative place then that's going to get in the way of their development because it will effect their behaviour and those around them. It's going to stop them having the opportunity to move on." (Specialist voluntary service manager, Scotland).

The semi-structured interviews with managers revealed an ongoing process of prioritisation that occurred within the existing waiting lists. Staff prioritised cases based on "urgency" or "need", which may have been a factor of the child's or young person's age, whether they were the subject of a child protection order or whether they were exhibiting problematic behaviour.

Prioritisation occurred for a variety of reasons. Services themselves may implement them as a way to cope with the demand for their service. One service in England that accepted referrals for children and young people, as well as adults who had experienced childhood sexual abuse, prioritised children and young people, but acknowledged that this was to the detriment of their adult clients.

²² Data from the CAMHS mapping exercise (2006) provides some information on waiting lists in those services. Fifty-one per cent of children and young people accessing CAMH services waited less than four weeks; 36 per cent waited one to three months; 9 per cent had waits of three to six months; and 5 per cent waited longer than six months. However, there is no indication which children receiving which services waited this length of time; and it is impossible to know how long children and young people with histories of sexual abuse waited for a service.

“We actually put children and young people first, particularly victims, so their waiting list is hardly anything at all. If anything it’s four weeks, and that’s an extreme measure. It’s the other people, for example historical rape. So children and young people are not suffering as the adults are.” (Service manager, England).

Another voluntary sector service manager described the response to a system that had previously held a waiting list of up to one year. This service has initiated a “rapid response” system, which means that children are allocated almost immediately after initial assessment, resulting in a reduction of the waiting list. However, the service has had to drastically reduce the number of children it can accept, which has had the negative consequence of reducing access to the still-existing number of children and young people in need of a service. Indeed, in a situation of resource scarcity, any reduction in waiting times will only be achieved at a cost of reducing access to a service.

Services may be forced to implement them by their commissioning agencies:

“There can be prioritisation of cases, as directed by our commissioner, and cases that may get a service quicker are children that are in the looked-after system”. Another voluntary agency manager said, “We are working within guidelines that we can’t take anyone onto the waiting list unless we can see them within 90 days.” (Voluntary service manager, England)

These policies serve to reduce access to a range of children with a range of needs.

Non-commissioned services will prioritise as part of their capacity planning. For example, in CAMH services, a child or young person will be prioritised and seen within 24 hours if they have been identified through their assessment process as being “urgent”; other children or young people may be assessed as “priorities”, in which case they would be seen within four weeks. All other children and young people may wait for up to six months to be seen:

“We would prioritise referrals for example, if it was a very serious piece of inter-familial abuse with child protection issues or if the young person was described as being very traumatised. We would prioritise those types of cases but what happens is that there are cases that aren’t prioritised and they would have to wait the six months or longer.” (Voluntary family centre, Northern Ireland).

This implies a possibility that referring practitioners may exaggerate a child or young person's problem in order to be seen quickly.

“...if a parent or carer called in and said: ‘I’m worried about my child’, we would probably say ‘OK, come in next week if you want’.” (CAMHS manager, England).

Prioritisation strategies can mean that children not exhibiting “critical” behaviour in relation to their abuse would have to wait for very long periods for a service, potentially undermining the notion of early intervention and compounding harm: it means that equally traumatised children who do not manifest that trauma in problematic behaviour are less likely to get a service when they need it.

4.3 Manager’s perceptions of demand for services

Perceptions of current demand were also examined in the questionnaire component of the study. Managers were asked whether or not their service was currently exceeding capacity to supply it. Sixty-five per cent of services cannot meet the demand for services in their areas. Furthermore, 85 per cent of managers reported that there were not enough local services to provide therapeutic work for children and young people who have been sexually abused. Therefore not only could these services (participating in the study) not meet the demand, but other services were not available to cater for this group of children and young people. Services that were meeting demand (35 per cent) also tended to hold eligibility criteria that were much more narrow (eg by age, referral source primarily), and some were residential units or SHB services that were very expensive. Therefore access may have been more difficult, which would result in a lower number of referrals and the appearance of low demand. A few managers pointed out in the telephone interview that thresholds for accessing services were too high:

“As a result of this, more children will have suffered abuse than have been identified. This is partly why the service is not over-subscribed, plus I suspect that people do not realise that service(s) for abused children exist.” (Voluntary sector service manager, England).

Assessing staff caseloads can provide another picture of the demand for services. Eighty-five per cent of managers reported that their staff carry full caseloads. Of those managers who reported their staff did not have full caseloads (14 per cent), this was usually based on the

nature of the service as residential or that it was a newly opened service. Two services were only recently operational, thus staff capacity had not yet been reached. Three services were residential, providing long-term therapeutic work. One manager explained that residential care was not currently seen as a “desirable option” in light of recent scandals, compounded by the expense of a 24/7 service. Therefore local authorities were reluctant to refer and thus the service was able to cope with low demand. One service was a rape crisis counselling service, which was well funded by the local authority. On average, managers reported that three extra staff members would be required to help them meet current need.

Forty-two per cent of managers reported that demand would be more fully met through a greater skill mix of staff; 35 per cent that better capacity planning and management would help meet the need; and 35 per cent felt better training and staff development is required. Forty-eight per cent of services said that demand would be better met through “other” ways external to their own ability to meet demand, including: the provision of more preventative services generally; a better range and quality of buildings situated locally; more opportunities for group work; more opportunities for creative therapeutic work (less constraint within organisations); more funding to do national recruiting of staff; greater resources for providing outreach work (eg staff, funding); an entirely new vision of delivering services; services should be free of charge, to remove budget constraints; lowering thresholds for service access; inability to secure adequate funding; more resources devoted to counselling in schools; and more preventive and parenting courses offered locally.

When asked to comment about gaps in and challenges to provision during the telephone interview, 30 managers uniformly identified high demand as a serious issue. Ten managers in the semi-structured interviews specifically mentioned that demand outstrips capacity to supply services. Perceived high demand has meant that managers are even afraid to advertise the service:

“If more people knew about the service, demand would be overwhelming.” (Voluntary sector service manager, Scotland).

4.4 How do commissioners and managers assess the demand for services?

Semi-structured interviews with commissioners reveal that there is little consistent or coordinated effort to assess the needs for children and young people who have been sexually abused either locally or nationally:

“No, there hasn’t been a needs assessment on that front. We haven’t actually gone and done a spot check with social care workers or health visitors or schools to ask how many children do you think would access this service.” (Commissioner of a secure accommodation unit in Wales).

The CAMHS mapping for 2006/07 indicated that only half of PCTs have completed a fully comprehensive child health needs assessment, and that, of those, the best covered elements of assessments were indicators such as population, infant mortality and deprivation (Barnes, et al, 2007). Indeed, as one CAMHS commissioner put it:

“There hasn’t been a local needs assessment as far as I’m aware. There was a CAMHS needs assessment done a few years ago but there hasn’t been a wider assessment undertaken, as far as I’m aware. Again, this is something I’d like to think that we can get around to doing, but we’re still a long way from that. Again, I think that the capacity limits the availability and ability to meet the demand [for sexual abuse services] that there is.” (CAMHS commissioner, England).

Even the most recent plan for mandatory strategic needs assessments to be undertaken by all local authorities and PCTs does not account for sexual abuse as an indicator of wellbeing in children and young people. The joint strategic needs assessment (JSNA) was implemented on 1 April 2008 and grew out of a DH White Paper *Our health, our care, our say*, which identified the need for directors of public health, adult social services and children’s services to take regular strategic needs assessments of the health and wellbeing of their populations, enabling local services to plan short- and medium-term objectives (DH, 2007).

JSNA is a tool to identify the health and wellbeing needs and inequalities of a local population, aiming to improve outcomes and reductions in health inequalities. This is a partnership duty, which involves a range of statutory and non-statutory partners required to inform the commissioning process and the development of appropriate, sustainable and effective services (DH, 2007).

As a result of a review of the JSNA core dataset (APHO, 2008), there was a notable absence of indicators related to sexual abuse. As this dataset brings together data from a range of different sources, it is indicative of the low priority sexual abuse holds within the health services.

Commissioners also identified a lack of guidance in respect of implementing sexual abuse strategies. For example, a commissioner in Scotland struggled to prioritise sexual abuse above and beyond other health and mental health issues in the local area. While local CAMHS provision had been examined strategically, therapeutic provision relating to sexual abuse had not been looked at specifically and had not been raised as an issue by stakeholders. This commissioner explained that, in the absence of any guidance on appropriate levels of service provision in relation to sexual abuse, a perceived low volume of sexual abuse cases referred to social work, coupled with a lack of concern being raised by partner agencies, meant that therapeutic provision relating to CSA was not a high priority:

“I guess we have some bigger problems – let’s put it that way...cancer, heart disease, stroke, problems of old age, so...a very specific area like this might not get a full-blown needs assessment.” (Service commissioner, Scotland).

This indicates that the problem of child sexual abuse in some local areas is not seen to be as much of a problem as other health issues; and needs to be set as a priority at national policy level in order for it to be prioritised by some commissioners.

4.5 Accessibility of services

Current service use, waiting times and perceptions of the demand for services were described in the previous sections, and present a complex picture of overall need and demand. This final section of the chapter examines specific operational strategies, which relate in some way to the accessibility of services. A range of criteria for access, derived from questionnaire data, is examined, followed by an analysis of responses to the semi-structured interviews.

4.6 Eligibility criteria

Eligibility criteria may be seen as a method for prioritising or rationing a scarce service:

“I think they are entirely related to resources...eligibility criteria we know is all about disallowing certain people access to the service and the real issue is that commissioners can ask for what they like, but unless there are some level of resources to meet it, then we’re not going to be able to provide that level of service.” (Service manager, England)

The vast majority of services (98 per cent) had designated criteria that determined access to their service²³. The most commonly held criteria will be described briefly below and are: age; geographical location (catchment area); source of referral; and “other” criteria. Type of abuse, specific stage of child protection proceedings and gender are least likely to be used to limit access.

Table 8 Percentage of services having formal criteria for access to provision

Criteria	Number	Per cent
Age (n=195)	177	91
Specified catchment area (n=195)	157	81
Referral source (n=195)	112	57
Assessment of need (n=195)	87	45
Other criteria (n=195)	72	37
Type of abuse (n=195)	47	24
Specific stage of child protection proceedings (n=194)	41	21
Gender (n=195)	23	12

Ninety-one per cent of all services had an age criteria. There was substantial variation in age ranges, resulting in 50 unique categories reported among 149 services. Twenty-six per cent (n=45) accepted children and young people aged 0–18 and a further 4 per cent accepted children aged 0–16. The remaining 70 per cent set more restrictive criteria, with older ages being more commonly accepted, and eligibility tending to cut off around the 16–17 age range.

²³ Eligibility criteria may be set externally by commissioners of the service; and sometimes services internally set criteria in order to manage waiting lists or to reflect the skill set available. This data was not collected for the study, although we know that some of the services have had eligibility criteria imposed upon them.

Catchment area was a criterion for eligibility for 81 per cent of services²⁴, which is not surprising or unreasonable given levels of demand and limited staffing. Other factors are important to assess, for example, whether or not there is a local service in the first place. On the other hand, catchment area will restrict service eligibility for children who live outside of this boundary; who do not have a local service of their own to access; and who live in rural areas, who are least likely to get a service.

Fifty-seven per cent of services overall reported that “referral source” was a criterion for gaining access to the service. Qualitative data was recorded on the questionnaire for 72 services and spanned the following “categories of criteria”:

- In 65 cases, only professionals could make a referral to the service; this may have included only very specific professionals such as social workers within a local authority; it may include a broader, though still limited, range of professionals such as social workers, and education and health professionals; or any professional may make a referral. These services do not accept self-referrals or referrals from a parent/carer.
- Three services reported that they mainly accept referrals from professionals, but infrequently accept referrals from parents/carers.
- A further three took referrals from anyone, including self-referrals or referrals by parents.
- In three services, only self-referrals are accepted.

More detailed information on referral sources is reported in table 9 below.

²⁴ See chapter 3 for further detail on catchment areas.

Table 9 Referral sources accepted in Northern Ireland, England, Wales and Scotland

	England, Wales and Northern Ireland ^a (n=146)		Scotland (n=45)	
	No	%	No	%
Child	56	38	34	76
Parent/carer	64	44	29	69
Health professional	127	87	29	64
Social care professional	136	93	-	-
Youth justice professional	88	60	-	-
Education professional	108	74	31	69
Voluntary sector	71	49	27	49
Social work (child and family teams)	-	-	37	82
Social work (YOT)	-	-	34	76
Social work (children with disabilities teams)	-	-	34	76
Police/social work/CPIU	-	-	31	69
Children's hearings	-	-	22	60
Other	46	32	7	16

Statutory social care services/professionals are the most widely accepted source of referrals; 93 per cent of services in Northern Ireland and England report that they accept referrals from social care and over three-quarters of services in Scotland do so. A high number of services also accept referrals from health professionals (87 per cent in Northern Ireland/England; 64 per cent in Scotland). Forty-nine per cent of services across Northern Ireland, England and Scotland report that they accept referrals from a voluntary sector source. Referral sources from the voluntary sector are varied and include for example women's refuges such as Women's Aid, Barnardo's, the NSPCC, Action for Children and other local services such as community counselling organisations, youth clubs, befriending services, drug and alcohol projects, hospice services, victim support groups, women's refuges, homeless services and suicide prevention groups. Where "other" types of referral sources were reported, managers named the police as one of the major sources, but also lawyers, school nurses, community wardens and courts. Only a small number of managers reported taking referrals from friends and family members.

The requirement to obtain an assessment of need for accessing a place was a criterion in just over 45 per cent of services²⁵. Assessment of need may comprise the service's own in-house

²⁵ "Initial assessments" were referred to by some of the respondents. It is therefore necessary to differentiate between those initial assessments undertaken by children's services staff prior to referral and assessments undertaken by service staff prior to the start of therapeutic work. Services occasionally refer to these as "initial assessments" but are not referring to a CAF or traditional social services initial assessment. For example, services may undertake their own "initial assessment" (ie separate to a children's services initial assessment) "to determine if

assessment or may refer to an assessment already undertaken by a referring professional. Indeed, it may mean that a service requires an assessment by both the referring professional *and* the service upon first meeting the client. In many cases, “need” must be determined prior to a referral to a service as part of the eligibility criterion. It was reported that, for example, “gatekeepers” should have filled out an assessment for the service prior to sending through a referral.

Gender is a criterion in only 12 per cent of services overall and this likely reflects services designed as gender-specific, such as SHB services for boys or rape crisis counselling services for girls. Only 12 per cent of the SHB services reported that gender would be a criterion for eligibility.

Thirty-seven per cent of services overall reported on “other” types of criteria for access:

- Three services prioritised looked-after children over other service users.
- Ten services reported that they will only provide a service if the child was willing to engage in therapeutic work; or expressed a positive wish to come to the service²⁶.
- One service said there must be a child protection concern.
- Another service prioritised young people from minority ethnic backgrounds and White British young people where there were no other appropriate services available to them.
- Eight services stated that a child or young person must be living in a safe and/or stable place to receive a service: “This is probably why we don’t get neglect and physical abuse referrals.” (Service manager).
- Three services reported that parents and carers must be involved in the work or they must be involved in a service themselves.
- Two services would not accept children and young people engaging in substance misuse or who were struggling with addiction.
- One service would only accept children and young people involved in a criminal prosecution of the perpetrator.
- Three services prioritised children and young people who had mental ill-health.

they meet criteria and understand the service” (Service manager). This is common practice in therapy and counselling. It serves a number of purposes including determining whether the intervention is appropriate, the type of therapeutic approach needed, whether the therapist is “right” for the client, establishing rapport, assessing whether the client is willing to engage in the process and giving the client an opportunity to ask questions (see, for example, McLeod, 1998).

²⁶ This is likely to be true for all services, but only 10 services raised it directly as an important consideration.

- One service would only accept children and young people who had received another service from within their organisation.
- At least one Scottish service included in the UK analysis reported that a pending criminal case would affect the content of the therapy – details of the abuse would not be discussed.

4.7 How appropriate is the scope of eligibility criteria?

The semi-structured interviews with managers were designed to elicit further contextual information about whether or not the managers viewed their eligibility criteria to be appropriate or not.

The majority of managers (14) responded that they felt the criteria to be “about right”. Reasons included the belief that referrals came from a wide range of sources; and that the right “balance” of referrals was being made.

“We are all-inclusive, so we’re open to anyone, and that would include men as well. I think there’s far too many people to say it’s narrow. Anybody is open to our service.” (Manager of small voluntary service, England)

“I don’t think that it’s too narrow, because we don’t actually turn down cases.” (Manager of large voluntary service, England).

Two managers (in England) rated the service’s eligibility criteria as “too narrow”. This view rested on two specific issues. One particular frustration was the lack of capacity to work with adult survivors who do not have children. They felt services should be more flexible, incorporating work with adults into their service.

“The team have been quite verbal about this [criteria]. They used to be able to do work with adult women survivors of abuse. If an adult hasn’t got a child, we can’t do that any more, which is really a shame, because these children turn into adults and if they haven’t got children, then they’re not eligible for a service. It’s not fair.” (Manager of large voluntary service, England)

Another manager expressed the same frustration about the gap between services for children and young people and adults:

“The concern that I would have is about adult victims – you know, where they’ve been children who have been sexually abused, and as adults, they want to work through those issues...These young people are over 18 and suddenly there’s no service provision for them, and they can’t come to us unless they’ve been to us before as kids. So, that’s quite difficult, and it’s an area that’s quite difficult for practitioners, because they have a lot of people who come forward, or who come and say, can I have a service, and they can’t – unless they’re pregnant or they have a child somewhere. It’s not a service we can offer if they haven’t been known to us before.” (Voluntary service manager, England)

Some managers felt that their criteria were too narrow, but for a very good reason based on their professional judgment. Services would at times turn children and young people away who were not in a stable living environment. Therapeutic work with a child or young person, when nothing has changed at home, was not seen as being in the child’s best interests.

“A lot of the time the referrals we get are from social workers who haven’t got resources there in the community so they make a referral to us because – ‘Oh, this child has been abused’ – but a lot of the time in the referrals they’re making, the child is still in a very unstable environment, so to start therapeutic work would not be in the child’s best interests. That can cause a lot of conflict, and it does, because they (social workers) want a service and say ‘You can do therapeutic work’, well we can’t if it’s not going to be in the child’s best interests, because nothing within the home is going to change.” (Voluntary service, England)

Eligibility criteria could be seen as “too wide” for precisely the same reason it was seen as “just right”, as pointed out above. Some services felt that having a broad remit – accepting referrals from anyone with any difficulty – placed substantial pressure on waiting lists.

“Well, this was a project that was...developed into a project originally...to provide a service for children who had been sexually abused, and then we broadened our category to see any child or young person who has experienced any form of abuse. That’s neglect, physical abuse, emotional abuse and witnessing domestic abuse. What it means is that we developed a very, very long waiting list, which eventually had to be closed. It’s been closed now for – I think it’s been closed for nearly a year. We’ve been working through that very long waiting list, and we’re just opening it again now and the referrals are starting to flood in before we’ve

sent out the letters really to say that we're open again. I think that since we broadened our remit it's become clear that the need is huge and that we can't meet all that need." (Service manager, England).

4.8 Raising awareness of service to hard-to-reach groups

Managers were asked in the questionnaire to tell us about their strategies – if any – for raising awareness of the service to children and young people with particular needs, and those considered “hard to reach”. Responses revealed that raising awareness – or advertising – the service took place within a very limited strategy. Seventy-one per cent of services reported that they advertised themselves and their hours of operation. However, the services in the study were characterised as those that undertook specialist therapeutic work with children and young people who had experienced sexual abuse and had been assessed and identified by a professional. For this reason, the great majority of children who were seen by these services came primarily through a direct professional referral route (see 4.6). For most services, “advertising a service” therefore tended to mean advertising to other professionals who might be a source of referral, rather than advertising to the public.

