Transforming services for children and young people who have experienced sexual abuse

Executive Summary

A Department of Health and Social Care (England) commissioned pilot

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The Tavistock and Portman NHS
NHS Foundation Trust

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Introduction

The Department of Health and Social Care (DHSC) commissioned a programme of work to explore how a more supportive, joined-up service could be provided to children and young people who have been sexually abused. Three areas were selected by DHSC to develop and test new approaches for commissioning and providing services for these children and young people: North Central London, Rotherham and Birmingham. Although there was no single prescribed model, the projects were expected to develop and test a case-holding model. This would be based on an assessment of local needs, reflecting input from local key agencies, stakeholders, children, young people and their families, the Clinical Commissioning Group (CCG) and Local Authority, including public health, social care and children's services and aiming for earlier intervention.

During the course of the project, much of the focus was on the 'case-holding' model, whereby a practitioner (often not a 'clinician') would lead on being a consistent, key trusted adult, supporting the child or young person, co-ordinating services as a way of easing navigation through the complex network of support services available. This report sets out the different approaches to case-holding and describes the journey of each of the three areas and what they have achieved along the way.

There is increasing recognition of the extent to which children and young people are affected by child sexual abuse and exploitation – both in terms of its prevalence and the degree of harm inflicted on individual children and young people, families and communities as a consequence. Given the often hidden nature of the problem, assessing the true scale of the problem remains an imprecise science. However, the high profile cases of child sexual abuse (CSA) and recent cases of organised child sexual exploitation (CSE, collectively in this report referred to as CSAE) have led to a greater and welcome focus on the need to prevent CSAE and to provide more comprehensive earlier support and intervention for those affected.

A number of reports have been written in response in recent years, including the *Tackling Child Sexual Exploitation Progress Report*[1], the *Health Working Group report on Child Sexual Exploitation*[2] and the report of the Children's Commissioner for England[3]. The plan to transform the mental health of children and young people set out in *Future In Mind: Promoting, Protecting and improving our children and young people's mental health and wellbeing*[4] and subsequently in the *Five Year Forward View for Mental Health*[5] also sets out a way for local areas to meet the needs of children and young people with additional vulnerabilities who are in need of emotional and psychological support.

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[1] HM Government, Tackling Child Sexual Exploitation: Progress Report (February 2017).
[2] Health Working Group Report on Child Sexual Exploitation: an independent group chaired by the Department of Health focusing on: improving the outcomes for children by promoting effective engagement of health services and staff (January 2014).
[3] Berelowitz, S. et al (2013). "If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner.
[4] 'Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing'. Department of Health, NHS England (March 2015)
[5] Five Year Forward View for Mental Health: a report from the independent mental health taskforce to the NHS in England, February 2016.

This Executive Summary should be read alongside the main report [insert link] and the slide pack [insert link] which summarises the report and contains advice for those wishing to put in place a case-holder model for children and young people who have experienced CSAE.

The impact of abuse and need for support

CSAE is one of the most significant and damaging experiences that can happen in childhood. Although many children and young people experience other forms of early trauma and adversity, the experience of CSAE is uniquely toxic and debilitating - few other adverse events are kept so concealed and bring with them the stigma and shame that often accompanies it. The spotlight shone in recent years and the high profile of organised and systematic CSE has unintentionally led to less of a focus on familial CSA which remains the more common form of abuse[6] and on the services needed to address it. Agencies often take a different and separate approach to CSA and CSE despite the vulnerability of children and young people to experiencing both kinds of abuse.

Although most research focuses on the psycho-social impacts of sexual abuse, some children and young people also have physical injuries. Many of those interviewed for the Office of the Children's Commissioner's Inquiry[7] experienced physical violence. Between 50 and 80% of children and young people who experience sexual abuse have some symptoms of post- traumatic stress disorder (PTSD), anxiety and depression.[8] For some, their abuse translates into sexualised behaviour and promiscuity, poor self-esteem, withdrawal, anger/aggression and disruptive behaviours.[9]

Sexual violence and abuse can also cause long-lasting harm; chronic CSA perpetrated by a close relative or other trusted acquaintance can have more severe long-term consequences than isolated incidents perpetrated by strangers.[10] One study established that the severity of psychiatric symptoms increased with the number of additional childhood traumas experienced.[11] There is a growing body of evidence that CSA often co-occurs with other adverse childhood experiences (ACEs), including domestic abuse, parental mental ill-health and/or substance misuse, neglect and/or physical abuse[12]. Some studies that have taken into account other adversities found CSA to be a powerful predictor of disordered psychological and behavioural functioning in adulthood[13].

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6 Office of the Children's Commissioner's Inquiry into Child Sexual Abuse in the Family, Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action (2015). Final Report, p3.

7 Children's Commissioner (2012), I thought I was the only one. The only one in the world. The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups. Interim Report

8 Dominguez, et al. (2001) and Finkelhor (1990) cited in Makhija, N.J. The Relationship between Traumagenic Dynamic Responses towards Childhood Sexual Abuse, Ethnic Identity, Social Support, Trauma Severity, and Attitudes towards Interpersonal Relationships in Adolescent Females. (2014). Seton Hall University Dissertations and Theses (ETDs). Paper 1969

9 Dominguez et al., 2001 op cit; Finkelhor, 1990

10 Kendall-Tackett K.A., Williams L.M., Finkelhor D. Impact of sexual abuse on children: a review and synthesis of recent empirical studies. Psychol Bull. 1993;113:164–180; Silk K.R., Lee S., Hill E.M., Lohr N.E. Borderline personality disorder symptoms and severity of sexual abuse. Am J Psychiatry. 1995;152: 1059–1064

11 Fergusson D. M., McLeod G. F. & Horwood L. J. (2013). Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. Child abuse & neglect, 37(9), 664-674

12 Dong M., Anda R F, Dude SR, Giles W H, Felitti VJ (2003), The relationship to exposure to child sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood, Child abuse and neglect, 27(6), 625-639

13 Fergusson et al, op cit.

As well as the potential for a significant impact on mental health, sexual abuse in children and young people may have long term consequences for physical health. When sexual abuse occurs with other ACEs such as domestic violence, or drug or alcohol abuse within the home, it can increase the likelihood of developing significant long-term conditions in adults such as type two diabetes, heart disease and respiratory disease and their associated increases in health services utilisation.[14]

14 Bellis M, Lowey H, Leckenby N, Hughes K, Harrison D. Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. Journal of Public Health Volume 36 Issue 1 (March 2014) pp 81-91

Support and treatment

The need for good local services everywhere for children following sexual abuse and exploitation has been brought into sharp focus by high profile historical inquiries into child sexual abuse and cases of organised CSE, such as in Rotherham[15], Manchester[16] and Oxfordshire.[17] Reviews of these cases have found that children and young people (particularly those from homes where there is the potential for multiple other ACEs), need co-ordinated support to help them to get their lives back on track.

However, it appears that few children and young people obtain timely, evidence-based therapeutic intervention or support following CSAE. This 'treatment gap' was well described by the NSPCC [18] quoting Allnock (2009):

> *Having the courage to speak out after abuse can be the beginning of a long journey, and there is a significant shortfall in therapeutic support for children who have experienced sexual abuse.*

Not all children and young people who have experienced abuse will need intensive psychological support or therapeutic intervention - between 20 and 40% "will show no ill effect later in life".[19] However, the current provision of clinical and non-clinical early support for children and families is far from sufficient. This is despite evidence that early intervention and support could be cost-effective in the long-term.[20]

Future in Mind[21], based on the last UK epidemiological study[22], suggested that less than 25% to 35% of those with a diagnosable mental health condition access support. The chapter on *Care for the most vulnerable* suggests that those children and young people who have experienced CSAE should receive a comprehensive specialist initial assessment and referral to appropriate services providing evidence-based interventions according to their need. It recognised that some children who are suffering from a mental health disorder would benefit from referral to a specialist mental health service[23]. *Future in Mind* led to a national transformation programme with additional investment with each area required to produce a Local Transformation Plan outlining local priorities.

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[15] Jay, A. (2014) Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013)
[16] Coffey, A. (2014) Real Voices. Child sexual exploitation in Greater Manchester An independent report by Ann Coffey, MP.
[17] Blythe, M. (2014) CSE - Making a Difference. The impact of the multi-agency approach to tackling CSE in Oxfordshire
[18] Jütte, S. Bentley, H. Tallis, D. Mayes, J. Jetha, N. O'Hagan, O. Brookes, H. McConnell, N. (2015) How safe are our children? The most comprehensive overview of child protection in the UK, NSPCC
[19] NSPCC Scoping report, prepared by Allnock, D. and Hynes, P. (2013) Therapeutic services for sexually abused children: scoping the evidence base (p5)
[20] Tabachnick, J. (2013) Why prevention? Why now? International Journal of Behavioral Consultation and Therapy
[21] 'Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing'. Department of Health, NHS England (March 2015) Chapter 6
[22] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.
[23] Future In Mind, op cit, page 52

The DHSC commission and our approach

These pilots were commissioned by the Department of Health to consider how access to, and the response of, services to children and young people who have experienced CSAE could be improved. Three partners were appointed – North Central London, Rotherham and Birmingham - to explore what is required to:

> *[…] deliver a joined up and transformative service to children and young people who are sexually abused […] the support to be case-managed for every child user. The response is expected to be in a wider context that addresses both the physical, emotional and behavioural needs of children and other issues facing them.*

Simply put, the focus of this programme was to explore how a more supportive and earlier joined-up service could be provided to children and young people who are sexually abused. As the projects progressed, it became clear that a stronger trauma-informed approach was needed in view of the trauma experienced by children and young people. The project team adopted a focus on how best to implement a trauma-informed approach across services; development and clarification of a case-holder model; how sites could sustain their work in the longer term (particularly through embedding their work in future commissioning arrangements), and sharing knowledge to ensure spread of their work.

The Department of Health commissioned the Family Nurse Partnership National Unit with the Tavistock and Portman NHS Foundation Trust to support and lead the work with sites. The project team worked with sites to refine their project ideas, offered clinical and implementation advice, guidance and mutual support across sites and undertook the evaluation reported here. Evaluation of the individual projects was led by Chanon Consulting in partnership with the project team. This included face-to-face or telephone interviews with children and young people and/or parents as well as a number of professionals and representatives of local agencies. Claire Bethel, The Way Ahead Team, contributed to the writing-up of the project

The Department supported each site's project with a small grant, and provided funding to the project team to undertake the national support and evaluative functions. The project proposals focused on children and young people who in the main had experienced child sexual abuse, although Rotherham also had a focus on improving services for children who had been sexually exploited.