Forty six per cent of services reported that they actively raised awareness of their service among hard-to-reach groups in their areas. Similar to the above discussion, awareness-raising among hard-to-reach groups generally took place via commissioning bodies and professionals who referred to that service; or through training sessions, conferences or workshops, as opposed to direct awareness-raising campaigns in the community and to the general public. Responses also indicated a general level of wariness on the part of managers to advertise or raise awareness of the service too widely, for fear of receiving referrals that the service could not possibly accommodate. The following quote reflects very widespread perceptions across all service sectors of reaching out to a wider referral base:

“We're afraid that if we advertise too much, that's going to increase the referral rate and that will have an issue of capacity, safeguarding and waiting list. It's like a house of cards really. When we perhaps want to change an aspect of the service...we are very careful who and when and how we do it, because we just haven't got the capacity to pick up a wider based referral audience really.” (Voluntary service manager, Wales).

4.9 Children and young people whom services cannot accommodate

Over half of the services (53 per cent) reported in the questionnaire that there were some categories of children and young people with particular needs for whom they were unable to provide a service. The most commonly cited categories among these, and also cited frequently among the managers in the semi-structured interviews, were children and young people with physical disabilities, severe mental health difficulties and severe learning disabilities. In particular, children on the autistic spectrum were mentioned as requiring special attention relating to their vulnerabilities to abuse; one manager highlighted the public perception that they were almost seen as “asexual” and therefore were not in need of adequate protection. Managers would have liked to be able to provide “KeepSafe” work with these children to help them to protect themselves, but were unable to undertake this work due to scarce resources. Other groups of children with particular needs were cited less frequently, but drew attention to the fact that provision was patchy; in some areas, services lacked the skills and resources to undertake work around certain issues.

The other types of children and young people with particular needs that services were unable to cater for included:

- children and young people whose first language is not English;
- children and young people with SHB;
- children and young people with severe learning disabilities;
- children and young people with mild to moderate learning difficulties;
- young people with substance abuse problems;
- children and young people where there is ongoing instability in the home;
- violent children and young people;
- geographically isolated children and young people (eg rural locations);
- speech and/or hearing impaired children and young people;
- various: arsonists, children and young people with attachment problems, complex sexual abuse (eg ritual abuse);
- specific medical conditions (aside from the abuse issues).

There were some additional groups noted by managers in the semi-structured interviews not included in the previous list: trafficked children; children displaying sexually concerning behaviour (but who have not been assessed as being sexually harmful); girls who were

sexually exploited; young children; young people in prison; looked-after and accommodated children; and children who did not meet diagnostic categories for mental health provision.

In fact, it was unrealistic to expect all services to have the expertise to address the most severe mental health issues; and tier 4 in-patient CAMHS provision may have been required if the safety of the child or young person was at risk (eg through life-threatening weight-loss or self-harm). This was likely to be true of all non-CAMHS and CAMHS lower-tier services. The issue then became whether or not CAMHS could address CSA work adequately with children with complex needs such as these.

4.10 Chapter summary

This chapter provided an overview of current service use (through examination of referral rates); analysis of the demand for services as reported through waiting times and manager perceptions of demand; and other issues of accessibility including adequacy of hours of operation, raising awareness of the service, and provision for children and young people with particular (and sometimes complex) needs. The following bullet points highlight the key messages emerging from this chapter:

- The average referral rate for the participating services was 32, with wide variation depending upon the size of the service, the length of therapeutic work being undertaken with a child and the suitability of children for the service.
- The reported referral rates included very low numbers of children from minority ethnic backgrounds and disabled children.
- Waiting lists for a service averaged three months, although varied quite significantly and could be as long as one year. Services prioritised children with the most severe symptoms and problematic behaviour, as they lacked the resources to quickly see all children who had experienced sexual abuse.
- Methods of reducing waiting lists (eg prioritisation plans, targets, changes in response systems) potentially undermined the notion of early intervention.
- A majority of managers reported that demand for services exceeded the availability and capacity to supply them.
- A majority of managers reported that their staff held full caseloads.

- Commissioners reported that there had been few efforts observed locally or nationally to appropriately assess the demand for provision for children who had experienced sexual abuse; moreover, commissioners did not feel equipped, through a perceived lack of guidance on effective provision, to direct resources towards interventions that had not been proven effective.
- Managers acknowledged that they were inadequately reaching out to the public and to hard-to-reach groups, citing fears of increased demand that they were unable to cope with at resource levels current at the time.
- There was a range of children with complex needs, which services were unable to accommodate. Services such as tier 4 CAMHS must therefore be equipped to provide a sexual abuse service for these children, or must be willing and able to work collaboratively with other services to provide a joined-up response.

5 The nature and availability of therapeutic services

This chapter describes the therapeutic provision that was on offer to service users, who provided it and how it was reviewed. The types of therapy on offer are described, as well as other aspects of the service (eg associated family service, family therapy); staffing complements and descriptions of their training and supervision; and methods used to review their service and involve service users in its design and delivery. The chapter begins by describing how managers define “therapeutic” and its application within their service.

5.1 Defining “therapeutic”

Identifying a common definition or understanding of a “therapeutic service” was not an easy task. The services worked across different contexts, to different paradigms and within different sectors and therefore it might be thought that definitions would indeed not be consistent. Few service websites or documents offered definitions for this term and its intended outcomes, yet many utilised it in broad descriptions of services. However, the term “therapeutic” points to the general notion of improving wellbeing, and while services may be very different in their approaches, it may be possible to identify a common understanding of “therapeutic”.

Managers were asked to provide a definition of a “therapeutic service” in the questionnaire component, with the aim of exploring its meaning. Definitions of what a therapeutic service was, and what therapy did, did indeed vary. Managers provided mixed responses, some referring to what their service did, as well as a description of its aims and intended outcomes. However, the most common definition included the general aim to overcome the effects of abuse: “A service to help children and young people overcome the effects of abuse and achieve their potential.” (Voluntary sector service manager)

The following aims and activities were also included:

- to address the impact of abuse
- conflict resolution
- prevent future abuse/break the cycle of abuse
- cope with abuse
- create positive change

- enable a young person to achieve their potential
- exploration of the abuse
- improve and strengthen resilience
- improve emotional and psychological wellbeing
- recovery from abuse
- providing support to make informed choices
- enable a young person to understand the abuse.

None of the definitions provided clues about the length of time a therapy should be delivered; nor about the specific point of intervention. Furthermore, none of the definitions provided consistent descriptions of the kinds of work undertaken.

5.2 Therapies on offer

Managers were asked to report in an open-ended question in the questionnaire on the types of therapeutic provision offered within their service to children and young people who had experienced sexual abuse. A range of models and contexts within which these were delivered was reported. Of course, this was a simplified view of models of provision, as different models were comprised different strands of practice and could be undertaken within a range of different contexts, such as in an individual setting (eg a counselling session) or could take place within a group setting. It was not our intention in this report to evaluate specific models or interventions, and as such, data on how services were specifically applying these therapeutic models is limited.

Creative therapies, in particular art and play, were the most widely offered model, reported by 63 per cent of services. Counselling, cognitive behavioural therapy (CBT) and “other” models of therapy followed closely, each being offered in 59 per cent of the services. Psychodynamic and family therapy were offered in just below 40 per cent of services, with less than a quarter offering attachment therapy, narrative therapies, transactional analysis and sensory motor therapy. Group work (which may have incorporated any of the above models of therapy) was offered in a third of the services. Group work was mentioned in other components of the study as an aspect of provision not offered as regularly as services would like; the costs of group work were described as being outside the available resources. In addition, managers reported a scarcity of appropriate venues for group sessions that were easy for all children/young people taking part to reach.

Although AIM assessments were not considered a therapeutic service²⁷, we thought them worth mentioning here because a number of services reported them to be an important part of their work prior to therapeutic intervention. There were only 15 services that reported the use of the AIM framework; 47 per cent of these (n=7) were classified as SHB services with a therapeutic component for children who had experienced sexual abuse. Thirty-three per cent of managers (n=5) who reported the use of the AIM framework described their service as “other” (eg generic mental health service); and 20 per cent (n=3) described their service as a post-abuse service dealing with any/all types of abuse. No specialist post-sexual abuse service reported using the AIM framework, although one service manager of a post-sexual abuse service in England clarified that “workers sometimes need to address sexually harmful/worrying behaviour and would therefore use techniques learnt from the AIM approach”.

There were some important differences between sectors in respect of models of provision, although it must again be emphasised that these differences were based upon the services that participated in the study. A much smaller number of statutory services participated than voluntary sector services, although there were a higher number of statutory services overall providing some level of therapeutic work around sexual abuse. Creative approaches were used more widely in voluntary and private sector services than in the statutory sector. In the voluntary and private sectors, 70 and 71 per cent (respectively) used creative approaches in contrast to 49 per cent of statutory services. CBT was used more often in private services, reported by 79 per cent of managers; by 69 per cent of managers in statutory services; but only 49 per cent in voluntary sector services. Voluntary sector services were most likely to report using a model of counselling, reported by 69 per cent of managers; 57 per cent of managers in private services; and only 42 per cent in statutory services. Family therapy was reported to be used most widely in the statutory sector by 64 per cent of services; by 36 per cent of private services and 31 per cent of voluntary services. Psychodynamic work was undertaken more often in both the voluntary sector (48 per cent of services) and the private sector (50 per cent of services), where only 27 per cent of statutory services reported using this therapeutic approach.

It is also worth exploring here the role and meaning of “family therapy”, as the term was at times loosely applied to a range of work that may or may not have been “family therapy” in the officially recognised therapeutic sense. “Family therapists” are qualified and accredited psychotherapists who work in ways that acknowledge the contexts of people’s families and

²⁷ AIM is an approach used in work with children and young people displaying sexually harmful behaviour – see www.aimproject.org.uk/index.php

other relationships, sharing and respecting individuals' different perspectives, beliefs, views and stories, and exploring possible ways forward. Family therapists thus not only support change with individuals but also in their relationships in the family and beyond, so children, young people, adults and/or those important to them are supported in continued recovery. Work with families can be undertaken by those not formally accredited as family therapists, however this type of work (as in all other therapeutic areas) is likely to achieve necessary standards only if practitioners undertaking this kind of work have access to current best practice and if they have access to supervision through properly trained family therapists (Stratton, 2005).

In light of this, we undertook further analysis of those services reportedly offering family therapy within their service to explore the provision of "family therapy" as opposed to less formal support for families and carers. We matched their reported use of family therapy to their description of current staff; where they reported that they had employed family therapists and/or psychotherapists as members of staff, we concluded that the family therapy on offer was of the accredited kind. In all other cases, we suggest that the kind of family therapy services offer was an "associated family or carer service", which was work undertaken alongside work with the child (and is discussed in greater depth in the following section).

Services reported that they offered "family therapy"; however, closer examination of staffing complements indicated that few services employed accredited family therapists. Two services directly reported employing family therapists in addition to other staff such as counsellors, psychotherapists, psychologists or social workers. Only two other services reported that they employed family support workers or family workers; no other service indicated that staff included family therapists or workers of any kind. Twenty-five per cent of services reported that they employed psychotherapists (who may or may not have undertaken family therapy); the mean average number of psychotherapists employed was very low, at just over one half-time post.

In summary, it is likely that the sort of "family therapy" being undertaken across services referred to more general family support where services were able to do this; it may have included family support groups or individual counselling with family members. It is unlikely, however, that family therapy of the accredited kind was occurring widely across therapeutic services in this mapping study.

Other types of therapeutic provision were mentioned on less frequent bases and are listed below.

- Post-abuse trauma therapy
- Solution-focused therapy
- Psychological and milieu therapy
- Integrative therapy
- Anger management
- NLP; cognitive hypnotherapy
- Alternative therapies, such as Indian head massage or Bach flower therapy
- Planned environment therapy (ie in residential homes)
- Life story work
- Systemic approach/systemic “eclectic” approach
- Assessment control and change therapy (in relation to SHB)
- Person-centred therapy
- EMDR (Eye Movement Desensitisation and Reprocessing – a NICE guideline approved, trauma-focused therapy technique)
- Recovery work
- Non-directive therapies
- Therapeutic crisis intervention (derived from a planned environment therapy setting).

The majority of services (95 per cent) delivered therapeutic work from within their own service. In other words, they employed staff with particular specialist skills to deliver the therapeutic work. Only a small number of services contracted at least some of the work out. Agencies that tended to be involved in providing specially trained staff came from voluntary agencies.

Just below 50 per cent of services required an additional specialist qualification (over and above a professional degree) of their staff who delivered these therapeutic models. These extra qualifications were in addition to a first qualification. A number of managers highlighted the requirement that staff should be fully qualified in the therapy that they were providing. This was likely to be the case for many other managers, but responses did not directly highlight this. For example, if a staff member was providing filial therapy, they should have had training and a qualification to use that therapy in practice. One service manager summed it up in this way:

“All practitioners should have additional training in therapeutic work with children, over and above social work/counselling qualifications.” (Service manager, England)

Some services did not necessarily require extra qualifications per se, but would require training in specific therapies or aspects of provision, sometimes while “on the job”. A number

of services offered examples of training requirements although the specific question was not asked in the questionnaire. They included:

- For example, in some NSPCC SHB services, staff were required to undertake AIM assessment training before carrying out assessments with children and young people.
- Child protection training was mandatory in some services, particularly with non-social work qualified staff members.
- Although no extra qualifications were required to carry out the therapies, it was expected that staff would continue with a post-qualifying award or further training in therapeutic work.
- Two services provide their own in-house training programme, in which all staff were required to participate.
- Where care staff were referred to, managers tended to require an NVQ level 3 for staff across the board, with the expectation that staff would continue with ongoing training up a “qualification hierarchy”.
- Only one service stated that training in “family therapy” was an additional requirement for working in the team.

It was clear by the data in the questionnaire on staff complements that some services had staffing that was diverse, employing professionals such as psychologists, psychotherapists, psychiatrists, social workers, community workers and nurses. Three managers noted in the telephone interview that because of the diversity of their teams, they did not require additional qualifications on the basis that their service was multidisciplinary in nature, and that the specialist expertise of the range of in-house staff could be drawn upon to deliver a variety of therapies to service users.

A number of managers described their desire for particular personal qualities over specific and/or extra qualifications:

“I am more interested in the personal qualities they bring...[they should] demonstrate abilities to make a relationship with a young person.” (Service manager, England). Another manager said that the staff should have a “demonstrated aptitude for working with children...and that additional specialist qualifications are seen as a bonus.” (Service manager, Northern Ireland)

5.3 The provision of associated family/carer services

Sixty per cent of services overall offered an “associated family/carer” service alongside therapeutic work with children and young people. Of those services who reported offering a family service, a higher percentage (59 per cent) were voluntary services; 35 per cent were statutory and only 5 per cent were private. Both statutory and voluntary sector services were more likely than not to offer a family service, compared with private organisations who were less likely to offer an associated family service. Few respondents (mainly voluntary sector respondents) provided a detailed description of the kinds of work they were doing with family members, but it potentially ranged from a recognised therapeutic framework to ad hoc support to family members.

The higher reported provision of family services in the statutory sector was potentially related to the availability of other specialist workers within, for example, other teams in the organisation. One CAMHS manager in England described how his own service lacked these types of workers, and was structured differently from another regional team, which had a range of professionals available to them to undertake different kinds of work:

“Teams in the south run slightly differently, as two trusts merged and they had a different system. They have family workers and social work assistants and stuff like that, which we don’t have here.” (CAMHS manager, England)

Some respondents discussed the importance of focusing on the child and family holistically, but did not provide detail of how they were doing this:

“Well, we usually refer to the child as one person, but we know that we can’t work in isolation with the child, and so, in most cases, the parent or carer, or other family members are brought into the work that we do, in order for them to be able to respond accordingly to whatever work we’re doing. That obviously takes more time than just working individually with a child.” (Manager of a large voluntary organisation in England)

“CSA has an impact on the whole family so it makes no sense to work with the young person and not the family. Historically in this area services are individual-focused and we take a more systemic family approach.” (Voluntary service manager, Scotland)

For some services, this kind of intensive work with families proved to be impossible to carry out due to the pressures on resources such as time, money and staff.

“We used to provide a lot of support to parents but because of our waiting list we’re kind of focusing on children and young people now.” (Manager of large voluntary organisation in Wales)

“The constraints of a case that is meant to be at a specific place and a specific time each week, but in fact has to include the occasional home visit – that again involves travel – there’s not enough time to do justice to the case.” (Voluntary service manager, England)

A manager of a voluntary service in England described family work as being important and identified it as a gap in service provision, however her own service lacked resources to do anything more than occasional ad hoc work with families:

“We are really set up to work with children and young people. Occasionally we will work with family – but we don’t have resources to take this on as part of our work. There is family support service but remit is tightly controlled. So the gap is around working with families around sexual exploitation. And there is not much else to support families in the area.” (Voluntary service manager, England)

5.4 Reviewing services to improve the quality of provision

Services used a variety of methods to review the quality of provision. Table 10 below presents these methods for Northern Ireland and England only.

Table 10 Methods of reviewing and monitoring services for improving the quality of service provision²⁸

	Number	%
Feedback from child/young person	120	89
Feedback from family of child/young person	104	77
Regular case assessment	125	93
Use of client outcome measures	99	73
Use of service outcome measures	83	62
Monitoring returns to internal data collection body	101	75
Monitoring returns to external data collection body	103	76
Internal evaluations/audits	79	59
External evaluations/audits	58	43
Other internal research	53	39
Other external research	31	23

A significant majority of services (89 per cent) utilised feedback from children and young people to inform the service of its quality of provision. Just over three-quarters obtained feedback from families/carers.

Ninety-three per cent of services reported that they undertook regular case assessments. Services were not uniform in their regularity of undertaking such assessments; responses ranged from monthly, six-weekly, quarterly to six-monthly.

Client outcome measures were used in just under three-quarters of services. Managers appeared to have interpreted this question to mean service-user satisfaction, which was reflected in the majority of responses describing qualitative measures; for example, verbal and written feedback from children and young people and exit questionnaires. Managers less frequently cited standardised measures, such as the Trauma System Checklist (TSC) and Goodman's Strengths and Difficulties Questionnaire (SDQ), to describe client outcome measures, but often reported that these were used to measure service outcomes. However, this discrepancy may have been an artefact of questionnaire fatigue, as consultants and advisors indicated that the TSC was generally used as a clear measure of change for the individual service user, as well as an indication of overall improvement as a service outcome. Other, less frequently reported measures were the Parenting Stress Index (PSI), the Every Child Matters (ECM) five outcomes (by respondents in England) and a service's own service-user outcomes developed in-house. The latter two measures were not elaborated on further, so it is not possible to describe their use further. One key message from this data was the absence of any long-term service reviews underway, as no service mentioned long-term evaluations of therapeutic interventions or outcomes.

²⁸ Scotland was excluded from this analysis, due to the omission of this question on the shortened questionnaire. Wales was excluded due to the very low number of responses to the questionnaire.

5.5 Supporting access to therapeutic services

In the questionnaire, managers were asked to tell us about the ways in which they supported access to services for children and young people, including their own facilities, but also outreach and advocacy services. They were provided with a list of typical support items and were also given space to report about other types of support they may have offered. Findings are reported in the table below.

Table 11 Forms of support for service users^a

	Number	%
Service accessible by public transport (n=143)	127	89
Wheelchair access provided (n=144)	117	81
Adapted toilet/bathroom (n=144)	113	79
Advocacy for people with mental health problems (n=144)	101	70
Transport costs (n=145)	99	68
Alarm system (n=144)	91	63
Sign language interpreter (n=145)	90	62
Foreign language speech interpreters (n=145)	89	61
Transport provision (n=144)	88	61
Telephone counselling (n=144)	86	60
Advocacy for people with learning difficulties (n=145)	84	58
Written translation facilities (n=145)	79	55
Home-based therapeutic support (n=145)	76	52
Information in other languages (n=145)	71	49
Information in Braille (n=145)	41	28
Lift ^b (n=108)	29	27
Induction loop (n=145)	35	24
Trained disability support worker (n=145)	35	24
Other types of support (n=144)	17	12

^a Scotland was excluded from the analysis due to the omission of this question on the shortened questionnaire.

^b Twenty per cent of respondents indicated that services were delivered on the ground floor and therefore no lift was required.

A majority of services (89 per cent) reported that their service was accessible by public transport and therefore it was felt that a majority of people in the local community could access it with ease. Other support offered widely by services included: wheelchair access (81 per cent); an adapted toilet/bathroom (79 per cent); advocacy for children and young people with mental health problems (70 per cent); and transport costs, such as for taxis and public transport (68 per cent).

Support provided most infrequently included the employment of a trained disability support worker (24 per cent); installation of an induction loop (24 per cent); a lift (27 per cent) – although 20 per cent of respondents indicated that services were delivered on the ground floor, and therefore no lift was required); and information in Braille (28 per cent).

Managers said there were specific types of support that could be accessed through the larger organisation to which they were attached (eg trust, local authority, large voluntary organisation), partially explaining some of the low percentages observed above. Those services included interpreters, translators, other types of advocates and a trained disability support worker.

5.6 Assistance in the transition to adult services

Managers were asked to report on whether or not they had a strategy in place to help young people transfer to an adult service. Seventy-nine per cent of services across Northern Ireland and England²⁹ reported that they had a strategy in place to do this.

A small number of services stated that transitions such as these were planned at early stages and involved relevant practitioners:

“There is always a planned ending to work with children and young people in conjunction with health and social care (if involved) and other appropriate services for young people. Such referrals are always underpinned by what the young person wants and/or needs.” (Voluntary sector service manager, England).

Further analysis of the semi-structured interviews revealed that, while no *written* procedure was in place, the service would facilitate this transition when a young person was ready. The following quote summarises a number of responses by managers:

“[There is] no formal written strategy, but liaison with adult services would take place on behalf of young people who might need such services from age 18.” (Statutory sector service manager, England).

Where there was a dearth of adult services available in the local area, managers reported that they would continue working with the young person until they were settled elsewhere:

²⁹ Scotland was excluded from this analysis due to the omission of this question on the shortened questionnaire.

“There are not a huge number of adult services around – we will continue to work with them to the end of the counselling process. We will signpost and work with them until they get settled into a new service.” (Voluntary sector service manager, Wales).

There was evidence of a rather more informal system in place, which involved colleagues who may have known each other or have worked together in the past and who shared an understanding of the need to provide a smooth transition:

“We try to involve adult colleagues as early as possible – but we end up getting favours from other colleagues of like mind. That’s the informal ‘favour’ basis. The formal system is hopeless! The informal system is typical in CAMHS.” (Voluntary sector service manager, England).

Other responses echoed and supported the difficulties with formal systems, particularly in statutory services:

“They have a pathway planning team for children leaving the care system to adult services – not terribly effective, since this group is difficult to engage and the adult services are not that accessible.” (Statutory sector service manager, England).

5.7 Service staff, training and supervision

The number of staff working in each service varied from 35 professionally qualified, full-time equivalent (FTE) to 249 FTE, with a total number of 1655.47 FTE staff members working in 161 services. The mean average number of professionally qualified full-time equivalent (FTE) staff per service was 10.25; in reality, however, services varied in size as described above.

Services with greater numbers of professionally qualified staff tended to be residential services. Services with high numbers of staff raised the average number of staff per service; indeed, services with high numbers of staff were large private or voluntary sector residential units, which were national in scope.

The table below presents the data on the main profession of staff employed in the services. By far, the largest group working within these services were professionally qualified social

workers (n=506) and they were employed across 73 per cent of the services. Counsellors followed, making up a significant number of staff providing therapeutic services (n=215) and were represented in 28 per cent of services. Psychotherapists and psychologists were spread over 26 per cent and 24 per cent of services respectively, but made up a very small number of professionally qualified staff. “Other” professionally qualified staff included those qualified and employed for specific therapeutic approaches, such as art and play therapists; nutritionists (in residential settings); independent sexual violence advisors³⁰; and family support workers. Some residential settings were set up as schools and were therefore regulated by government, which meant they would employ teachers; and were represented in 14 per cent of services.

Table 12 Types of professionally qualified staff working in services

	Total FTE in all services	Mean average per service	Number of services employing	% of services employing
Social worker (n=164) ^a	506	3.1	120	73
Counsellor (n=164)	215	1.3	46	28
Psychotherapist (n=163)	91	0.56	43	26
Psychologist (n=163)	60	0.37	39	24
Nurse (n=163)	135	0.83	36	22
Psychiatrist (n=163)	42	0.26	24	15
Teacher (n=164)	132	0.8	23	14
Youth worker (n=164)	37	0.27	15	0.09
Community worker (n=164)	7.5	0.05	7	0.04
Health visitor (n=164)	9	0.05	5	0.03
YOT worker (n=164)	0.1	>0.05	0.1	>0.01
GP (n=164)	0	0	0	0

^a The reported numbers in this column – such as (n=164) – refer to the number of services that provided figures for each category.

Table 13 Types of non-professionally qualified staff and volunteers

	Total number all services	Mean average per service	Number of services	% of services employing
Social care workers	216	1.3	25	15
Health workers	24	0.14	4	0.04
Other	290	1.75	50	30
Volunteers	206	1.25	30	18

Table 13 presents the data on paid non-professionally qualified staff, with high numbers observed for social care workers and “other” types of staff. Non-professionally qualified

³⁰ Independent sexual violence advisors offer independent help to victims of sexual crime; these posts were developed as part of a £3 million government effort to provide targeted professional support to victims of sex crimes in England and Wales, offering advice, support and advocacy.

health workers were represented in far fewer numbers. A majority of these staff worked within large residential settings as care workers. Managers were also asked to describe the paid non-professionally qualified staff who “contributed to the therapeutic service”. This question was likely to have been interpreted in a range of different ways and should therefore be read with caution: some managers, for example, assumed this meant a contribution to delivering the therapy itself. However, a few managers insisted on including administrative staff they deemed crucial to the delivery of an effective service. Administrative staff were seen to be significant in welcoming children, young people and their families, and making them comfortable, which managers believed was part of the therapeutic process. Other staff included in this category would be students on placement; staff who provide transport for service users; and child care workers. Services were also taking on volunteers on an unpaid basis, who may have acted as “befrienders” or who may have helped to organise events.

Overall, paid staff who were not professionally qualified and unpaid volunteers could be found in a relatively low number of services. The specialised nature of the services meant that staff delivering the therapeutic models needed particular qualifications, leaving a relatively few number of posts for those who were not professionally qualified or unpaid.

5.8 Staff experience and skills

The required skills and experience of staff were described by managers for professionally and non-professionally qualified staff in an open-ended format in the questionnaire. The most commonly cited experience required by managers was working with children and/or young people. Where managers reported length of experience as important, they tended to require between two and five years of post-qualifying experience. Many managers cited experience of both group and one-to-one work as desirable, as was working within a therapeutic environment/community. Experience in child protection was important to managers, for example, experience of having made child protection referrals.

Required skills were varied and diverse, describing personal qualities as well as technical skills. For example, managers wanted staff to have the ability to communicate with children and young people, with parents and other professionals; additionally, some managers specified the ability to work with professionals in a multidisciplinary way as being highly desirable. They listed skills such as ability to be empathetic, caring and considerate and ability to put the needs of children first. There was an array of technical skills identified as important to managers, including the ability to apply particular therapeutic models/

approaches; undertake assessments; and knowledge of the legal process and child protection/safeguarding. The ability to use evidence effectively and write reports was mentioned by nine respondents. For example, one manager said they required a candidate to have “an ability to talk about the work confidently and write persuasive, evidence-based reports”.

It was somewhat concerning that experience and knowledge of safeguarding were not mentioned consistently as a primary consideration for managers in respect of required skills and experience of staff. Children and young people who have experienced sexual abuse were potentially open to further abuse, making them a significantly vulnerable group. Knowledge and skills relating to wider safeguarding issues were crucial in protecting the wellbeing and safety of these children alongside the support and interventions received through the service.

5.9 Training and supervision

Managers were asked to rate the quality and quantity of both training and supervision provided for staff. A five-point Likert item was presented and managers were asked to rate quality and quantity of training, and quality and quantity of supervision, with 1 equalling “very poor” through to 5 equalling “excellent”. The mode, or most frequently cited response for all four categories of training and supervision was mid-range at 3.

Ratings for training were slightly out of step with the qualitative answers given; this could be accounted for by the diversity in quality and quantity of training, which meant managers struggled to rank their responses adequately. In other words, respondents felt that some training was good and some was not – and that there was enough of some types of training, but not enough of others:

“Overall training could be improved – but there are good bits within the overall training.”
(Statutory service manager, Northern Ireland)

Similarly, the most common answer for amount and quality of supervision was “good”, but in-depth responses were variable and provided a more complex picture. While managers felt that supervision overall was “good”, their responses relating to clinical supervision indicated that they felt that general first-line agency/organisational supervision was not sufficient to address problems emerging from practice. The desirability for clinical supervision was evident across nations and sectors as illustrated in the following quotes:

“Staff would prefer to have individual clinical supervision rather than the group arrangement that currently exists.” (Voluntary sector service, England)

“It feels a real challenge to be doing this work without clinical supervision. It feels wobbly and unsafe really.” (Manager of a large voluntary service, Wales)

“I feel that I need something more, clinical supervision, because of working with sexual abuse. It can on occasions impact on you individually even though we all try to be professional...it would be more beneficial to me if I had more clinical supervision but that’s not available...it would have to be paid for by the trust and again, there is a lack of funding. I’m not able to access that anywhere.” (Joint statutory/voluntary service manager, Northern Ireland)

Data on clinical supervision from the questionnaire component showed that a high percentage (86 per cent) of service managers reported that their service “facilitates access to clinical supervision” for their staff. However, some managers pointed out that clinical supervision was by no means uniformly provided across services, nor even among staff within any given service. Some services would provide that as part of their employment; but some respondents indicated that staff had to pay for this type of supervision out of their own pocket:

“Its a real problem for people who are employed not as social workers because they have to keep up their registration...part of this is having regular clinical supervision...so currently some of us buy in our own clinical supervision and have to do it in our own time. Cause of great under-valuing really.” (Voluntary sector service manager, England)

An overarching question in evaluating these responses related to the effectiveness of clinical supervision for practitioners, and the issue was by no means a straightforward one. It was not in the remit of this study to assess the effectiveness of clinical supervision across services, but it is worth noting the challenges that organisations faced in respect of the provision of this type of supervision; challenges that played a part in fostering the conflict observed within interviews in this study.

First, clinical supervision for practitioners in many cases tended to be related to their requirements for training, accreditation and registration. In other words, in order for many practitioners to continue working in their field, their respective professional bodies required them to maintain a clinical supervisory link. However, this was not the case for all practitioners, which could foster feelings observed among practitioners in some of the

participating services around inequality in the provision of clinical supervision by the professional bodies employing those practitioners.

Second, many practitioners received their clinical supervision from sources external to their employing agency. Agreements between the practitioners and clinical supervisors (provided they were external to their employment) made it difficult for employing agencies to assess the quality of clinical supervision, considering that practitioners sought clinical supervision from disparate sources. This difficulty in assessing quality may have led employers to question the provision of supervision that had not necessarily proved effective.

Finally, there was no robust evidence to prove that having clinical supervision was *better* and *superior* to practice undertaken by professionals who did not have access to clinical supervision. The NSPCC inspection unit found that good practice existed where clinical supervision was facilitated, but also where it was not (NSPCC, 2007).

A better understanding of what works and achieves better outcomes for children in respect of clinical supervision would be beneficial to agencies aiming to provide high-quality services but struggling with these issues. In the short term however, these outstanding issues serve to foster feelings of inequality and raise questions among practitioners about their own value within organisations.

5.10 Chapter summary

- A range of therapeutic models was used across the services in the study and included techniques beyond the use of counselling and CBT. They were used in both group and individual contexts.
- Services were undertaking work with families where it was possible and enough resources were available; however this tended to be supportive work as opposed to accredited family therapy.
- Services reviewed their provision in a range of ways, most commonly through the use of feedback from the child or young person. A range of client outcome measures and service outcome measures was used, although there was little consistency in what was applied across services.

- By and large, the staff providing therapeutic services were professionally qualified. A small percentage of services involved non-professionally qualified staff and unpaid volunteers in the delivery of therapeutic work.
- Services provided a range of support for accessing services. Although not all services had every support facility in place, most managers reported that they would have been able to access support where it was identified as a need.
- A majority of the services reported that they had strategies in place for helping young people transfer to adult services. Some were formal agreements with organisations; but there was evidence of an informal process in place between the therapeutic service and close colleagues in statutory services.
- Social workers/social work staff were the largest component of the staffing complements in services, followed by counsellors. There was a range of other professionals delivering therapeutic provision, but in much lower numbers.
- Managers looked for technical skills (eg skills in delivering therapies) as equally as they sought child-centred personal qualities in their staff. There was a notable absence in responses prioritising skills and experience around safeguarding children alongside support and intervention from services. Safeguarding is crucial in protecting the wellbeing and safety of this vulnerable group of children.
- Managers had mixed feelings about the quantity and quality of staff training, indicating that both required an improvement in order to deliver services effectively.
- There were also mixed feelings about supervision. Line supervision was generally perceived as “good”, but there were concerns expressed in respect of unequal access to clinical supervision. These concerns sat within wider challenges facing services around being able to assess the quality of clinical supervision adequately and questions as to the added value of clinical supervision.

6 Joint working, funding and commissioning arrangements

This chapter reviews data from the questionnaire and semi-structured interviews around collaboration of services, funding structures and aspects of how agencies commission therapeutic services for children and young people who have experienced sexual abuse.

6.1 Working together

In the field of child welfare there has been an increasing emphasis placed on working together in partnership across professional and organisational boundaries (Frost, 2005). This is nowhere more important than in the area of child sexual abuse, where children may have some of the most complex needs, which cross over a variety of organisational boundaries (eg schools, health, children's services). Managers were asked to tell us about the ways in which they work together with other services to improve information sharing and expertise about this particular group of children and young people.

Table 14 Ways in which services are working together with other professionals³¹

	No (n=142)	Services %
Signposting/referring to other services	129	91
Staff receive specialist consultation <i>from</i> other services	112	79
Staff provide specialist consultation <i>to</i> other services	103	73
Shared delivery of services to children and young people	90	63
Any other joint working	25	18

Of the possible categories provided (see table 14 above), the largest proportion of services indicated that they regularly signposted and/or referred children/families to other services, particularly where they may have had a long waiting list or where they lacked the specific skills to work with particular groups of children. They described attempts to build knowledge of local services by attending seminars, training and workshops, which would keep their local information on services up to date. Nearly 80 per cent of services brought in specialist consultants from other services; and conversely 73 per cent provided specialist consultation

³¹ Scotland has been excluded from this analysis, due to the omission of this question from the shortened questionnaire.

to other services. Sixty-three per cent reported that they jointly delivered services where possible, although few concrete examples of what this looked like were provided.

There was a range of other ways in which services were creating collaborative relationships with other services, reported in 18 per cent of the sample. Most frequently, managers reported their involvement in case conferences, as well as other consultation groups and panels, for example, raising the needs of children in statutory consultations:

“The new children’s trust seems to have forgotten about sexual violence and we intervened to bring the issue more attention.” (Statutory service manager)

One manager of a service in England described their collaborative activity around the creation of new systems and services in the area, such as the development of a SARC. They also had in place a formal working relationship with the Crown Prosecution Service. Another service was running a pilot project on attachment jointly with a local clinical psychologist. Several managers described their involvement with fostering agencies in providing support for foster parents and adopters who may have had attachment difficulties and sexual abuse experiences. A number of services reported that they were members of local safeguarding children boards and other local partnerships, such as a violence against women partnership and an early intervention group for young people.

Semi-structured interviews revealed some of the challenges present in collaborative working, which were already well documented (Frost, 2005). The perceived difficulties have been associated with a range of organisations/professionals, for example, GPs and schools, where services would have liked to enhance collaboration but lacked the time to do so. For example, fourteen managers mentioned gaps in school responses to child sexual abuse they would have liked to help change:

“...lack of trained staff in schools to educate children about risks. Work needs to be done in schools at a younger age to prevent sexual abuse. We would like to see more action in schools and education to prevent sexual abuse.” (Statutory service, Northern Ireland)

However, local context and partnership history was said by some to influence the effectiveness of working together. Some relationships worked better than others, even within the same organisation. For example, a CAMHS manager pointed out the range of successes they had had within schools:

“Better schools I would rate higher than worse schools in terms of effective working...it depends on the SENCO, the head teacher, who then generate the culture in a school, and some schools, as I say are absolutely brilliant and other schools just ignore the existence of mental health problems and undermine everything we try and do.” (CAMHS manager)

More significant tensions existed between children’s services and CAMH services. Children’s services managers mentioned the confusion of professionals over the role of specialist provision and the work undertaken:

“Social services get annoyed that we pick and choose the referrals we take, so it’s trying to get them [social services] to understand that we can’t just take everything because they haven’t got anywhere to put it.” (Voluntary sector service manager, Wales)

As in other areas of service provision (Allnock and Tunstill, 2007), there was also a reported fear some families hold in respect of local authority involvement:

“The families view the local authority ambivalently if their child has been referred – and know they are a policing agency...we [the service] are the ones, for the first time, that parents will trust and will engage with. It’s not that local authorities fail, but it’s based on the tense relationship. It’s not impossible but takes a lot of skill and effort to be both policeman and the therapist.” (Private sector service manager, England)

Finally, some managers identified a specific practice by referring agencies of “closing the case” once the child or young person had been referred to the sexual abuse service. Four managers in the interviews suggested that in some cases, it was more than appropriate for professionals/agencies to remain involved for the benefit of the service user and their family:

“Quite often we find that there are agencies that refer to us and then close the case...in some circumstances we don’t find that helpful...it’s not an either/or situation for these children and young people...it’s almost like, refer them on and close, because it’ll be picked up by someone else, and that’s just not possible for many of these really chaotic and vulnerable families.” (Voluntary sector service manager, England)

This was a concern in respect of safeguarding children and young people who had experienced sexual abuse. They were a particularly vulnerable group who required, in addition to support and intervention by services, attention to wider safeguarding issues. If attention was not focused on the home and social environment alongside direct support, these children and young people may have been open to further abuse and victimisation.

There were more difficulties raised by managers with regard to working with CAMHS than any other agency mentioned. Voluntary and private sector providers saw these as being impediments to effective local provision. A manager of a voluntary sector service in Wales summed it up in this way: “[There is] woefully inadequate CAMHS provision.” The interviews placed CAMHS squarely in the centre of a debate over problems in service provision and raised questions as to whether or not CAMHS should be attempting to offer specialist therapeutic work for young people affected by sexual abuse.

Interviewees emphasised the need for CAMHS to develop better eligibility policies, increasing accessibility for children and young people and promoting more specialised training for CAMHS staff. Indeed, chapter 3 highlighted that many services were unable to undertake work with children and young people with very complex needs such as severe mental health issues or physical disabilities. In this case, tier 4 CAMH services may have been seen to be an important avenue through which these children could access therapeutic work for the abuse they experienced, perhaps in collaboration with specialist sexual abuse services.

On the other hand, if CAMHS should remain focused on general mental health issues, leaving specialist work around sexual abuse to specialist staff in specialist services, managers stressed the need for greater collaborative working between the agencies, greater funding for specialised staff and resources to be able to deal with the range of needs and circumstances of all children and young people who had experienced sexual abuse.