The project took place between 1st April 2016 and 31 March 2017 – the findings therefore represent what the project team found and the views that participants put forward during that time. There have inevitably been developments in all three sites since the conclusion of the project; few of these are reflected here.

The approaches in each area represent one way of transforming services for children and young people who have been sexually abused or exploited. It is not necessarily the only way nor indeed necessarily the best way of doing so and we are aware of many other approaches. As the report shows, each area took a different approach that reflects their own specific local needs and priorities and takes account of the views of local stakeholders including service users. The report sets out usefully the processes that the three sites went through, some of the difficulties encountered and

what they have learned which we hope will be useful to other areas in addressing similar issues and in transforming their own services.

Clarifying the case-holder model

One of the questions that needed examination was the potential impact of a case-holder worker trained in the impact of trauma to receive informal feedback from victims and survivors as to how this might work in practice. The aim was to find out whether a case-holder would be able to provide guidance, listen to the child, young person and family and help them to navigate through the system, and reduce the need for more specialist intervention later. This was established early on as central to the project. The need arises from the complexity of services that children, young people and families will have to navigate to secure help at a time of great stress - from immediate post-abuse medical assessment and treatment, to the criminal justice system, psychological assessment, social care assessment, voluntary sector services and others. This is undeniably a highly complex system to navigate at a time of extreme distress and often limited support. Time was spent with the project sites in clarifying their understanding of the role of case-holder in the local context.

When children and young people come to the attention of services as a result of suspected or known sexual abuse or exploitation, they should receive a holistic assessment of their needs, including their experience of other ACEs. Children and young people identified during the lifetime of the project who did not reach the threshold for mental health or social care support services and/or whose family are unable or unwilling to support them, were allocated a case-holder.

The function of this role is to provide earlier intervention and support to help that child or young person navigate/broker their access to other services, to advocate for them, provide support and advice – but primarily their role is to 'walk alongside' the child, young person and their family at a time of great distress, and provide a trusting, consistent relationship. The average time period for this support should be six to nine months in the first instance (though this will need to be flexible) to allow time for the initial phase of recovery. The offer should be flexible in that it can be more or less intensive, measured by the number of sessions and time between sessions for each child, and this can vary over the course of the support depending on the child's needs.

Key lessons

Access to timely and effective support: A relatively small proportion of children, young people or families are receiving early help or support to manage the aftermath of the abuse, or in support of their ongoing challenges. Providing access to appropriate therapeutic and supportive services is a significant and growing challenge for local commissioners and national policy makers. Long waiting times in CAMHS continue to be a challenge with access limited to those with a diagnosable mental illness and no early emotional support.

The difficulties in accessing services are compounded by the following:

- In a majority of cases, significant amounts of time have elapsed between abuse and disclosure (sometimes years),[24]
- Abuse is often disclosed to family members or peers and this results in either support within the family or the child being 'silenced';[25]
- Families may be discharged from services where a protective parent remains present (the 'coping conundrum'); this may lead to the case being stepped-down by Children's Social Care if the perpetrator of abuse no longer has access to the child and the child is deemed to be safe, irrespective of his or her need for ongoing support.

High expectations of CAMHS: given the large numbers of children and young people with emerging mental health difficulties, some of which will be related to trauma and other ACEs, it is unlikely that even with a very high level of investment, specialist services would be able to accept every referral of a child or young person who is experiencing difficulties or who has been subject to trauma. Finding different workable approaches that include the provision of accessible, holistic, high quality and trauma-informed support through a wide range of agencies including universal services remains a challenge for all areas.

Local pressures: One of the challenges for the project was the high level of turbulence locally, particularly in Rotherham as a result of the high level of scrutiny following the various enquiries into their handling of CSE, which led to a sense of stasis. In addition, the fiscal environment in the public sector remains tight with local authorities generally and children's social care in particular[26] seeing continuing pressures on their budgets leading to reductions in services and a degree of instability for many services, however innovative.

Cost of case-holding: At least one area (Birmingham) found the case-holder model implemented there to be resource-intensive (with each member of the family being offered support individually and having lower caseloads than the equivalent statutory services) which means that it might not be considered a cost-effective option in the long run. This meant that in some project areas, there was pressure to close cases based on factors other than the needs of the child or young person and family.

Information systems: Further thought needs to be given to the fact that different agencies use different IT systems so that, even where services are co-located (eg: within the Hub in London), different and incompatible systems are used, making it more difficult to share information and leading to duplication of effort by staff. . One way of overcoming this would be through the use of a shared care record with clear information sharing agreements in place.

Transition: Some of the VCS organisations provide services up to the age of 25. However, some concern was expressed about the lack of therapeutic support for young people transitioning out of

[24] Allnock, D. and Miller, P. (2013) No one noticed, no one heard: a study of disclosures of childhood abuse, NSPCC

[25] Allnock, D and Miller, P. op cit

[26] Department for Education (201f) Children's services: spending and delivery research report by Aldaba and the Early Intervention Foundation

children's services at the age of 18 which will need to be addressed so that survivors can have confidence that support will continue.