In general, CAMH services were seen by non-CAMH and some other statutory service managers as *non-specialist* in nature. Five managers in the semi-structured interviews acknowledged that CAMHS did undertake therapeutic work, but quickly pointed out that they should not be seen as a specialised service:

“Specialise is the wrong word – do they do some of that work, yes, they do – but the CAMH service obviously is much more generalised for children’s therapeutic needs across a range of emotional, possibly behavioural difficulties.” (Voluntary sector service manager, England)

Furthermore, they were seen to have strict eligibility, only working with children/young people displaying problematic emotional behaviour, and were stigmatising for service users:

“The thing is, that being sexually abused and raped is not a mental illness – quite rightly so, it shouldn’t be labelled as that. But, of course, that then means that the criteria for children

getting the help they need cannot be accessed by CAMHS. CAMHS have a very particular remit, and often children will need to be acting out their behaviour, be self-harming, maybe have eating disorders, post-traumatic stress disorder, you know, sexual abuse links in with a lot of those reactions, and they would then get through and be seen by a CAMH service. But, actually, young people saying they want to talk about this [sexual abuse] and make sense of it, will not get a CAMH service.” (Statutory sector service manager, England)

Managers suggested two main reasons for CAMHS’ reluctance to offer therapeutic work for children and young people affected by sexual abuse. First, CAMHS practitioners were not trained to work with sexual abuse and, second, CAMHS were under significant pressure and overloaded with high caseloads of children and young people with a broad range of mental health needs.

Some of the CAMHS managers we talked to were aware of these difficulties and how they affected their ability to take on therapeutic work with sexually abused children and young people. One manager explained the decisions she had to make about what was an appropriate referral as follows:

“A social worker may decide that we’ve got the skills required in a particular area, so may refer it to us. Now, in those circumstances, because of the pressure on us, we would tend to ask them ‘why us, and why not [another service]?’ If they make a good case, then we might pick it up. If it’s just for professional reasons like ‘your waiting list is shorter’, that’s not a sufficient reason to move people from one service to another.” (CAMHS manager)

Non-CAMHS managers clearly acknowledged that CAMHS staff were experienced and qualified social workers or therapists. Generally, however, they were not seen to hold the specialist skills and resources necessary to carry out work in relation to sexual abuse.

Although a number of challenges were identified in working together, there were managers who felt their services were working “effectively” with others. Two managers in the interviews indicated the importance of “keeping promises” to other professionals with whom they were working:

“People know that if they ring us, we’ll ring back...they don’t get a sense of being left. I think that’s very important when you’re dealing with such an anxiety-provoking topic really. You can’t just let people keep hanging on.” (Statutory service manager, England)

“I think we’ve got a very good reputation in North Wales because we do what we say we’re going to do.” (Service manager, Wales)

There was some effort by services to work with other agencies. However, lack of time, resources and tensions between agencies appeared to be persistent barriers to overall effective collaboration.

6.2 Funding of services

Information gathered from the services showed the often complex nature of funding arrangements in place. Services were more often than not funded by multiple sources, which could be insecure and required a great deal of work on the part of managers and staff to renew and renegotiate. A widespread concern was the lack of sustainable funding for services providing complex and often long-term therapeutic work.

Fifty-five per cent of services reported that they received multiple sources of funding. Three-quarters of these were voluntary sector services; 12 per cent were statutory; and 12 per cent were private. Where statutory services received funding from more than one source, they were generally social care settings. Health-based provision (ie CAMHS) relied on pots of long-term or “core”, statutory funding to undertake this work.

6.2.1 Duration of funding

In the questionnaire, managers were asked to report on the sustainability of funding for their service. Services that had multiple sources of funding were asked to report the duration of their funding that was the *least* secure. Responses revealed that, on average, funding was secure for three years, which reflected that many commissioned contracts were on three-year cycles; secondary and tertiary sources of funding were even more fragile, typically lasting a year or less.

6.2.2 Long-term funding arrangements

Some therapeutic services were secure through the provision of long-term funding, which had been mainstreamed and was therefore “indefinite” in duration. This kind of funding referred to a public commitment by an organisation to provide an agreed level of support for a specified length of time, which allowed organisations to plan their operations on a longer-term basis than shorter-term annual cycle grants allowed.

Questionnaire responses showed that services that only had one source of funding tended to be the statutory services where longer-term funding was provided through a trust or local authority. The most common timeframe reported by 69 per cent of services was “indefinite”.

However, the most complex arrangements are those where services had this kind of funding, plus one or two service level agreements (SLAs) in place, perhaps also alongside “spot purchasing” arrangements. In this case, an SLA was a formally negotiated agreement between the organisation providing a sexual abuse service and “referring agencies”, who may not have possessed the skills or resources to provide that service. The SLA would specify conditions and length of funding to the service. On the other hand, spot purchasing referred to case-by-case payments by a referring agency to the sexual abuse service to undertake work with a particular child or young person. In other words, it was a situation where the money followed the child, rather than a child entering a service that was already paid for.

Where services did not have a long-term funding source, such as a local authority or voluntary agency, much of their funding would be based solely on SLAs and/or spot purchasing arrangements, making survival more precarious. These services were working without the buffer of long-term funding that would keep the service in motion, and had to constantly review and renew contracts within short-term grant cycles. In some cases, insecure SLAs were at the mercy of changes in commissioning strategies and capacity planning within local authorities, which may have impacted on the amount of funding that was earmarked for children and young people and/or services perceived as “mental health”.

6.2.3 Service level agreements

Service level agreements (SLAs) were made on variable short-term timeframes, generally on a one-year or three-year basis. Even where the contract was in place for three years, in many cases services had to review and report annually to the organisation with which they had their SLA. Some of the SLAs were reported as secure, with managers confident that they would receive a renewal. Other services were under constant worry that the SLA may not have been renewed. Half of the interview participants felt secure about their SLAs being renewed; the other half felt insecure.

6.2.4 Spot purchasing

Managers by and large referred to spot purchasing arrangements that occurred when a child or young person was outside the boundary covered by the sexual abuse service. Spot purchasing also took place by local authorities within a service’s catchment area when

“purchasing” a service for a specific child or young person from a specialist voluntary or private organisation. This could be a highly unstable way of generating income:

“Money comes with the child, not money – and then children. It is our only source of income. The money goes if the local authority decides the child no longer needs the service.” (Private sector service manager, England)

Two services reported that spot purchasing was their only source of income. One of those services noted that this was due to its status as a national resource. Several other services reported that spot purchasing comprised 30–40 per cent of their entire income.

6.2.5 Other funding arrangements

A number of services reported that their income was generated from alternative sources, such as a one-off donation; funding generated from local businesses via payroll contributions from employees; and a collection of small grants. Some residential services, which were also “schools”, were funded on a school-term basis.

6.3 Gaps in and challenges to provision

One hundred and nine services reported that they were under-funded and their capacity to provide enough therapeutic support was consequently limited. Sixteen managers interviewed also cited inadequate funding as a problem for service delivery. However, funding was a broad term, which did not distinguish between those “resources” needed to deliver a service, such as staffing and facilities. The in-depth responses to the questionnaire and interviews helped to identify the specific non-monetary resources mentioned most frequently by managers as crucial to meeting demand.

When services lacked adequate funding, important resources necessary for delivering that service were reduced and managers had to find ways to prioritise. Managers described how poor funding: restricted staffing capacity; reduced the amount and type of training, staff development and supervision available to staff; changed the type/s and nature of services or therapy that could be offered; limited when and where the service could be offered; impacted on the capacity – and willingness – of services to advertise their existence and accessibility (and therefore reach more children); and restricted eligibility of/access to the service. Poor

funding also limited a service's ability to provide evidence/generate knowledge of its users in order to provide information aimed at service improvement.

Eleven managers highlighted in the questionnaire the prioritisation of cost over the welfare of the child or young person needing a service:

“Cost matters prevail over the welfare of the young person for social services. There is a delay of months between identifying young people and referring them because of funding shortfalls.” (Private sector service manager, England)

Managers said there was also uncertain funding for children and young people in need of long-term support. SLAs lasting only one year can hamper longer-term plans for children needing it:

“Funding depends on referrals – there is not a long-term commitment of funding for each child. This is a considerable problem. Frequently, financial considerations outweigh care decision.” (Private sector service manager, England)

These funding challenges potentially had negative impacts on children and young people's recovery, if their treatment was cut short, or they were referred on elsewhere:

“Children are constantly moved at short notice purely on financial reasons. It is a constant theme. This undermines the continuity and sense of security and being settled. Children want stability, but the funding is a constant threat to that stability.” (Private residential service manager, England)

Indeed, as mentioned in chapter 4, service managers stressed that therapeutic work should only take place once a child was in a safe and secure environment, as stability was absolutely crucial to the child's recovery.

6.4 Perceptions of security of funding

The interviews revealed that service managers had significant concerns over the stability of overall funding arrangements. A small number of services felt relatively “secure” about their financial future and service sustainability, but a greater number of managers expressed

concern. Some managers expressed an uncertainty, although this did not necessarily mean they felt insecurity. Managers in two services in Wales expressed feelings of uncertainty about funding. The services were provided through the same (large) voluntary organisation, and as such, recent funding directives had been affecting both. The services received core funding through the voluntary agency, but recently had experienced a push to search for alternative funding (eg SLAs) to supplement core income. Voluntary services across the board reported uncertainty due to the current economic climate, as voiced by one manager:

“I think I am as secure as the next person in this financial climate and choosing to work in the voluntary sector.” (Voluntary service manager, Wales)

Larger voluntary organisations did not, however, report feeling the same pressures as those faced by small organisations:

“We have had heavy investment from [the core] so the funding seems secure...the next two to three years are likely to be periods of maintenance rather than growth because funding regulations are becoming more difficult and there is also the political climate, which makes the future more difficult to predict.” (Manager of large voluntary service, Wales)

6.5 Service commissioning

This section sets out the commissioning process as described in the interviews with commissioners. Respondents came from county councils, residential services, local authorities and CAMHS.

6.5.1 Who do they commission from; why and why not?

Agencies commissioned from a range of services or only from a single service. Agencies also jointly commissioned services. This depends partly upon what services are available in the catchment area. Some of the reasons for commissioning services were historical: “the way they have always done it”. More often they were commissioned because they matched the levels of service needed for the children they (commissioning bodies) accommodated. One commissioner in Scotland acknowledged that their organisation did *not* commission services for sexual abuse because sexual abuse was not prioritised as a need.

“It’s never been identified as an area of need that we should be addressing....other areas have...but therapeutic services to support children who have been sexually abused is not something that has been flagged, it’s not something that we’re dealing with so much that we should be commissioning. It’s also not really featured in terms of the child protection committee business.” (Commissioner, Scotland)

Clearly it is important to investigate further whether or not this is because sexual abuse of children and young people is not identified as a significant issue. This would mean exploring further the debate we noted earlier in this report about whether or not we know whether the prevalence rate of sexual abuse is increasing, stable or declining.

6.5.2 What influences the choice of services commissioned?

A range of factors influenced the choice of services agencies commissioned. For almost all of the commissioners interviewed, the skills and experience of the staff undertaking the therapeutic work were paramount in the decision to buy in their services, more so even than the level of qualifications held by the workers:

“We would be looking for expertise rather than specific qualifications...It would be essential...for staff to have a good record of communication and engagement with young people and in their practice, taking planned therapeutic approaches.” (CAMHS commissioner, England)

“To undertake work with a child who has disclosed abuse, it’s for somebody to undertake that treatment work, and to do that you need particular skills.” (Trust commissioner, Northern Ireland)

Commissioners also indicated a number of other reasons for commissioning: It was partly to do with a strategic vision of the service, and where it sat more widely within the commissioning organisation. Geographical proximity and reputation of the service may also have played a part in the choice of services commissioned.

6.5.3 How long are services commissioned for?

Average lengths of contracts (SLAs) reported by commissioners ranged from one year to three years. Some contracts would be dependent upon the need from the therapeutic services. Longer-term work would be on a three-year cycle with yearly reviews; but some agencies

also spot purchased on a case-by-case basis. As some trusts reorganised, commissioners predicted that yearly contracts would move to a three-yearly basis. The length of contracts was based generally on the organisation of funding streams within the commissioning agencies. It also had to do with the viability of contracting a service and whether or not the service could deliver in respect of the level of need the commissioning agency had:

“It needed to be of a reasonable length for the money provided, for the provider to commit themselves to a service, which can sometimes involve recruitment of additional staff...it needs to be of reasonable length.” (Commissioner, residential service, England)

6.5.4 How are commissioned services reviewed?

Reviews of commissioned therapeutic services were undertaken by commissioning bodies through a variety of “formalised” mechanisms, which were more developed in some local authorities than in others. One route for reviewing contracts was face-to-face meetings, which were attended by contracts managers, business managers, operations managers, heads of commissioned services, managers (area manager or project manager) of commissioned services and, at times, therapeutic staff were present. Formalised meetings were described by one commissioner as a mechanism for developing relationships with some local service providers:

“Currently it’s a face-to-face meeting that we have. That’s about building relationships and things as well, because they just haven’t been there in the past.” (Local authority commissioner, England)

6.5.5 Accessibility of commissioned services

There were four issues related to accessibility upon which commissioners commented: geographical accessibility; accessibility for disabled children; accessibility issues linked with the existence of waiting lists; and, finally, internal process and policy within the commissioning agency, which could block accessibility.

Two commissioners highlighted the difficulty of accessing services with particular reference to rural areas. Capacity was limited in the context of a very large geographical area covered by the commissioned service; it could take two hours to get from one end of the county to the other.

“If they had more capacity then we could commission more capacity, and they would be able to be in far more locality areas.” (CAMHS commissioner, England)

Four commissioners also indicated that their commissioned services did not exclude on the basis of disability, and that they were able to provide services for most children, although they acknowledged that severe disability presented challenges in respect of service provision.

Three commissioners indicated that waiting lists presented a problem for accessibility at times; that some services’ capacity was limited and/or the contracts held with the service were small and therefore also limited access.

Finally, one commissioner expressed frustration and concern around the limited eligibility criteria; that the only way children could access a therapeutic service was when they also had a “named statutory worker”, either from an earlier intervention (eg a tier 3 service) or a previous contact with CAMHS:

“I’m concerned that a young person...who has suffered post-traumatic stress as a result of their experiences...may not be able to access this kind of service.” (Commissioner, England)

6.5.6 How do children access a service?

Commissioners were asked to describe how children and young people accessed therapeutic services. Overall, few described an open access system advertising services to invite self-referral. It was rare for services to be brought to the attention of even a broad range of practitioners in the area. A number of commissioners blamed this on the lack of resources to pay for therapeutic services and expressed concern that advertising would result in service saturation. It was felt that the services that did exist would not be able to cope with any increase in demand:

“I’m fairly clear that unless we have a lot more resources it wouldn’t be awfully wise to publicise a whole lot more, because quite clearly, health visitors, schools, GP surgeries know about the NSPCC because their referrals keep coming. I think if we were going to extend the provision hugely, it might be a very good idea to do a bit of publicity, but as it is, I think we’re probably stuck with what we have.” (County council commissioner, England)

Commissioners described instead a limited route for accessing a service, through direct referral from a practitioner involved with the child and family:

“The entry point would be through statutory social services, for instance the service that’s provided...then, we contract in the NSPCC to do the work, but it would only be based on referral through ourselves. They would not accept direct school referrals or whatever. Some of our services we would contract with would accept community referrals and we would signpost people down those roads, but really the more specialist provisions would be purely on our social work referral basis, because clearly you’re rationing very scarce and expensive resources, so that’s really how they would be referred in.” (Commissioner, England)

This of course raised the issue of service accessibility in the circumstance where there was no social work involvement, for example in the case where it was known that the abuser was not a family member.

One commissioner described that their commissioned service publicised more widely through leaflets made available to social workers, CAMHS workers, the police, GPs and health visitors, which could be distributed to children/young people and their families when sexual abuse had been identified. This form of access, where direct self-referrals could be made, was not evident in interviews with the other commissioners.

What is the unmet need? There were two broad views held by commissioners regarding unmet need. There were those who saw no immediate problem; that existing need was being met adequately by the services they commissioned and therefore demand was being managed:

“I am not aware of any waiting lists for children who have been sexually abused requiring therapeutic work.” (Commissioner, Northern Ireland)

This manager also reported being unaware of any children requiring a service who were not getting it.

However, there were other commissioners who recognised the lack of capacity, including the kinds of services that were available. For example, some commissioners felt that the quantity of services was acceptable in the financial circumstances current at the time, but were also aware that referrals increased and therefore contracts had to be renegotiated. They also suggested that they would like to have seen the commissioned service expand if financially possible:

“Yes it does [meet the need] in the sense that they are providing the quantity that we have asked for. Obviously in terms of development, it would be nice to be able to develop the

service a bit more, but we are not able to....it is down to finances.” (Commissioner at a secure children’s home, England)

Three commissioners acknowledged that there were not enough services available for the children in their areas. All three respondents suggested that the commissioned services lacked the capacity to take all the referrals they would have liked to put through:

“I think capacity is a big issue...they can’t offer as much therapeutic work as they would like. They do more group work...as it’s more efficient in capacity terms to do group work...but they haven’t got the entire range.” (Local authority commissioner, England)

Another commissioner recognised similar capacity problems and also pointed to the waiting list as evidence of the demand for services:

“Quite clearly it isn’t met because there is, for example, a waiting list and the waiting list has been closed for several months. I’m quite sure that if the service had more staff resource and hours available, we would have more referrals to put through.” (Local authority commissioner, England)

Yet another commissioner felt that there was unmet need, but based this judgment on anecdotal evidence:

“I suspect there is not sufficient quantity...because of anecdotal evidence...primarily from Doctors saying ‘I’ve had this parent in my clinic who is talking about a young person who could do with some intervention but can’t get it’.” (CAMHS commissioner, England)

Again, this particular point highlighted commissioners’ anxieties about having no standard to judge against due to a lack of guidance around the appropriate levels of provision for children who had experienced sexual abuse.

6.5.7 Views on quality of commissioned services

The quality of commissioned services was reported by most commissioners to be very good. They described that their understanding of the quality of services came largely from word of mouth – through other professionals or through the children and families themselves, who may have still been in contact with the local authority.

“I know about the quality from professional word of mouth. My tier 3 and tier 4 clinicians are happy referring to the service...we are happy about what they are providing even if it is a bit limited.” (CAMHS commissioner, England)

Another respondent similarly reported that they based their judgments of quality partly on the feedback they received from young people and also on the evidence produced, which charted the progress of planned interventions. This commissioner also pointed out with confidence that the service was well reviewed:

“I am very convinced that practitioners, and the rigour within the service in terms of monitoring service delivery, are such that it does ensure a very high quality.” (CAMHS commissioner, England)

Another commissioner based their judgment on the confidence they had in the skills and experience of the service providers:

“With regard to their practice, it is their bread and butter work with children who have been sexually abused.”(Commissioner, Northern Ireland)

6.6 Challenges in the commissioning of services

Commissioners reported that the main challenge for them was to understand the local need; and to apply resources appropriately:

“It’s not entirely about more money...it’s about being clear about the need and to make sure you are utilising the current resources.” (Trust commissioner, Northern Ireland)

Lack of funding was highlighted by numerous respondents as a problem for commissioning. This lack of funding could be a problem on the commissioning agency side or on the part of the therapeutic service. Low funding levels prevented the commissioning of large contracts; and restricted the capacity of the therapeutic service, which prevented commissioning agencies from buying in further services. A lack of financial resources also prevented commissioning agencies from seconding workers to therapeutic services, where they would have been able to pick up the skills and experience and return to the agency with that knowledge.

A further challenge highlighted by one CAMHS commissioner was the difficulty of effective communication and joint working; this was a significant concern of voluntary and private services as well. However, this commissioner pointed to the growth and change that commissioned services could undergo, with little publicity on the part of the service:

“You might get a provider going along with a bright idea...and the commissioners are the last people to hear about this!” (CAMHS commissioner)

A final concern expressed by a CAMHS commissioner reflected the pressures they were also under to “do the right thing”. Commissioners themselves felt they played a part in providing a much needed service to traumatised children, but were unsure about the validity of the interventions. Without up-to-date and appropriate guidance, commissioners found themselves in a difficult position to buy in the right services:

It’s a highly specialised area, and whilst there is some guidance, there is not a huge amount of guidance, so it does make you feel a little bit that you are working slightly blindfolded...there isn’t a model of best practice saying this is the evidence for therapeutic intervention per se...it’s about knowing whether it’s right or not.” (CAMHS commissioner)

6.7 Chapter summary

This chapter examined data on working together, funding and commissioning obtained from the questionnaire and interviews with managers and commissioners. Key messages include the following:

- As in other areas of service provision, working together was not a straightforward or easy task. Services had aspirations about working collaboratively with other organisations, and activities, such as signposting/referring and consulting with other professionals, were occurring regularly. However, there were a number of barriers at the most crucial stages of their work, which frustrated shared delivery of services and continued involvement of agencies with children and young people receiving a therapeutic service.
- Therapeutic services had complex funding arrangements, often with two or more sources of income, which tended to be short term, unstable and insecure. Unstable and insecure funding interfered with the nature of therapeutic work, which was often long term. The

loss of funding could therefore affect the overall outcome of the therapeutic work if that work had to be terminated early.

- This instability meant that services were constantly searching for new sources of funding and working all the time to renew and renegotiate existing funding, which interfered with the actual day-to-day delivery of services to children and young people.
- Funding for commissioned services depended upon commissioners' assessment of need, which was not always understood adequately by the commissioning bodies. Commissioners suggested there was a lack of guidance to help make the right judgments about levels of need and what interventions worked.

7 The views of young people

In late 2008, the NSPCC undertook a series of consultations with young people around the country to find out their feelings about confidentiality, confidential space and issues that stop children and young people getting safeguarding help and support. The groups included both non-service users and service users in Wales, England, Scotland and Northern Ireland. There were some consistent messages found across the groups, highlighting a range of important considerations taken by young people in respect of confidentiality and choice of service. It was found that, while confidentiality was important to children and young people in respect of these sensitive services, it was not necessarily the single key factor for children in choosing someone to talk to. Other factors included active listening, working at the child or young person's pace, control, information, accessible communication, respect, honesty, feeling safe, the ability to sort out the problem and trust. Of those factors, trust was the most important thing for children and young people when choosing someone to talk to.

The scope of this study's focus group activity with children and young people was more limited than that undertaken by the department in the NSPCC responsible for services for children and young people (SCYP), in that we were only able to meet with two groups of young people. Both groups were non-service users, although our focus group participants identified a wider range of themes in the discussion. The two focus groups were made up of 10 young people who were non-service users. We explored with the young people several vignettes, asking them what advice they might give the two characters, Dan and Beth (see appendix 3). A range of themes emerged and these are discussed in this chapter, and where relevant, set into the context of the SCYP consultations.

7.1 Awareness and knowledge of services

Most of the young people had limited awareness and knowledge of services providing support for children and young people experiencing sexual abuse despite the fact that they thought themselves to be well-informed young people. National organisations, such as ChildLine and the NSPCC, were the first suggestions made, although they did not know if the NSPCC had a local office. Along with these organisations, they also mentioned the police, children's services and Connexions. Their knowledge of these services and whether they could help was partial:

“In our case, we know a lot that’s going on.” (Sese³²)

“I would tell ChildLine.” (Ben)

“NSPCC, ChildLine they are the two major ones and they advertise broadly and everyone knows them.” (James)

“What about social services? If they still have them? Coz Mum says loads of them are gone.” (Ben)

The police were mentioned by the young women, but only in cases where they perceived the experience of a young person could easily be identified as abuse:

“Well, maybe not the top one [Dan’s story]. I think that’s a lot more difficult because it’s not quite, well like Sarah said, it’s not so obvious, it’s not what you’d think of for child abuse. But for Beth’s story I’d definitely say go to the police.” (Jessica)

There was some confusion over whether Connexions would deal with or be able help young people experiencing sexual abuse although most were confident that they would be able to signpost a young person somewhere else. What or where the “somewhere else” might be was less clear:

“You can just go to Connexions...if this is England-based. Connexions does that sort of stuff for you.” (James)

“They are a One Stop Shop...They give out careers advice, and free condoms and just general advice.” (Jimbob)

“It’s more than that [pause] coz they have their own website [pause] where you can contact them...” (James)

“Yeah, but they are not here to deal with these problems. Connexions [pause] do they refer, I don’t know? Connexions are good if you just want to go to them and get condoms. But can they deal with something like this? Do they have professional training? I don’t know. Maybe they do. But if you want to go somewhere, you don’t want them to send you to other people³³.” (Paul)

³² All names were pseudonyms chosen by the young people, except one where the name was chosen by an interviewer.

³³ In fact the One Stop Shop (for 13 to 25 year olds) offered counselling services provided by CAMHS and opportunities to access other specialist therapeutic services.

Two young women and one young man were aware of a local rape and sexual abuse centre:

“I’d try to get them to go to the [name] rape and sexual abuse centre and talk to a counsellor.”
(Anne)

They had recently learned of the centre and the work it did³⁴ through having been involved, via a young people’s participation project, in the local authority commissioning process and had interviewed staff from the centre. Prior to this they did not know of it. Without this knowledge, Anne again suggested Connexions but also mentioned “Talk to FRANK” the online confidential drug advice service.

James suggested a local mental health charity, which had a service for eight to 25-year-olds:

“I think there’s a group of people in [name of service]?” (James)

 “They just deal with mental health issues...That’s mental health.” (Paul)

 “But that’s connected to this, confusion and unstable. So there are groups, but [service] is a group that isn’t, doesn’t have advertising.” (James)

 “I didn’t even know about this until a few months ago.” (Paul)

Again this was recently acquired knowledge and, although James was able to see that such a service was relevant for young people experiencing sexual abuse, Paul did not. It was unclear whether this was a lack of understanding of the potential impact of childhood sexual abuse or resistance to pathologising young people:

“If I had a story like one of these, I’d be put off by the word ‘mental’ because, well, there isn’t anything wrong with me, it’s other people.” (Anne)

However, the use of “mental” might be a barrier to accessing services. A discussion about CAMHS took place only after direct questioning about whether and what young people knew about the service:

³⁴ This refers to a small voluntary sector organisation run by women providing support and counselling to women and young women who have been raped or sexually abused. The helpline service and two independent sexual violence advisors (ISVAs) are available to men and young men from age 11.

“It’s the child and adolescent mental health service.” (Jessica)

“I haven’t heard of any of these!”(Chanelle)

“Me neither.” (Sarah)

“I know they help young people who have been self-harming, suffer from depression etc [pause] and I know they are supposed to be very good, a few of my friends have been there and said they are good. Other than that I don’t know loads.” (Jessica)

Overall the young people were not confident about services that might offer help:

“I wouldn’t know what to do [pause] I don’t have links, I don’t know [pause] I’d probably tell someone else and see what they think, but I wouldn’t directly know what to do.” (Sarah)

This was unsurprising, given that the findings from the geographical mapping and questionnaire components of this study showed that there were a limited number of services, the vast majority of which advertised solely to other professionals.

7.2 Information about support and services

The young people suggested many ways in which services could be publicised; although, of course, the vast majority of services did not accept self-referrals from young people and few advertised to the wider community as part of a strategy to manage demand (see chapter 3). However, the young people proposed using a range of media including TV (both adverts and programme content); radio; billboards; buses; leaflets, particularly in GP’s surgeries and libraries; and on the doors of public toilets. These media all offered the opportunity to obtain information anonymously, which was very important:

“Why not on buses? No one’s gonna criticise you for reading an advert on a bus.” (Anne)

“Women’s toilets!” (Amy)

“Women’s toilets would be good.” (Chanelle)

“Toilets is the best place, you always look at the door.” (Anne)

“Nobody would see you taking the phone number if you’re in your own cubicle.” (Chanelle)

Where young people knew of a service, being able to seek information from it anonymously was essential, so SMS (text), email, websites and phone were suggested:

“...if you could text them for more information first is useful.” (Anne)

7.3 Seeking help

There was some agreement that initially many young people might seek help from an adult they knew through choice, rather than necessarily through lack of knowledge about services and “Sometimes speaking to someone you know like a friend or parent isn’t the best option” (Sarah). Teachers, school nurses, school counsellors, (education) welfare officers and GPs were all mentioned, although mothers were too. However, what was significant was not the role of the person but that it was someone they respected, trusted and thought had the power and authority to help stop the abuse. The important issue of trust highlighted here elided closely with the findings of the SCYP consultations, as well as other literature around important factors for children and young people in choosing services (Evans, unpublished).

One issue raised here was that of the competence of professionals in universal services (all of those named above are in education or health) to respond to disclosures of sexual abuse in appropriate ways. This was significant for two reasons: first, the initial response mattered to the young person and the first person they tell must be “just somebody who believes them! It’s the most important thing” (Anne); and, second, this professional is the first step to accessing other services. Both the findings from this study and earlier ones (Baginsky and Baginsky, 2001; Baginsky, 2008) cast concerns on this. Not all the young people said they would talk to a known professional because of issues over confidentiality, the lack of which was a barrier and is discussed more fully in the next section.

Young people’s perceptions of whom services appear to be targeted at influenced their decision making about approaching them. While the NSPCC was one of the two organisations widely known by the young people, some were clear they would not contact NSPCC services.

“Personally I wouldn’t phone the NSPCC. Coz I do think that, it’s slightly more for children. You think children. Not young people.” (Jessica)

“It’s different.” (Amy)

“That word children [pause] it [pause] it upsets teenagers. They’d go mad at you...”. (Sarah)

“It’s patronising.” (Amy)

The young people recognised that someone telling their mother might be dependent on the complexity of the relationships in their family; this was seen as a barrier where the offender was the father, stepfather or mother’s partner. There were cultural differences in the young people’s views of “family”. Both young men and young women from BME families appeared to think telling someone in the family was more appropriate and acceptable than those who were White British. It was difficult to interpret what this meant in relation to service use, although previous studies have reported a number of issues in BME children accessing CAMHS and the findings from the questionnaire of this study indicated a very small number of BME children using therapeutic services.

7.4 Confidentiality and anonymity

In the focus groups for this mapping study, confidentiality emerged as a theme in the discussions with young people. Like the SCYP consultations with young people, confidentiality was very important to them in choosing a service/someone to talk to.

Most of the young people were aware of child protection/safeguarding procedures:

“...if you told at the school, they’d have to tell the head teacher” (Anne)

This lack of confidentiality meant that some would not tell a known professional, partly through anxiety of being judged:

“...but if it’s in the school, I wouldn’t want to go. If they [school nurse] passed that information on to a teacher, that teacher might look at me differently.” (Anne)

For this reason, choosing to work with unknown adults was preferable for some:

“I wouldn’t go to the school nurse, I’ve never met her. I have no, I don’t even know if it’s a woman. I have no connection with her. I have no understanding [pause] I wouldn’t, well I don’t know who she is. I wouldn’t recognise her if I saw her.” (Jessica)

“I think I prefer that.” (Amy)

“I’d rather go to an environment I didn’t know.” (Anne)

“Yeah. You can, there’s no judgment there, she doesn’t know you, you can tell her everything, you can just let rip really.” (Amy)

Confidentiality and anonymity were also related to non-traceable phone calls and phone numbers:

“...if it was a phone number showing up on the phone bill, I’ve heard people say that before, they don’t want to ring a number in case it shows up. So you’d need to know the number is completely confidential not traceable” (Anne)

For some, concerns about confidentiality extended to all services and was linked to a fear of losing control of the situation:

“It’s to do with confidentiality I think. [pause] I find that a weird issue, organisations are like, ‘we won’t tell anyone anything but if you’re in danger we have to tell’. I personally, even if I was in danger, I may not want them to do anything until I said so. But they don’t follow this rule. I think, if you are going to set up a group [for young people], and direct people to combat this [pause] then the people who call shouldn’t have to give details and no one should act on it until the young person says they’re ready.” (Paul)

However, there was an understanding that there were limits to both anonymity and confidentiality. Where some action was to be taken over the abuse, such as if the offender were to be prosecuted, then it would be necessary to breach anonymity and confidentiality:

“But for some people [pause] there’s pros and cons. If you have a case and you want to prosecute someone, for you to prosecute them you would have to give a few details, and that

scares people. I think the best thing is to offer a face-to-face service, where anonymity would be involved in it, but not to such an extent that a person's details are not known.” (Sese)

Unlike the SCYP consultations, we did not ask young people to identify the most important issue in choosing someone to talk to, so we are unable to report what was the highest concern for them. However, our findings supported the work done within SCYP, in that confidentiality was an important factor considered by young people alongside a range of other factors, such as trust and choice. It meant that the existence of confidential spaces such as ChildLine were important for children and young people concerned about sexual abuse, so that feelings and options could be explored. It was important to recognise that children and young people needed services and support other than that provided by child protection or CAMH services, before they developed behavioural problems or mental health difficulties.

7.5 Diverse support and services

Both groups recognised the difficult situation that young people experiencing sexual abuse were in and were clear that young people needed some sort of help:

“They need to talk to someone. Mum or dad or whatever, but they need to talk to someone.”
(Ben)

“I think Beth needs actually someone to sit down, a counsellor, to sit down and talk to her and make her see it's not ok.” (Jessica)

However, diverse types of services were necessary since young people had different needs:

“...the level of help needed, that needs to be assessed and looked at.” (Jessica)

This finding was supportive of the SCYP consultations, where choice emerged as an important factor for young people in choosing someone to talk to. In the focus groups, need was not dependent on the acts perpetrated or the severity of abuse but by the subjective experience of the young person:

“I think in some examples of child abuse, any kind of abuse, it should be more [pause] ‘I was made to feel like a victim, therefore I was abused,’ never mind what actually happened.”
(Anne)

“Abuse is abuse. Because who’s to say that’s not affected Dan as much as it’s affected Beth.”
(Amy)

Face to face, web forums, phone and email were all suggested ways through which young people could gain support and/or counselling but young people “need options” (Chanelle). However, there was the possibility that having choice might be difficult for some:

“At the same time, if you give someone a list of choices and they’re not confident, I would think ‘it’s too much for me’. At the same time, even though you need a choice, that person needs a mentor, or somebody to guide them through.” (Anne)

There was a lengthy discussion among the young women on the dilemmas of using the internet to support young people. Some could see the potential for peer support through web forums while others were cautious about the potential dangers:

“In my opinion, it’s not necessary, it is dangerous, you could end up making it worse than better.” (Sarah)

Some also insisted that professionally trained adults were needed to work with young people (see later). There was some agreement that websites for services could provide useful question-and-answer information and that professionals could answer emailed questions. However, face-to-face work was not marginalised by new technologies:

“What about face-to-face talking? I don’t know which I’d prefer coz I’ve never been in a situation like this....The option should be there to talk to someone face to face I think.” (Paul)

Providing face-to-face work, both individually and in groups, was important for some:

“If you set up groups that deal with these kinds of issues, and promote the issues so they know they are there, people can come to them, rather than thinking they have to call a number or that there is no one to help me. You know this group exists.” (Paul)

While for others there was recognition that some young people could be helped initially with information:

“The fact that you can say call this number, this is where you can go, just getting that across is getting further than what you would have got in any other way.” (Sarah)

The need for ongoing support, beyond dealing with the abuse was identified:

“...it’s not just about getting over what happened but it’s about everything else. What do you do with your friends, and ‘how is school, why don’t you like school?’ So it’s an all around help for that individual. It’s not just about dealing with the abuse with the person, because people need to accept it and overcome it and then move on. They need to have more after they’ve done that. If they don’t have that network already, they’ll be a bit lost.” (Anne)

Support should “give them [young people] chances” (Anne) and include practical issues such as housing.

The role and value of friends in giving support was recognised, and services should be flexible to allow this:

“She took a friend with her for confidence and she didn’t feel all alone.” (Ben)

“Maybe these services, maybe they can have, maybe a friend could be a part of that. Just for the support [because] it’s a lot easier to get talking.” (Chanelle)

The importance of friends has been identified in earlier research, which showed that young people initially confide in and seek help from their friends rather than adults (Kelly and Regan, 2000). However, peer counsellors were regarded as unsuitable:

“You really need an adult. I’m not saying young people are incompetent, but the point is, if you get an adult, it’s someone,...if someone has authority, someone you know who can help you, if you look at someone my age, we are still learning and have a lot to learn, having an adult would be much better. It would give people the strength to know someone is there and can help, bigger in stature and mind...” (Sese)

“...You want someone who is a trained professional and a bit older and knows what they’re on about.” (Paul)

7.6 Gender-specific and gender-sensitive services

Gender-specific issues did not emerge from the SCYP consultations. However, it was an important issue for the female focus group in this study. Interestingly, only the young women

linked gender with the issue of services being provided in different ways in relation to the needs of young people and how these needs might be met:

“There’s a whole masculinity issue with men’s services, coz, they’re gonna be less likely to come forward. Like DV [domestic violence], it still happens, but less for men. So they need to be targeted in different ways, and they need to treat a man differently than they would a woman. I’m sure a woman might like a centre, with facilities she can use and people she can talk to. And a man might just like to speak to someone over the phone.” (Anne)

The young women identified the need for work to be done in gender-sensitive ways with boys, as young men might have more difficulty in naming their experience as abuse:

“And it’s that general knowledge that everyone thinks that abuse happens to girls. I know people know it happens to boys, but if you think about it straightaway, you will think ‘little girl’. I think it’s that boundary that you think, you shouldn’t be being abused coz you’re a boy.” (Sarah)

“That’s why it needs to be treated sensitively with boys. From a masculinity aspect, they probably feel a loss of that.” (Anne)

The literature and findings from the questionnaire supported some of these views in relation to the number of men and boys who disclosed sexual abuse and how many used services.

The sex of the staff working with young people was also discussed:

“A counsellor, someone to talk to, for Beth it would have to be a woman.” (Chanelle)

“I think so for Dan as well.” (Anne)

“I think Dan might feel more comfortable talking to a man.” (Chanelle)

“But he’s a man who did it! Maybe it’s more a point for them to be able to choose what kind of service they want....I’d feel more comfortable if I knew that was a women-only service and that it was designed for me, and not anyone else.” (Anne)

“I agree, I think it should be two separate services. Maybe, maybe not even like separate services, but, different branches of the same service.” (Jessica)

The findings from the questionnaire did identify a small number of gender-specific services. While it may be unrealistic in the context of the extremely limited number of services currently reported to suggest that consideration in any expansion of services is given to provision that is gender-specific and sensitive, this may from the young people's perspective, enhance access and be more fitting. This approach was supported by findings from an evaluation of SARCs recommending that "female staff become the default position" (Kelly et al, 2004, p79), since both male and female service users expressed a preference for female staff.

7.7 Professionals

The adults who work with young people who have experienced sexual abuse should be

"...trained and fully equipped" (Sarah)

"...prepared for her [Beth's] situation...Someone prepared to deal with the worst of that."
(Chanelle)

The young people expected professionals to have a particular skill set. They needed to be approachable and serious; listen and not give advice unless it was asked for; be non-judgmental and not stereotype young people; have some understanding of young people's culture; and be able to relate to young people.

"...basically they need to have a skill to draw out information from a person." (James)

"I think it's about people being able to have someone to listen. They aren't looking necessarily for advice but someone to listen and able to understand them, what's happened to them and then help them. Sometimes you end up seeing someone and all they do is bombard you with information you don't need. You spend an hour wasting your time. It's important for people to know it's for someone to listen to them. When someone gets the courage and energy to come and see them, they have so much to talk about." (Sese)

Young people's perceptions of the role of some professionals made them unapproachable and inappropriate along with their personal qualities:

“If it was my school, I wouldn’t have gone to the nurse. She isn’t there to listen to that sort of thing. She’s there to fix up a bent finger or something. Or give you Tampax when you’ve run out. She’s not trained to listen to that sort of stuff. Sometimes people don’t like their school nurse. Mine wasn’t very understanding.” (Chanelle)

7.8 Location of services

The location of services that young people might attend was important, partly to protect confidentiality and anonymity, and for the young women it was about feeling safe. For these reasons, young people were not in favour of these services being located in town or city centres.