Cost of accessing services: For some families, particularly those outside London, the cost of attending services such as a parent support group was high and limited their ability to help their child do the things that made a difference to them. This should be taken into account and innovative approaches such as online or videoconferencing support considered.

Engaging families: As this project has found, the benefits of engaging children, young people, families and professionals in local service development cannot be overstated. However, in an area as sensitive as CSAE, this can be both time-consuming and challenging, and requires expert input – care needs to be taken to avoid retraumatising those who have experienced CSAE.

Service user evaluation

From the outset, in line with Article 12 of the UN Convention on the Rights of the Child, all of the projects sought and articulated the voices of children and young people as well as family members. Parents and children whose views were sought described clearly the impact that sexual abuse and exploitation had had on them and their family, the consequences on their mental health and wellbeing, and the services that they required. They contributed useful ideas on how services could be delivered.

The service user evaluation aimed to achieve in-depth engagement with a small number of children, parents and professionals rather than gathering more superficial information from a larger group. This recognises the sensitivity of the subject matter and the emotional cost to the children and their parents who generously agreed to talk to us about their experiences. The feedback provided is set out in detail in the main report. The views expressed helped to shape the services developed locally.

The children and young people interviewed verified that case-holding is worthwhile, ideally wanting to see the trusted adult once a week – and that having this consistent relationship was key. They outlined their appreciation for help with making decisions, listening to their feelings, and liaising or advocating with their parent or teachers on their behalf. They identified what works for them, but overall they told us that they value expert support from outside the family, telling their story only once, and having a consistent, trusting relationship with one person over their support journey.

The parents told us that they valued practical support, consistency, co-located support for them and their child, and activities that aren't focused on abuse but on recovery. However, for some, financial hardship – including the travel costs of attending services such as the parent support group - had an impact on their ability to help their child do the things that made a difference to them.

Project evaluation – Birmingham

The project in Birmingham, led by Forward Thinking Birmingham (FTB), the new mental health partnership responsible for providing services to 0-25 year olds across the city, focused on:

- testing the feasibility of providing a case-holder service for children who are referred to children's social care, including where the case may be stepped down;
- seeking the views of children and young people for a case-holding service;
- building capacity in the workforce to identify and respond to abuse and exploitation through trauma-informed training, and
- developing a library of resources for practitioners and parents/carers to enable early identification of CSAE.

The context and project approach

FTB worked with the three Voluntary and Community Services (VCS) organisations commissioned to deliver services to children and their families who have experienced abuse: Barnardo's Amazon Project, RSVP (the Rape and Sexual Violence Project) and The Children's Society.

The project was set up at a time of significant turbulence and challenges in the city that affected the ability of agencies to deliver a consistent, joined-up service to children and young people who have experienced CSAE. Some of the difficulties highlighted included:

- children not being identified as having experienced sexual abuse, or identification taking a long time which made them less of a priority than cases that had just come to light;
- cases being prioritised on the basis of risk of further sexual harm, which meant that those who were no longer at risk were not regarded as a priority;
- existing services being oversubscribed;
- long waiting list to access CAMHS though this improved because of the new service, called 'Pause', which offers Early Help and is part of the Forward Thinking Birmingham 0-25 service, providing a drop-in mental health service where children and young people can access advice, information and support.

The aim of the case-holder in Birmingham was seen as assisting the child and their family to navigate through the system to get the services needed at the right time and appropriate level of intensity. This was not the case prior to the project when a social worker would be allocated only to those whose needs met statutory thresholds. Part of the project involved consultation with service users on what kind of support they wanted following CSAE and the outcomes were used to help plan the approach of the project.

What the project achieved:

15 families were offered the case-holding service – half of these accepted. The service was found to go some way to address the gap in care for all levels of need, to taking a more holistic view and to improving both the experience and outcomes for the child and family.

Resources and training, comprising a suite of materials including a set of 20 short training films for professionals and parents, have been commissioned to promote early identification of CSAE. The aim was to prepare professionals working in universal services (and eventually parents) with a sufficient level of skill and confidence to support children and young people who have been sexually abused. By the end of the project, 819 professionals had been trained in early identification as a result – including how and where to make a referral and in providing a trauma-informed response. There is now, therefore, a critical mass of people in the city who are able to identify and support children and young people who have experienced CSAE. A website is under development that will provide a single portal to access CSAE services across the city.

Through the Local Transformation Board delivering the Future in Mind priorities, FTB have procured a CSAE support service through Barnardos and RSVP to provide specialist skills, training and development support to the integrated workforce delivering core mental health & social care services. This also includes consultation, case review, sign posting and Advice & Guidance in support of improving skills and knowledge around CSAE in core services. This has helped to re-balance services in favour of CSA and there is greater recognition that CSE can be revictimisation following childhood CSA. There is a clearer, more child-centred way of working driven by the needs of the child and a renewed focus on all sources of trauma, rather than just ensuring short term safety.

Much closer collaboration between the VCS and commissioners now exists as a result of the work done jointly across the voluntary organisations, the commissioners and other agencies involved. The commissioners were members of the project partnership and this was intended to ensure that there was full support for the project and that the learning would be shared effectively. One legacy of the project has been that the learning and collaborative working between the agencies are expected to continue beyond the project as the services are recommissioned.