“If someone saw me going to an actual place, people might think and reach a conclusion about what’s going on with me. So, if you just meet somewhere else, so people think you’re just there chillin’.” (Paul)

Multi-purpose centres, such as the One Stop Shop, where a young person might be going for a number of reasons were important. Residential areas were seen as unsuitable:

“...they do so much, someone goes into a one-stop shop, and someone says, ‘what did you go in there for?’ I just went in for jobs or something.” (Sese)

“I wouldn’t want it just near the house in case he [the abuser] drove by or something.” (Chanelle)

For some of the young women, the co-location of services for women and men was potentially a barrier:

“I think having both in the same place as well, it might be intimidating for a woman to go if there is men there...If I was Beth, and that deep into something, I would be so worried about it, I wouldn’t want to walk down the street if I knew that the men’s service was there.” (Amy)

7.9 Awareness-raising and early intervention

“I think the basic point is advertisement and education.” (James)

The young people thought that public education campaigns (for adults and children) and school-based work (tier 1 services) on child sexual abuse would be beneficial to children and young people. One barrier to children seeking help and support of any kind was them not knowing if their experiences were abuse or being confident to name them as such:

“I think it’s that not knowing if it is abuse, like the top story [Tom vignette]. I don’t know if you’d know it was abusive or not. Like, all the adverts you see about abuse are, like, they are definite, they’re certain. And if it’s just like, ‘boy talks’ or whatever and you see it on movies, you might think you’re over exaggerating. It’s not knowing what the scale is.” (Sarah)

“Not being able to actually define exactly what child abuse is.” (Jessica)

There was general agreement that children should be educated about sexual abuse and where to go for help. Although the young people had had lessons on sexual health this topic was not addressed and they thought it should, and could, be incorporated into sex and relationship education:

“I think that, in schools, seems like a lot of these, both people, they were like, they’re both, the stepfather and father were working on them at a young age, manipulating them and what not. So you need to start teaching this in schools at a young age. If it starts at 16 they would automatically know it’s wrong, and would probably tell someone. Where if it starts younger, you probably won’t. If you start teaching when you’re younger...” (Paul)

They thought it should be taught by specialist staff and not teachers, although that raised issues as “some schools won’t let them in” (Sese), particularly faith schools; and in community schools some children would be withdrawn on religious and cultural grounds:

“Like, our school, parents have complained saying they shouldn’t be telling our kids to use condoms. It’s against Islam to use a condom.” (Paul)

“The kids say they’re not allowed to learn about it...It’s against some religions [pause] so why don’t the parents notify the school that they’re not allowed to learn about it.” (Ben)

“That’s what happens and the school has to do it. If you do that at our school, then you’ll have two kids left to do it! [laughter] You’ll get no one in the class left! Then [specialist sexual health service] won’t go there and won’t able to teach about those things.” (Paul)

Young people highlighted the potential value of using advertising as awareness-raising rather than, or as well as, fundraising, and were critical that such information was not given out in advertising (including the NSPCC):

“Advertise only for funding, you don’t get education. But do the advertisements for education, this would be good.” (James)

“Maybe charities should focus on stopping it at an earlier stage. You know, making people know that if you’re not happy, then, don’t be scared to say something.” (Sarah)

Parents needed to be educated about sexual abuse too, so they were able to recognise it. Responsibility for this was placed on mothers:

“...ensuring that mothers have a better relationship with their children increases their chance of being able to confront the issues through their mothers.” (Sese)

This may have been an implicit recognition that mothers were more likely to be a non-abusing parent and that children (as professionals) expected mothers to protect children within current family arrangements. The idea that child sexual abuse was everyone’s responsibility was hinted at through discussion of neighbourhood watch, communities looking out for children and being able to challenge neighbours when abuse was suspected:

“It’s interesting to see how we can get other people who are not directly in the family to influence situations. I think that could be a help.” (Sese)

The young people saw sexual abuse as a social issue of collective concern and providing a range of services was needed to support and help children and young people who experienced sexual abuse as proposed in the *Cross Government Action Plan on Sexual Violence and Abuse* (HM Government, 2007).

7.10 Summary

Although our focus groups with children and young people were more limited than we had hoped, the young people nonetheless provided helpful guidance on the types of services they felt would be appropriate. Many of the factors raised in these groups supported the findings

of the SCYP consultations and provided further evidence of what young people thought was important in choosing someone to talk to. Important issues were raised regarding the advertising of services so that young people knew who to turn to and, most importantly, were able to self-refer. Young people's views on service accessibility sat in stark contrast to the very limited access to services described by service managers and commissioners in earlier chapters of this report.

8 Conclusion: policy and practice recommendations

This research revealed a significant gap in the provision of therapeutic services for children and young people who had experienced sexual abuse. It found that services to meet estimated levels of need were too few and that, for many services, demand outstripped supply. In some, predominantly rural areas of the UK, services were too far away for children and young people to visit without an overnight stay, which few services had the resources to offer. Services were often provided too late: although urgent cases were often prioritised, the average waiting time to get a service was three months and there were substantial numbers of children affected by sexual abuse who had to wait an unacceptably long time to receive support. Some services were managing excess demand by closing their waiting lists.

The findings also revealed that, too often, costs mattered more than the welfare of children and young people, highlighting that these services were resource-led rather than needs-led. Service managers reported that the shortage of funding caused unacceptable delays for the assessment and referral of children who needed therapeutic services. Furthermore, funding for services was not sustainable, so that long-term therapeutic work was often disrupted by the end of a contract.

The report documented a wide range of interventions being used by services across the UK. Some of these interventions (eg CBT, counselling) were delivered on the basis of greater evidence of effectiveness than others (eg creative therapies). Although a majority of services reported that they were internally recording outcomes in some way, none of these services were undertaking long-term research on effectiveness of outcomes. Furthermore, outcomes were not being measured consistently across services, making comparisons using reliable baseline measurements difficult.

Commissioners revealed that they struggled with the prioritisation of funding for sexual abuse because of inadequate local needs assessments. In addition, there was insufficient guidance around effective interventions. Better information for commissioners about need and what works was essential to inform planning and commissioning of services for children.

Despite concerns that children with disabilities and special needs may have been more vulnerable to abuse, a high proportion of services were unable to accommodate these children. This was reflected in very low rates of disabled children and young people who

were referred to services. Similarly, there were low numbers of children and young people from minority ethnic backgrounds who were service users.

Existing services had well-trained and highly qualified staff but serious problems were reported in recruiting sufficient numbers of staff for this work. Responses indicated uneven and inadequate training for professionals working in this area, and a lack of crucial clinical supervision for safe delivery of services. It was also highlighted that there was a continuing need for professionals of all types to receive training in the identification of child sexual abuse. These are all areas of concern for the Children's Workforce Development Council.

Finally, it was found that there had been a lack of priority given to child sexual abuse in CAMHS, the Audit Commission's Comprehensive Area Assessments and local safeguarding children boards. For example, this had been reflected in the inability of CAMHS to accept referrals expressly related to sexual abuse and their recording systems, which did not include a category for children who had experienced sexual abuse.

The NSPCC recommends the following:

1. We recommend that specialist service provision for children and young people who have experienced sexual abuse is expanded nationally.

It is recognised that in a period of recession funds are limited. However, the future savings that could be made by providing services to distressed children in a timely manner should be considered. The Scottish Executive has invested in providing services for children living with domestic violence, and a report showing the impact this has had on outcomes for children is forthcoming. Governments across the United Kingdom should invest in these as core services.

2. We recommend an expansion of resources to increase the likelihood of early responses to sexual abuse.

Early responses will save money in the longer term. Currently, waiting lists are too long, leaving children without any service. CAMHS should be required to ask service users about experiences of abuse, so that young people who have experienced abuse can have their needs for services assessed.

3. We recommend that workforce expansion is accompanied by innovative service provision that provides more flexible services based around the needs of children and young people, for example:

- a. **The costs of transport to bring clients from rural areas to service premises as part of outreach work should be factored into the commissioner/provider “bidding” process**
- b. **Consideration should be given to forming area or even regional clusters to ensure a variety of therapeutic interventions are accessible across a range of providers.**

4. We recommend that agencies undertaking generic work with children and young people, such as CAMHS, include classifications of sexual abuse in their initial assessments.

Adequate provision of therapeutic support for sexually abused children and young people will only be achieved if the need for such services forms an overt element of the initial assessment process. Our research revealed that there is little consistent or coordinated effort, either locally or across jurisdictions of the UK, to do so. However, this is particularly important because identifying this need is a prerequisite for referral to a specialist service. Thus, unless initial assessment considers sexual abuse, the extent of unmet need will remain concealed.

5. We recommend that classifications of sexual abuse are collected for submission to and inclusion in any national CAMHS mapping exercise.

Information about sexual abuse assessment and provision would form a useful extension to the data currently collected through any CAMHS mapping process undertaken by the UK and devolved governments. It will provide an accurate picture of local need, which will inform local and national planning and assessment, and enable individual and joint commissioners to identify an appropriate level of service provision. In addition, it can be aggregated into regional and national information and reporting systems, thereby enhancing the quality and detail of information currently available.

6. We recommend that where a child is successfully referred by local authority children’s services, a health and care trust in Northern Ireland or CAMHS for a specialist sexual abuse service, the case must be allocated to a social worker or lead

health professional, depending on the referring agency, and remain “active” until such time as work with the child or young person is complete.

The research identified a number of aspects (both positive and negative) around collaborative working. Of particular concern was the common practice by referring agencies of “closing the case” once a child or young person had been referred to, and accepted by, a sexual abuse service. The research went on to identify significant problems at very crucial stages of service delivery because of the failure of commissioners and other providers (children’s services and CAMHS in particular) to maintain their engagement with the child or young person.

7. We recommend that consideration is given to the issuing, or reviewing, of joint guidance concerning the commissioning of services for children and young people who have experienced sexual abuse. This guidance should:

- a. locate accountability for the commissioning of such services with the relevant partnerships or statutory agency**
- b. recommend a minimum commissioning period.**

A recurrent theme emerging from our research was the issue of short-term commissioning (frequently referred to as “funding”) particularly in secondary or tertiary services. The research also revealed the complex and insecure nature of funding arrangements, with services supported by a number of different income streams from a number of diverse sources. Finally, the research highlighted the lack of a clearly accountable body for the commissioning of such services. This complexity and uncertainty was a particular concern for small specialist providers, who were less likely to have the requisite business management skills and capacity.

Joint commissioning bodies provide an ideal framework for simplifying the commissioning of such services. However, the process of commissioning must be founded on an understanding of the complex and often long-term nature of therapeutic support services. Providers must be enabled to give a sustained and reflective service, which allows them to develop their practice, provide informed feedback for research and evaluation purposes, and to provide long-term therapeutic support where appropriate. This will require commissioners to consider how commissioning arrangements might be satisfactorily entered into for significantly longer than the one- to three-year periods cited in the course of this research.

- 8. We recommend that UK government's sexual and domestic violence action plans specifically address the needs of young people to access services. In particular, sexually abused, raped and sexually exploited young people should be able to access confidential advice and support, and to self-refer to specialist services.**

The *Cross Government Action Plan on Sexual Violence and Abuse* (2007) brought together the measures that were underway and in planning stages to a) maximise prevention of sexual violence and abuse; b) increase access to support and health services for victims of sexual violence and abuse; and c) improve the criminal justice response to sexual violence and abuse. One purpose of this plan was to identify gaps in existing work that required further consideration. In particular, the plan should consider the needs of children and young people in light of the gaps in provision revealed in this piece of research. Rolling out and evaluating sexual assault referral centres (SARCs) for children's services would be particularly welcome in this context.

- 9. We recommend that governments across the UK ensure that their budgeting process enables sustainable funding to be prioritised for the provision of services to children and young people who have experienced abuse, including sexual abuse. This should be accompanied by outcome indicators to ensure delivery locally.**

Local partners must be in no doubt about the importance that governments across the UK place on the provision of services to abused and sexually abused children and young people. The simplest and most immediate way of achieving this is by ensuring the inclusion of appropriately focused performance indicators.

The lack of an appropriate performance indicator to drive the quality and quantity of services for children and young people who have experienced abuse, including sexual abuse, was reinforced by the findings of the research, which revealed the relatively low priority given to sexual abuse. The absence of clear levers for sexually abused children, (indeed children who have experienced any form of abuse) was notable.

- 10. We recommend that plans related to the development of the children's workforce in each part of the UK explicitly consider how to increase capacity in this sector of the workforce.**

The research revealed a need for higher staffing levels and a more diverse skills-mix, if any impact on waiting lists is to be made. This would also provide for expansion in

provision to otherwise hard-to-reach groups of children, for example those with particular needs or living in rural areas.

11. We recommend that the UK government and the devolved administrations work together to commission research into the effectiveness of a range of therapeutic interventions in respect of sexual abuse, with the objective of expanding the existing evidence on what works.

The research highlighted the need for more information on the range and effectiveness of different types of therapeutic support for children and young people who have experienced sexual abuse. The intervention with the most robust evidence is cognitive behavioural therapy (CBT). However, while there is some evidence that CBT-based treatments can improve mental health outcomes for sexually abused children with post-traumatic stress disorder (PTSD), anxiety or depression, there is conflicting evidence on its effectiveness in reducing child behavioural problems (Macmillan et al, 2008).

This leads us to question why at times very limited evidence appears to justify the use of particular types of therapeutic support. It points to the need to improve and expand our knowledge of a wider range of therapeutic support models, particularly taking into account young people's own views about the services they receive and the support they would like to have.

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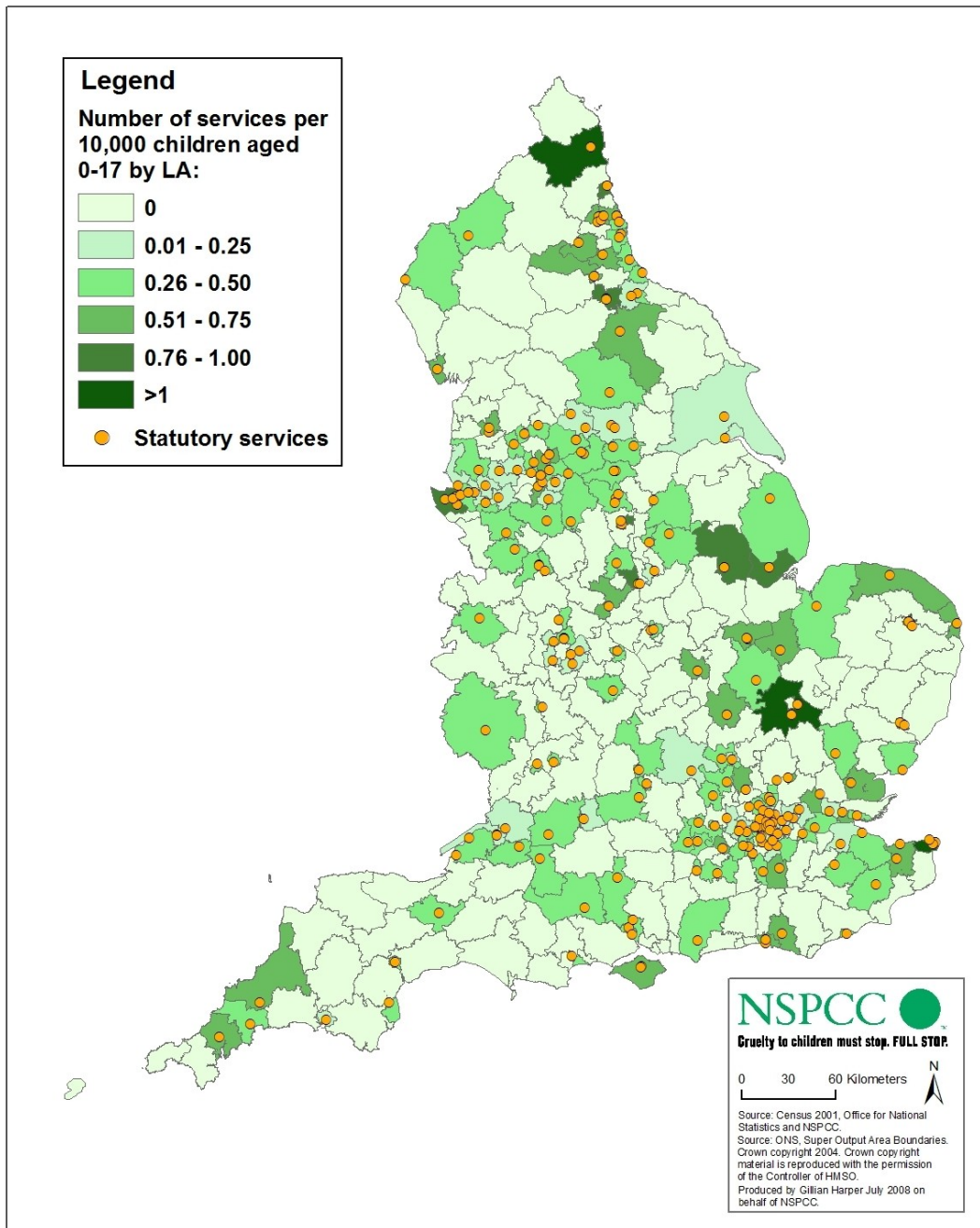
Appendix 1: Individual maps – England, London, Wales, Northern Ireland and Scotland

Taking maps 4 and 5 together, there was a troubling lack of statutory, voluntary or private services across all regions in England. In particular, large parts of Northumberland, Cumbria, Durham, North Yorkshire, Lincolnshire, Lancashire, Norfolk, Suffolk, Somerset, Dorset, Devon and Cornwall, Warwickshire, Worcestershire and Leicestershire were without any services for children and young people who had experienced sexual abuse. Areas without any services available were matched with rural classifications produced by the Department for Environment, Food and Rural Affairs³⁵. A large proportion of these areas in England were found to be rural, and indeed, analysis of the maps showing the number of services per 10,000 children aged 0–17 alongside data indicating numbers of children per local authority confirmed these areas had the lowest population of children and young people aged 0–17.

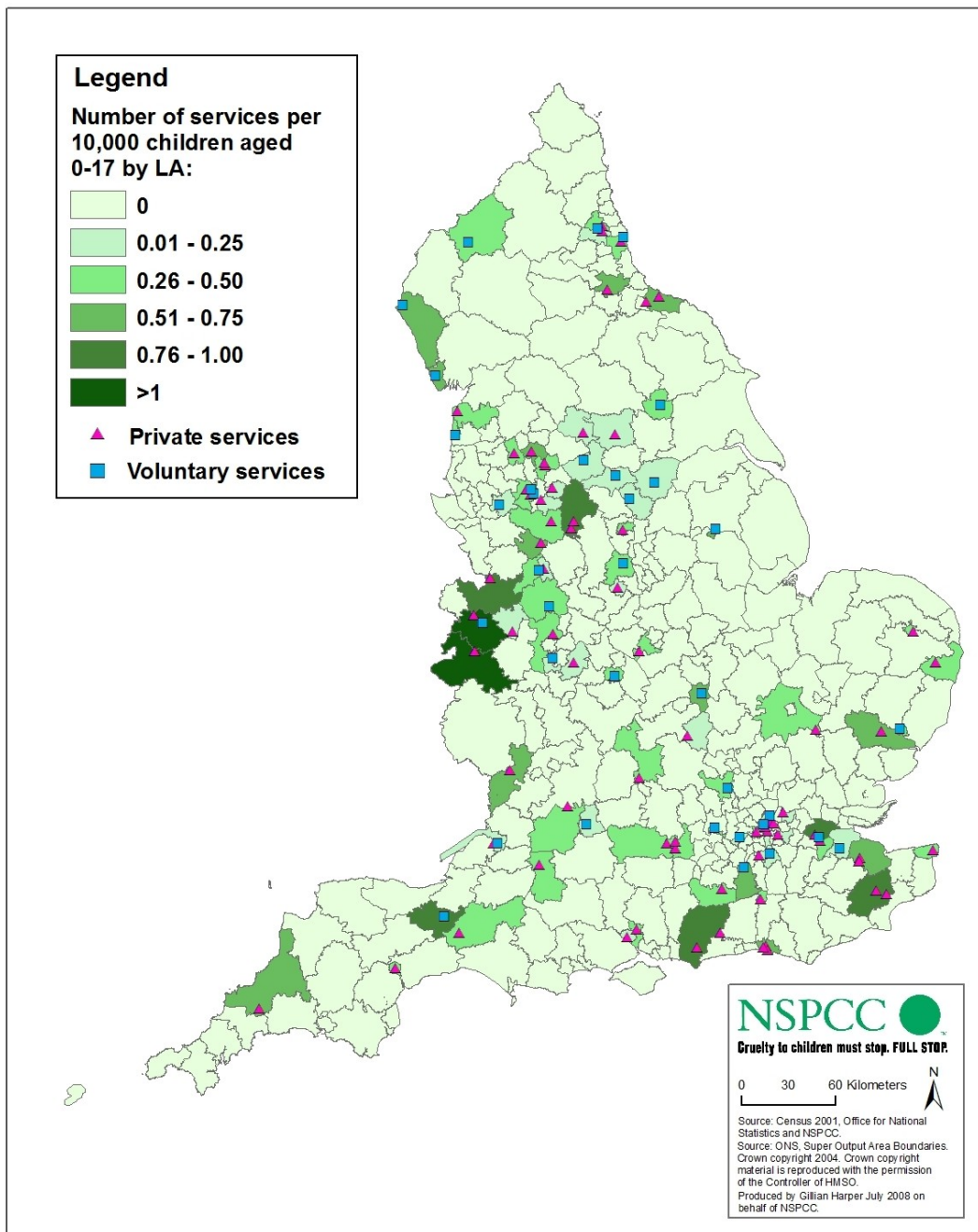
However, even in areas where there were therapeutic services, the proportion of services per 10,000 children aged 0–17 was very low. There were very few local authorities across England that had a sufficient number of services for children and young people who had experienced sexual abuse. Only two local authorities in England had more than one statutory service operating for that number of children and young people, and only one local authority with more than one voluntary service. For the majority of local authorities that did have services located in their boundaries, there was less than three-quarters of a service for every 10,000 children.