The project also helped to accelerate the process of breaking down barriers between providers, since each organisation fulfilled a different but interdependent role and all were involved in delivering the objectives specified in the project. The sexual abuse and exploitation provider services are being recommissioned, led by Birmingham Children's Trust who are now responsible for the provision of local authority children's social work services, during 2018/19 and will begin delivery in April 2019.

Project evaluation – North Central London

The project focused on enhancing the existing CSA medical clinic by creating a holistic team assessment with doctor, advocate and/or CAMHS practitioner. This initial assessment was followed by short-term support from the case-holder (advocate or CAMHS practitioner) to provide early emotional support, navigation into local services and liaison with wider multi-agency network.
The new approach has enabled early intervention and support to be offered, including a multi-disciplinary team meeting before the clinic which looks at all the current and referred cases and agrees an action plan for each.

The context and project approach

The approach in London has been embedded within a wider and longer-term programme of work funded by the London Mayor and NHS England (London) to improve the CSA pathway. The London project team were engaged in this work before the DHSC-funded project was initiated, had a pre-existing project management infrastructure in place, developed relationships across the complex systems, had carried out a comprehensive needs assessment on children and young people who have experienced sexual violence[27], and had undertaken other improvement projects, including a review of the pathway following sexual assault, the Goddard Review.[28] A description of the London model is described in more detail in the CSA Hub Toolkit. [29]

Up to 1000 children and young people in London attend for a CSA medical examination each year, including approximately 400 for a forensic medical examination following an acute sexual assault and approximately 600 for a medical examination with a local community paediatrician[30]. This number is thought to represent less than 5% of the children and young people living in London who have experienced contact sexual assault and suggests a significant unmet need. Based on the NSPCC study[31], it is thought that around 12,500 children aged 11 to 17 years in London have experienced contact sexual abuse during the past year. However, during 2013/14, it is estimated that less than 4,000 children and young people reported to the authorities or statutory services. 2,485 under 16 year olds are known to have reported their sexual assault to the Metropolitan police[32] and practitioners reported that young people frequently present at sexual health clinics or Emergency Departments after sexual assault.

In London, the Havens provide a single Sexual Assault Referral Centre (SARC) service for the whole city with a presence on three sites. One of the sites has been specifically designed around the needs of Children and Young People and offers a tailored SARC service to children and young people following acute sexual assault (ie: within the past seven days) where they can access forensic

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[27] Sexual violence against Children and Young People: the London Sexual Violence Needs Assessment 2016 for MOPAC and NHS England (London); Mayor of London Office for Policing and Crime and NHS England (November 2016)
[28] Goddard, A. Harewood, E. Brenna, L., Review of pathway following sexual assault for children and young people in London (March 2015)
[29] Child Sexual Abuse Hub Toolkit, A practical guide for commissioners and practitioners to establish a CSA Hub, NHS England (March 2017)
[30] Data provided by CSA Transformation Lead, Healthy London Partnership
[31] Radford et al, Child abuse and neglect in the UK today (2010)
[32] Goddard et al, op cit

medical examination, specialist advocacy, mental health and wellbeing support. The Havens are also working with criminal justice partners to pilot new ways of working - such as psychologist-led ABE interviewing. However, CSA more commonly comes to light some time after an assault has taken place, and this is being addressed in London by investment in a 'Child House' pilot. The Child House will provide medical and emotional support to children who are victims of sexual abuse but do not require forensic examination, ie: where the abuse was longer than seven days ago as well as other non-recent cases - a role the Child House will fulfil in partnership with the Havens..[33] The aim is to increase the number of children being identified early and seeking support. The model is also seeking to drive faster timelines for children from reporting to a criminal justice outcome.

The piloting of the Child House model was recommended in the Goddard Review[34], which identified gaps in care provided to children following CSA, and by the Children's Commissioner for England in *Protecting Children from Harm*[35] in 2015. The North Central London CSA Hub is intended to be the first step towards the development of a Child House model. The Hub brings together statutory health and mental health services, VCS services and the early emotional support and case-holding elements commissioned through this project. It was part-launched in July 2016, just as this project was getting under way, and fully staffed by November 2016.

The service offered by the Hub includes medical examination and follow-up; support for the ABE interview and advocacy for those engaging with the criminal justice system, and six brief intervention sessions provided by the advocate or CAMHS practitioner to provide the children and protective parent with initial emotional wellbeing and mental health support. It is recognised that longer term therapeutic support will frequently still be required, generally provided more locally and away from the Hub. The majority of referrals are for familial CSA - many more children and young people have been referred since the project opened.

What the project achieved

The London team have put in place early emotional and mental health support from the first clinic appointment and up to six sessions of brief intervention, regardless of whether the child or young person has a diagnosable mental illness.

A case-holding system has been established, led by the Hub team who can make appropriate referrals based on the provision of a support service for children and their families similar to the Team Around the Child model often used to support younger children with complex needs. This has removed the need for children and their families to repeat their story as professionals involved with the child now work together and a multi-agency response is now available.

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[33] The 'Child House' concept originated in the 1980s USA, implemented in 1998 in Iceland followed by other Nordic countries under the name 'Barnahus' or Children's House. In essence it comprises a child-friendly, inter-disciplinary and multi-agency co-located immediate (and in some cases longer term) response to child sexual abuse.

[34] Goddard, A. et al, op cit.

[35] Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action (2015). Final report of the Office of the Children's Commissioner Inquiry into child sexual abuse in the family environment.

There is now follow-up after six months to ensure that the child or young person is receiving appropriate support, and services provided for all children up to the age of 17. Of the 337 children and young people who reported CSAE to the police between July 2016 and February 2017 (ie: a 7 month period), 144 attended the CSA Hub, compared to 141 for the whole of 2015. At the CSA Hub, they were given a full health check, sexual health screening tests and video examination of the ano-genital area, and this was followed by immediate access to emotional and psychological support, advocacy, and family therapy.

The Advocate and CAMHS worker are present for the first appointment which is also attended by the mother, the social worker and the paediatrician. As a result, 82 children have been able to access immediate emotional support from the Hub and a separate referral to CAMHS is no longer required which is more acceptable to families.

The CAMHS clinician has also provided liaison work and case management – this is in line with the recommendation in *Future In Mind* that specialist services should be available to provide a consultation and liaison service for children who are causing concern, advising on what those working directly with the child need to do, rather than to see all of those who need help within specialist CAMHS.[36]

Barriers to accessing both advocacy and CAMHS support have been removed and multi-agency and professional co-operation have improved. An outcome tracker has also been developed with the aim of undertaking further work on evaluation. Children and young people have been 'contained' within family relationships through the provision of help to process the trauma and to improve their resilience, leading to reduced disruption.

The Child House pilot, due to start in 2018, will build on the work of the Hub and will offer longer term therapy including a range of trauma-informed interventions.

[36] Future in Mlnd, op cit, page 53.

Project evaluation – Rotherham

Rotherham has a pre-existing 'trusted adult service' meeting the needs of vulnerable children. This is provided by Barnardo's Reach Out (funded externally to the local safeguarding partnership). The Rotherham project was therefore designed to explore ways of improving multi-agency working, particularly in complex cases of child sexual exploitation, with a view to improving CAMHS access and support; building capacity in the workforce to identify and respond to abuse based on an understanding of attunement/attachment issues for children, and learning the lessons from previous inquiries.

The context and project approach

The project in Rotherham was undertaken in the context of significant challenges following the recent history of CSE including the conviction of several perpetrators and the deficits subsequently uncovered across the system. This led to the Local Authority being placed in special measures. It is therefore unsurprising that CSE has been a major focus for this project and there was little specific focus on familial CSA. There have been many developments since the project's conclusion and recognition that services have improved. The most recent Ofsted report of the re-inspection of children's services concluded that services for children in need of help and protection were now good, and that the local authority has taken a systematic and rigorous approach to improving services since they last inspected in 2014.[37]

An innovative multi-agency and multidisciplinary team ('EVOLVE') has been set up to tackle CSE. The team, which includes social workers, a CSE specialist nurse, a Barnardo's project worker and police officers, is co-located and aims to provide 'wrap around' support and protection to children and families.

CAMHS has been under considerable strain, mainly due to rising demand. This has made it difficult for services to be responsive and flexible as recommended in the Casey Report,[38] particularly as symptoms are not always immediately obvious, making referrals problematic. Some children and young people have been referred to CAMHS who are then not accepted for services, even after lengthy waits. A 'fast track' care pathway has therefore been set up as a key element of this project to build capacity and to provide liaison and consultation as well as specialist case-specific consultations. However, services are provided by a range of local VCS organisations.

Case-holding in Rotherham has been based on a 'Lead Professional' role with a practitioner co-ordinating services for a child or young person. For those who meet the children's social care threshold, an allocated social worker acts as their case-holder. For others who meet the early help threshold, Barnardo's 'Reach Out' service provides a case-holder – there is no limit to how long a service is provided for.

[37] Metropolitan Borough of Rotherham, Re-inspection of services for children in need of help and protection, children looked after and care leavers (29th January 2018), Ofsted
[38] Casey L. CB, Report of Inspection of Rotherham Metropolitan Borough Council (2015).

A clear assessment of need focused on CSE has been undertaken locally and has identified vulnerability in specific communities, such as the Roma community. Staff from all agencies are able to use a free app to record and send intelligence relating to CSE to the police.

As part of the response to the issues raised by the cases of CSE and criminal investigations in Rotherham, an action plan has been developed to address these challenges which specifically supports and has been approved by the Rotherham Local Safeguarding Children and Adults Boards. The key learning points that the Action Plan aims to embed are that:

The response to CSE concerns should be conducted as multi-agency operations using prepare, prevent, protect and pursue methodology rather than Police-led investigations.

All multi-agency operations must have the voice of the child or adult survivor at the core. Operations should encourage a culture of constantly challenging accepted practice and processes to ensure that all multi-agency activity, while remaining compliant with statutory requirements, is innovative, flexible and responds most appropriately to the needs of the child or adult survivor (rigidly following artificial process led boundaries can create significant obstacles to successful outcomes for children and adult survivors).

All agencies need to feel valued and equally important to the operation. This requires strong leadership and a willingness to adapt an individual agencies own practices to the needs of other agencies wherever possible.