³⁵ www.defra.gov.uk/rural/ruralstats/rural_focus/rural_focus_la.htm#northeast

Map 4 Location of statutory therapeutic services by number of services per 10,000 children aged 0–17, by local authority in England

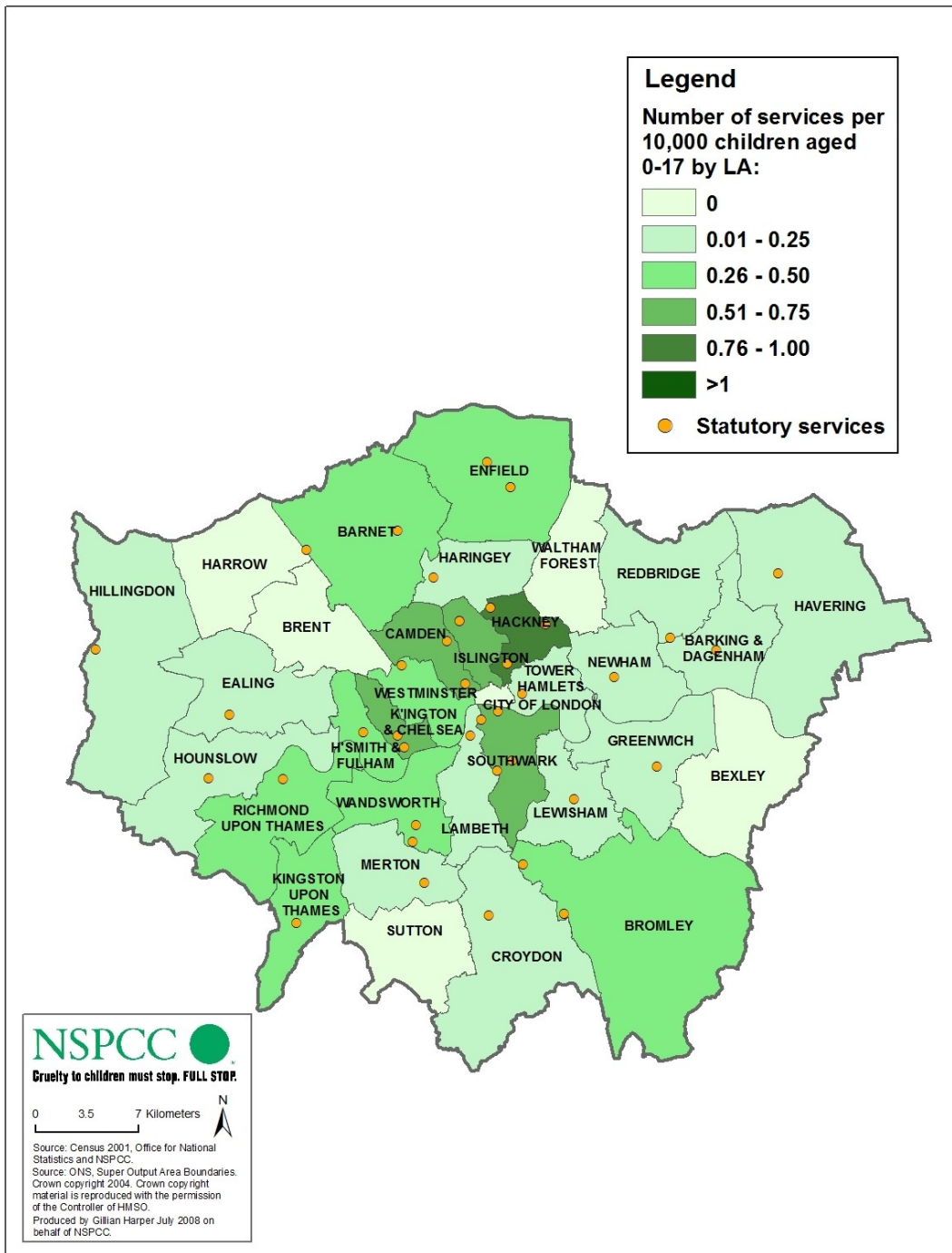


Map 5 Location of voluntary and private therapeutic services by number of services per 10,000 children aged 0–17 by local authority in England

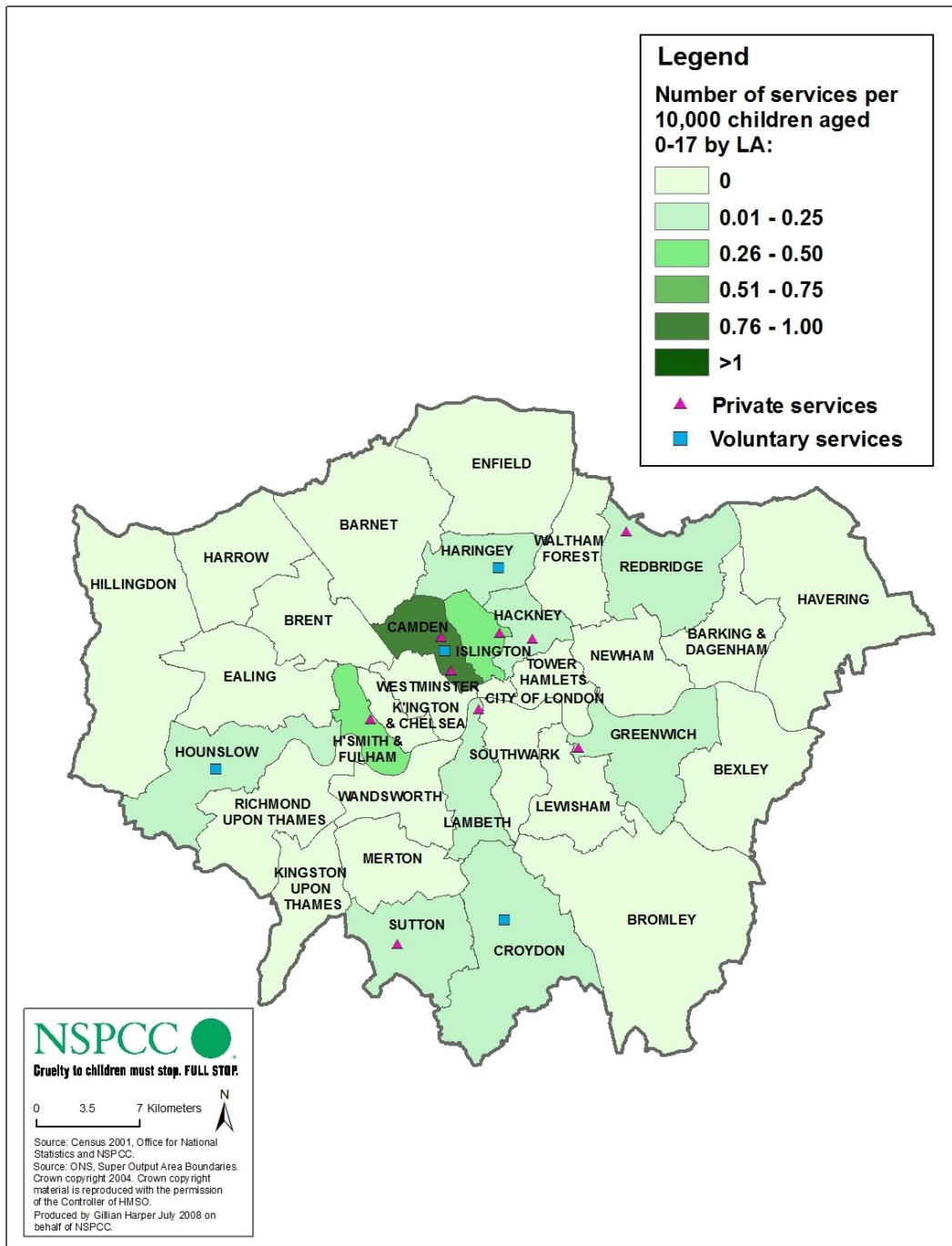


Maps 6 and 7 show the distribution of statutory, voluntary and private services across London. The majority of boroughs in London had a service located within their boundary, although the number of services per 10,000 children aged 0–17 was low in all but the Camden borough. Only four boroughs (Waltham Forest, Bexley, Bromley and Brent) did not have any therapeutic services for children and young people who had experienced sexual abuse located within their boundaries.

Map 6 Location of statutory therapeutic services by number of services per 10,000 children aged 0–17 by local authority in London

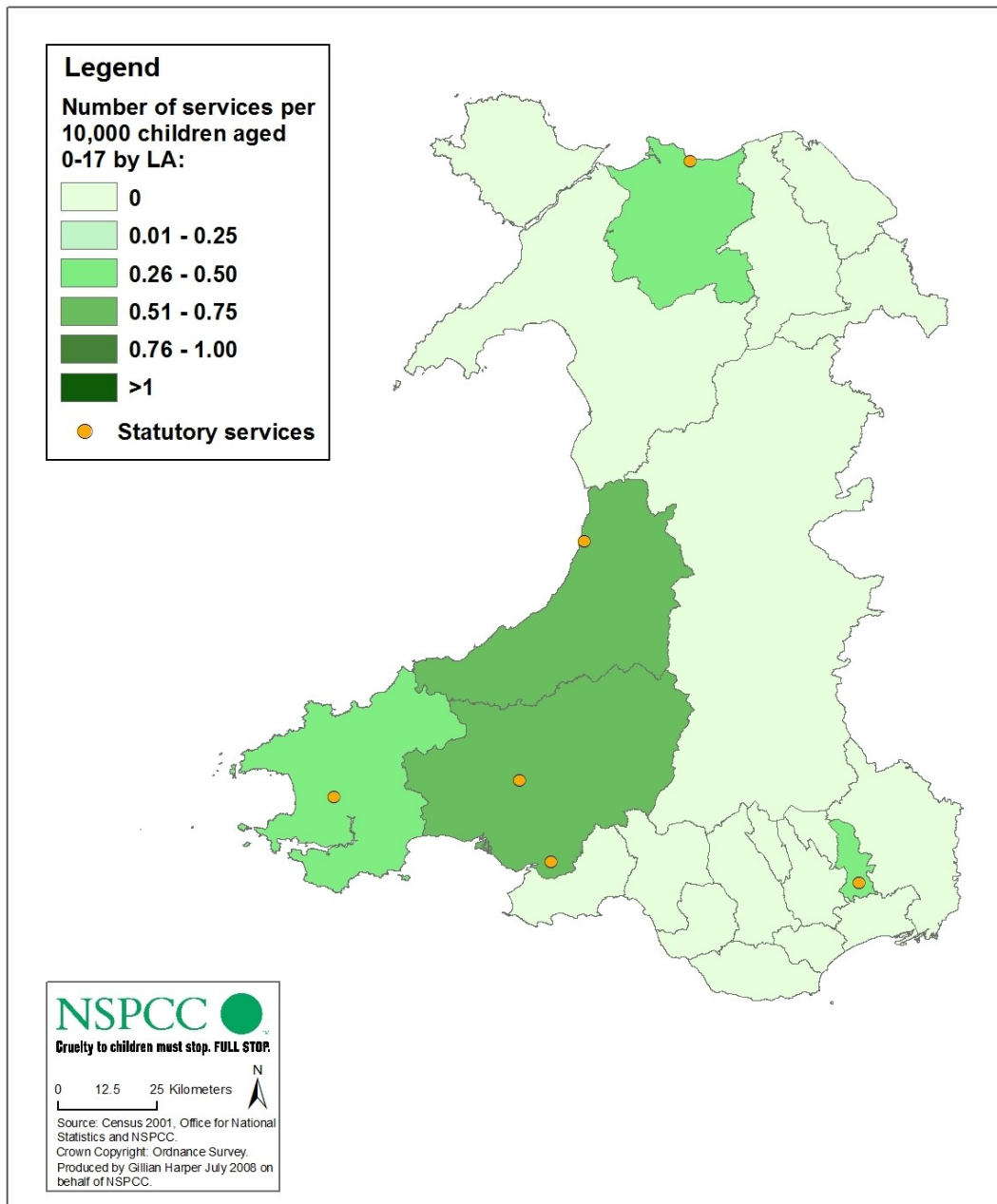


Map 7 Location of private and voluntary therapeutic services by number of services per 10,000 children aged 0–17 by local authority in London

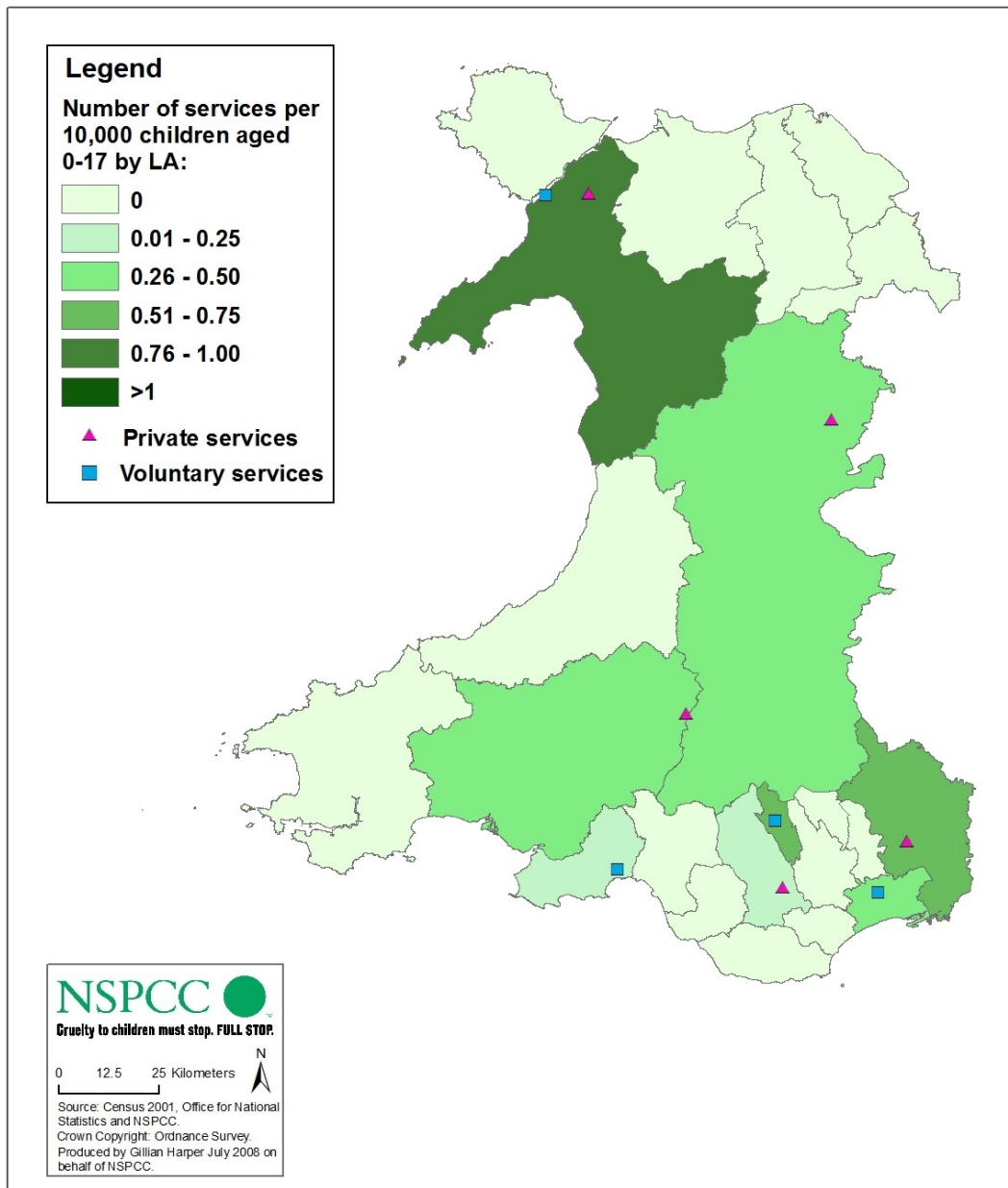


Maps 8 and 9 represent the distribution of services we were able to identify across Wales. As discussed in chapter 2, the identification of services, particularly CAMH services, in Wales was not an easy task.