Whilst strategic governance is essential, a forum is required that has a function and mandate to implement operational compromises and solutions in a sensible, pragmatic way across agencies to overcome operational difficulties. This could be a meeting initiated under complex abuse procedures, an operational steering group or silver command group.

What the project achieved

To improve the capacity in CAMHS, better links were established between the newly-formed EVOLVE team, social care and CAMHS. A referral route for assessment and further support has been set up that is visible and accessible to allow CAMHS to change the way they deliver services to children who have experienced CSE. A senior CAMHS practitioner specialising in CSE has been commissioned to bridge the gap with the multidisciplinary EVOLVE team. The practitioner carries out initial mental health assessments and brief therapeutic work, and works with other providers, social workers and therapists.

Between August 2016 and March 2017 when the CAMHS practitioner was in post, 55 children and young people were offered a consultation of whom 14 needed direct and ongoing intervention within CAMHS. The other 41 had input from the keyworker and the psychotherapist provided advice where appropriate. The practitioner was able to offer consultation and liaison support into 80 other cases where there were concerns.

As a result of the project, a trauma-informed approach was developed to help individual parents and professionals to understand the child or young person's mental health issues. Some waiting times for specialist services are now shorter and there is better communication and mutual learning across

the system. Some children or young people who may have been referred to CAMHS before may no longer need to be, as their own worker has sufficient expertise and confidence to undertake the work themselves with support where needed.

In recognition of the importance of the intergenerational impact of CSE and the need for professionals to understand attachment theory to enable them to take a trauma-informed approach, a 10 week course was commissioned from the Northern School of Child and Adolescence Psychotherapy. This supported earlier intervention and raised awareness of the importance of relationships throughout a child's development. Practitioners are now more confident in understanding infant development, and young mothers more likely to accept help rather than avoiding social care for fear that their children may be removed.

In response to concerns about the needs and vulnerability to CSE of the Roma community in Rotherham, Operation Scorpio had been set up by the police and the Council. This was a complex police investigation to look at the particular vulnerability of children and young people in the Roma communities in Rotherham, identified through the initial needs assessment. This enabled a formalisation of learning which will feed into future operations and facilitate future decision-making. This has strengthened the integration of the police into the local CSAE partnership.

Operation Scorpio had shown that working with and engaging with communities is key to tacking CSE, that there needs to be more joined-up commissioning of services, particularly health and public health services, that the social care thresholds need to be sufficiently clear and understood across all services and that additional policing tactics are required, particularly to disrupt CSE and gather intelligence. An action plan was developed which had strategic ownership and agreement by the LSCBs.

Key findings

Profile of CSA and CSE:

The project has helped to raise the profile of children and young people who have experienced CSA or CSE in the three areas. Their needs for immediate care and treatment, therapeutic support and system navigation are now better understood, leading to clearer needs assessment and profiling, including the use of service mapping as a planning tool.

The needs of parents need to be considered since good support for parents is vital to the recovery of their children and to boosting resilience in the whole family. This should be reflected in any assessment of needs and provision of services.

CSA and CSE should be considered together rather than having separate care pathways and services. Separation has arisen in response to the higher profile of CSE which has come to public attention recently and lowered the emphasis on CSA despite its higher prevalence. In some areas, CSA is dealt with under regular statutory arrangements led by Children's Social Care whilst separate arrangements have been put in place for CSE. All forms of abuse should be considered in needs assessments and a public health and 'place-based' approach taken to looking at all ACEs by estimating prevalence drawn from the best available data.

Care pathways and services need to recognise the significant overlap between different forms of abuse and the frequency of revictimisation, as well as the concurrence and cumulative impact of multiple ACEs. A greater understanding of the trauma experienced by children and young people is needed as well as a stronger trauma-informed understanding at every level – from practice through to commissioning.

The gap in services

Earlier identification provides an opportunity for intervening earlier - there was evidence that having a case-holder – a reliable, caring, compassionate, trusted adult - able to contain and 'hold' the child or young person - might obviate the need for more intensive, specialist services. Although case-holding can support families, it cannot – indeed should not - replace the therapeutic intervention that may be needed to meet the needs of children suffering from a mental health disorder as a consequence of the trauma experienced.

In all three areas, the lack of specialised services – both statutory and voluntary sector services - able to provide therapeutic support for those who needed it was and remains a limiting factor: timely access to therapeutic intervention – from brief to more intensive interventions - can be critical to a good recovery. Although there may have been some improvements since the conclusion of the project, access to CAMHS remains a significant challenge with tight access criteria and frequent long waits, and many people not receiving any service at all. The projects addressed this through investment in dedicated specialist resources (Rotherham), VCS provision (Birmingham - commissioned through the new

partnership covering 0-25 services) and the offer of six brief intervention sessions in the hub before referral back to local services (London).

To ensure that this is sustainable and to bring about the further improvements in access that the projects identified the need for, all practitioners working in this and related areas and all relevant agencies need to understand trauma and its impact and to be more aware of the impact of trauma on every aspect of children and young people's lives. This needs to be reflected in local planning and commissioning of services and may require additional training to ensure that people working with children and young people are aware of evidence of the impact that ACEs - including CSAE - have on people throughout the life course. This should be reflected in their multi-agency Local Transformation Plans to deliver the Five Year Forward View for Mental Health[39].