Map 8 Location of statutory therapeutic services by number of services per 10,000 children aged 0–17 by local authority in Wales



Map 9 Location of voluntary and private therapeutic services by number of services per 10,000 children aged 0–17 by local authority in Wales

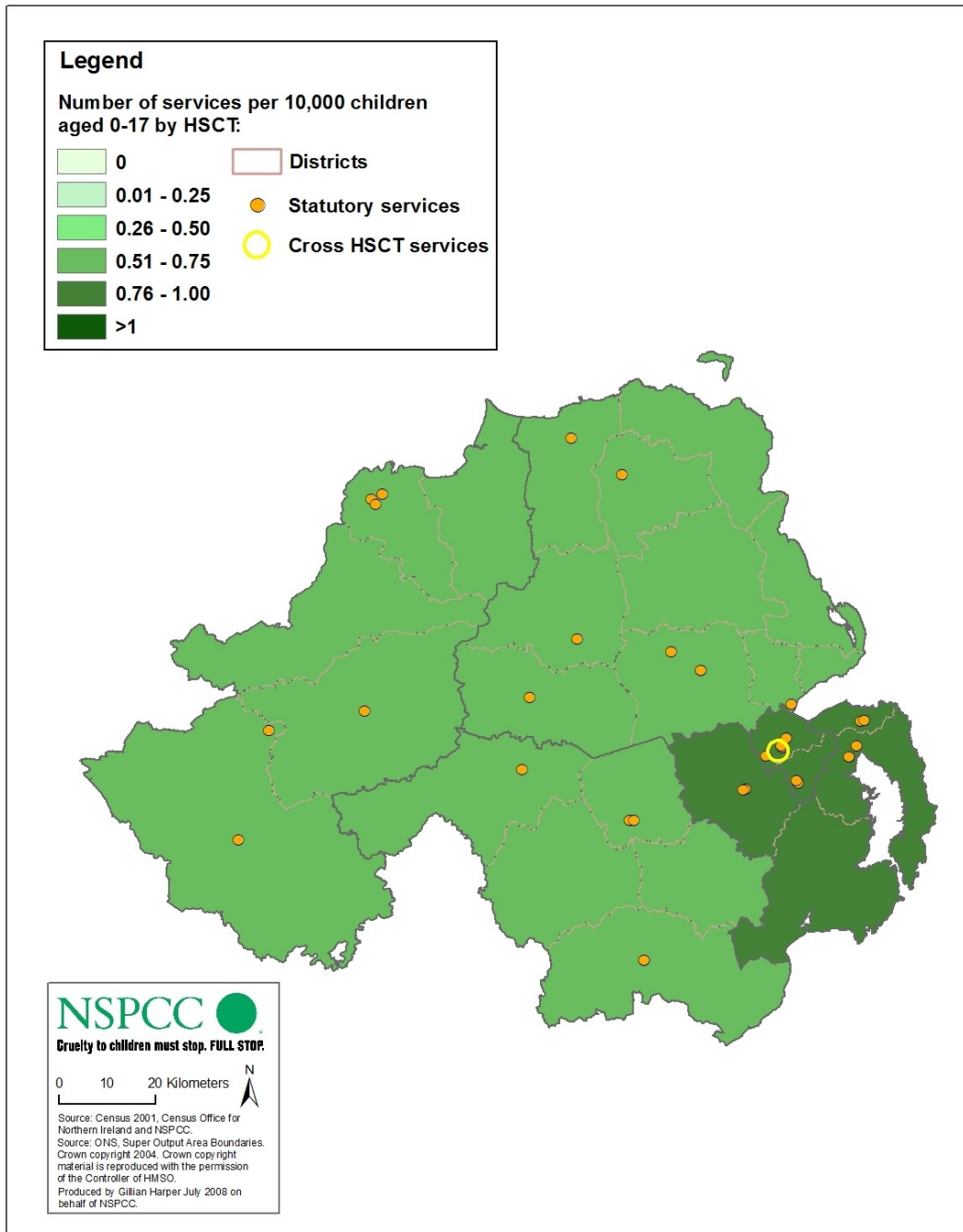


Northern Ireland differed from other health structures in the UK in that it had an integrated health and social care system, as described earlier in this report. Services were organised by trusts rather than local councils, and for this reason, the maps for Northern Ireland (maps 10 and 11) have been created to reflect this service organisation.

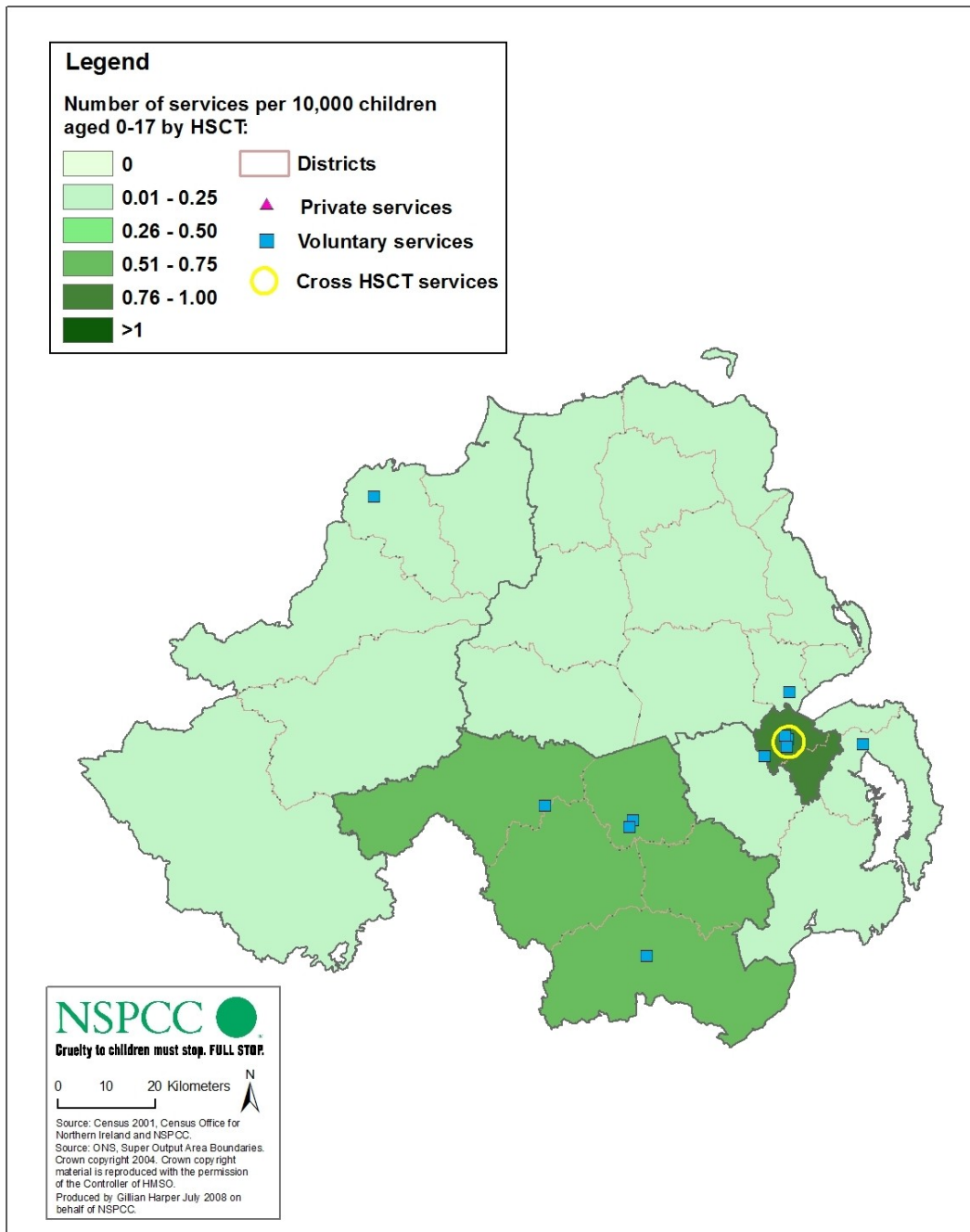
Statutory service provision across Northern Ireland was more comprehensive than that of voluntary service provision. Voluntary provision was concentrated in the south part of Northern Ireland, with only one voluntary service identified in Derry. Six councils were lacking in therapeutic provision (either statutory or voluntary) for children and young people

who had experienced sexual abuse: Strabane, Limavady, Moyle, Ballymena, Lame, Banbridge and Armagh. Belfast Council and areas around it had the best service coverage, particularly Castlereagh, Lisburn, North Down and Ards.

Map 10 Location of statutory therapeutic services by number of services per 10,000 children aged 0–17 by HSCT in Northern Ireland



Map 11 Location of voluntary sector therapeutic services by number of services per 10,000 children aged 0–17 by HSCT in Northern Ireland



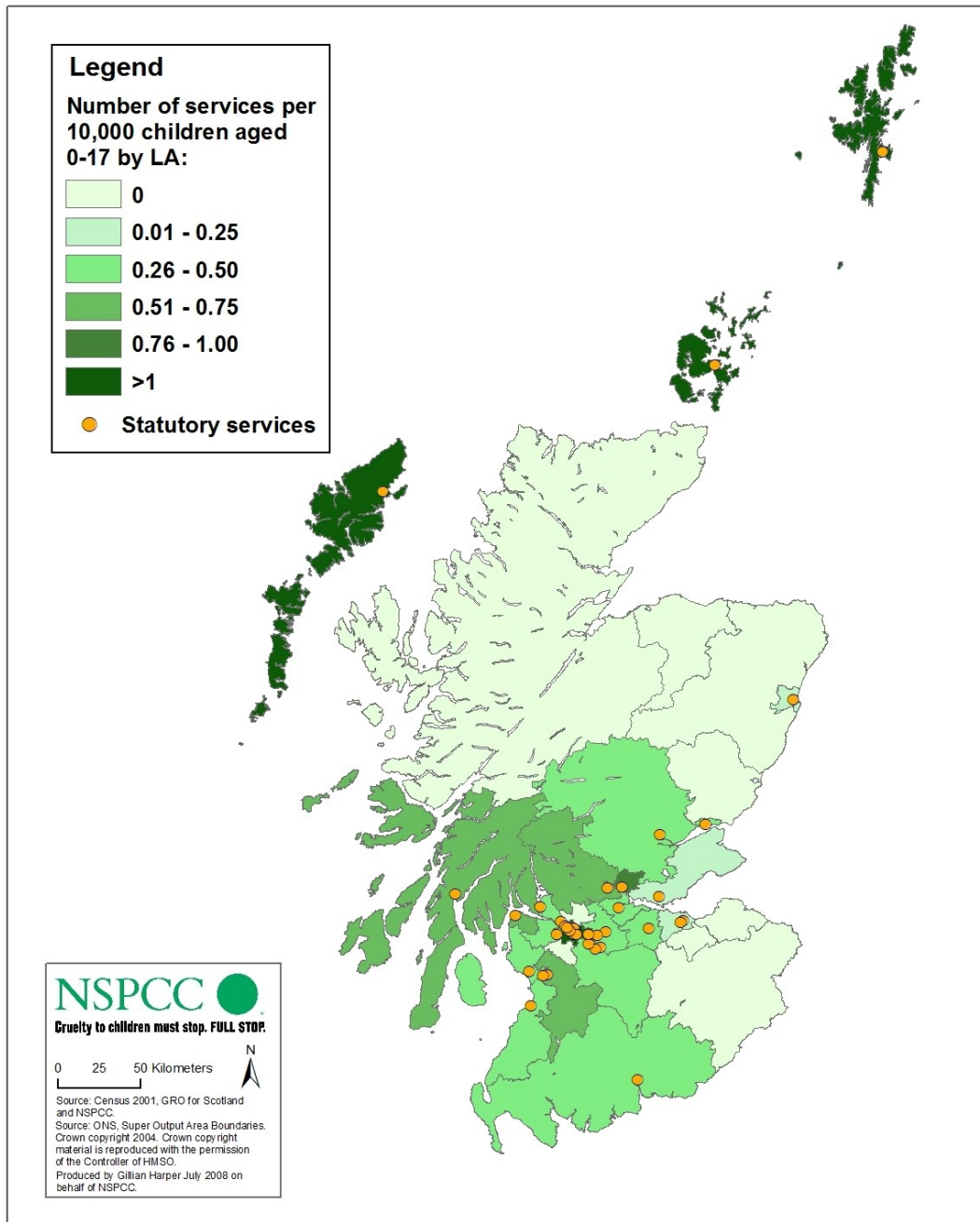
Most of the Scottish authorities had some level of service coverage through statutory or voluntary provision, as shown in maps 12 and 13. There had been no private services identified for Scotland. Glasgow City had the best service coverage in Scotland, with more than one statutory service per 10,000 children aged 0–17, and between one-half and three-quarters of a voluntary service per 10,000 children. Edinburgh was slightly less well covered by statutory or voluntary services as Glasgow, with less than one statutory service and less

than one voluntary service per 10,000 children. The only authorities without a statutory, voluntary or private service were East Lothian, Midlothian and South Lanarkshire. However, their close proximity to Edinburgh may have meant that children and young people from these areas were likely to be referred to services there. Similarly, children and young people living in and around Argyll and Butte, Inverclyde, North Ayrshire and South Ayrshire, where services were low in number, may have been referred to existing services in Glasgow.

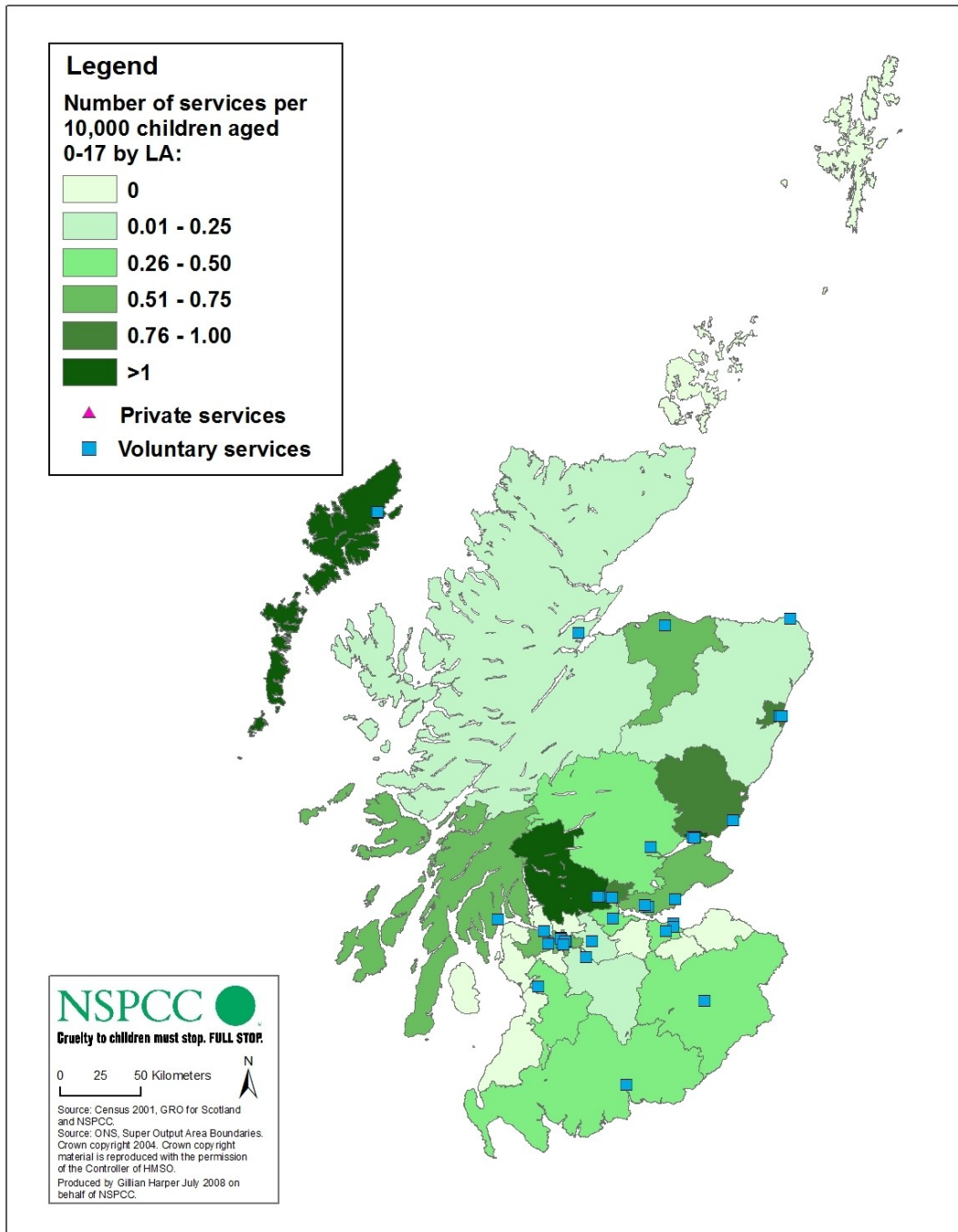
Rural areas in particular had a dearth of services. For example, in the Highlands and Aberdeenshire, there was less than a quarter of a service per 10,000 children aged 0–17. However, the city of Aberdeen had approximately one service (with coverage by both a statutory and voluntary service) per 10,000 children. Fife had low coverage by the statutory sector (less than a quarter of a service) per 10,000 children, but slightly better provision by the voluntary sector (between half and three-quarters of a service per 10,000 children).

Surprisingly, the Hebrides, Orkney and Shetland Islands had good service coverage relative to other rural areas in Scotland. For example, the Hebrides Islands had both statutory and voluntary provision, equalling two services for every 10,000 children aged 0–17. The Orkney and Shetland Islands had only statutory provision; nevertheless there was one service per 10,000 children.

Map 12 Location of statutory therapeutic services by number of services per 10,000 children aged 0–17 by local authority in Scotland



Map 13 Location of voluntary sector services by number of services per 10,000 children aged 0–17 by local authority in Scotland



Appendix 2: Referral data

Table 15 Total number of children and young people accepted after referral and their characteristics (age, gender), in the financial year 2006/07 in the United Kingdom

	Total number of referrals (n=127) ^a	Total number male (n=110)	Total number female (n=111)	Total number up to age 9 (n=102)	Total number aged 10–15 (n=101)	Total number aged 16 and 17 (n=102)
Mean	32	10	23	6	17	6
Median	20	5	10	2	10	2
Minimum	0	0	0	0	0	0
Maximum	190	82	216	53	120	42
S.D.^b	34.3	13.2	33.2	9.8	21.4	8.7

^a (n=127) refers to the number of services that provided data on this particular question; the same interpretation should be applied to the numbers reported in the top row underneath the column names.

^bS.D. = standard deviation

Table 16 Total number of children and young people accepted after referral by primary reason for referral in the financial year 2006/07 in the United Kingdom

	Total number for sexual abuse (n=115) ^a	Total number for other types of abuse (n=110)	Total number for SHB (n=109)
Mean	21	7	4
Median	9	0	0
Minimum	0	0	0
Maximum	190	71	86
S.D.^b	30.5	14.3	12.4

^a (n=115) refers to the number of services that provided data on this particular question; the same interpretation should be applied to the numbers reported in the top row underneath the column names

^b S.D. = standard deviation

Table 17 Ethnic backgrounds of children and young people who have experienced sexual abuse and were accepted after referral in the financial year 2006/07

	Mean	Minimum	Maximum	S.D. ^b
Total number of referrals (n=87)	34	0	190	36.9
Total number of White British (n=77)	28	0	118	30.5
Total number of White Irish (n=76)	1.1	0	50	6.0
Total number of "other" White background (n=78)	1.0	0	15	2.6
Total number of Mixed ethnic heritage (n=77)	1.6	0	35	4.7
Total number of Asian or Asian British (n=77)	1.2	0	22	4.1
Total number of Black or Black British (n=78)	1.1	0	35	4.1
Total number of Chinese or other ethnic group (n=78)	0.6	0	10	1.7
Total number of children and young people with a disability (n=74) ^a	1.9	0	22	4.1

^a The data on disability was limited; "disability" was not defined within the questionnaire, so it was uncertain what kinds of disability were being referred to.

^b S.D. = standard deviation

Appendix 3: Focus group vignettes

Dan's story

“My mum and I got really close when Dad left four years ago. I was only 10 then but I knew that my mum needed me and I know I needed her as I missed Dad a lot. I don't see him very much and since Toe Rag Tom (TT) has moved in I don't see him at all. My mother's partner, as I am supposed to call him, was all right at first. It was great to see Mum laugh again and begin to go out more and have fun.

“Then TT starts wanting to have man to man talks with me as he tells Mum that I have missed having a man around the house. It's not long before he's talking to me about sex, to complete my education, as he says. He wants me to tell him about when I feel 'horny' and if I have started to masturbate yet. I don't say anything but that doesn't stop him.

“The last time we had one of his talks he tells me not to be anxious like a lot of teenage boys about the size of my penis. Then, you won't believe this; he takes his out to show me. 'This is about the usual size' he says and adds 'you can touch it if you like'. I refused and he called me a prude and says it's the manly thing to do and that I will know this when I grow up a bit more. How do I tell my mum about this? She is so happy at the moment. Who would she believe?”

Beth's story

“I'm 17 and I think I'm pregnant. 'Stupid bitch' is what my mother will think if I have to tell her. Maybe everyone else will think that too, especially as my dad has been really strict and I've not been allowed out much or to have a boyfriend. So who's the father? My father, who else could it be. I can't tell you when it started. He has always loved me in that way. Special cuddles, kisses and secrets, that's how I grew up and I did love him didn't I?

“At least my little sister was safe if he was doing it to me. He taught me how to give him 'shivers' and how to clean him up afterwards. I don't want to think about it. When I was 16 he wanted to go all the way and what he wanted he got, didn't he. Now I'm pregnant he ignores me. But I see that he is starting with my sister. I thought as she goes to special school

he might leave her alone. I shouldn't have been so dumb. I need to say something to someone but then I'm just being stupid, aren't I, because who would believe me, my dad's a policeman."

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