Value and limitations of case-holding

Integral to the project was for each site to clarify what case-holding meant for their services and to see how best this could be developed and delivered locally. The sites were given support with this and the learning shared between them.

The children and young people verified that case-holding is beneficial and ideally wanted to see their consistent trusted adult once a week. They appreciated help with making decisions, listening to their feelings and having someone who would liaise or advocate with their parent or teachers on their behalf.

The employment of case-holders meant that children, young people and families no longer had to tell their story repeatedly to different professionals in different agencies. Their priorities are for practical support; having a consistent, trusting relationship with one person during their support journey; co-located support for children and parents, and activities focused on the child's recovery rather than the abuse. The value of case-holding lies in 'holding' or containing a child or family; taking a more rounded ie: holistic view of the services they require, and not stepping away once immediate crises are resolved.

Case-holding needs to be part of a clear pathway covering all services ranging from prevention and early intervention to intensive therapeutic support for those who need it.

Providing earlier trauma-informed case-holder support to children and young people affected by CSAE requires both system and practice change. This change is dependent on effective leadership to make the changes, unblock the barriers and ensure the resourcing, training and partnership work needed to sustain it is in place.

[39] Five Year Forward View for Mental Health: a report from the independent mental health taskforce to the NHS in England, February 2016.

In order to avoid repeat assessments and to ensure that the child and family do not have to repeat their story, clear information sharing protocols between the agencies concerned are required.

There is a need for further design and testing to agree (1) what an early trauma-informed case-holding model comprises and (2) to agree the business case for investment, with further refinement, testing and cost-benefit analysis of different models in order to achieve greater clarity and consistency.

There is a need to listen to, and learn from the voice and experience of children and young people who have experienced CSAE and include their views in developing local responses. The importance of having an earlier and easier response, supported by a consistent trusted adult working from a trauma-informed perspective, cannot be overestimated.

It is important to recognise the needs of the protective parent(s) and the impact on the whole family who may require support.

Commissioning and funding

The project found clear advantages in agencies pooling budgets, rather than having several separate funding streams owned by individual agencies, and in having joined-up commissioning of services.

Commissioners need to seek senior strategic support from their LSCB (in England and the equivalent committee in the devolved administrations responsible for the co-ordination of safeguarding arrangements - though LSCBs are likely to undergo significant change given the recent legislative changes), HWB and other local structures and ensure that there are clear links to the Sustainability and Transformation Plans and Local Transformation Plans for Children and Young People's mental health.

The project areas recognised the need for CAMHS practitioners to be able to provide a consultation and liaison service (in line with the model set out in *Future In Mind*[40]) as well as providing direct support to the individual child and family. This leads to better use of the practitioner's time and skills up those working directly with the child and family, enabling those in a range of agencies to manage children and young people with sometimes complex needs which may include mental health difficulties. It is important that commissioners reflect the need for this important aspect of CAMHS practitioners' work in commissioning and funding arrangements.

[40] Future in Mind, op cit, page 53. These services would offer advice, troubleshooting, formal consultation and care planning, or assessment and intervention in cases where this is required above and beyond the level of existing cross-agency provision.

Developing the workforce:

Investing in training of a wide range of staff in the agencies involved in the project areas is key. Training needs to cover the identification and early detection of CSAE in order for staff to be aware of the wide range of possible risk factors and symptoms; the need for a stronger trauma-informed approach in the responses given, and to raise awareness of the prevalence and impact of all ACEs. Professionals who are regularly in contact with children and young people would then be more likely to take a proactive approach to identifying potential cases of CSAE at an earlier stage.

The project highlighted the time and complexity involved in engaging staff in the process of transforming local services and allowing sufficient time to develop, implement and embed the changes needed. As with other forms of community outreach work, those engaged in supporting children and families need to be open, non-judgemental, compassionate, resilient and tenacious, capable of forming strong trusting relationships with traumatised children, young people and their parents. In working with the child or young person, staff should be able to work flexibly, based around the needs of the child, and not to be overly constrained by professional, disciplinary or organisational boundaries.

High quality clinical supervision is required to provide emotional containment, prevent burnout and to ensure that boundaries are maintained and that there is sufficient focus on optimising outcomes.

Leadership and promoting understanding of the impact of CSAE:

Strategic understanding of CSAE, its traumatic impact and the challenges for children, young people and their families in negotiating a changing service landscape at senior level across the agencies concerned is key to achieving any transformative service change.

Strong governance and leadership is required in order to forge partnerships between all the agencies who need to work together.

National leadership is instrumental in continuing to shape policy in this area and to encourage innovative practice and local investment; to investigate and disseminate ‘what works’; to reflect the needs of these children and young people in agreements with the ALBs; and to deliver the culture and system change needed to prioritise the response to CSAE through programmes including the transformation programme on children and young people’s mental health that is currently in development as part of the Five Year Forward View on Mental Health.

Conclusion:

The project has served to shine a light on the challenges that children, young people, families and communities face after abuse and provided the opportunity to reflect on the complexity in finding appropriate, timely and effective support. There have been several lessons learned through the work undertaken that can be useful for others seeking to improve the response to CSAE and to ensure that services are trauma-informed.

We are grateful to all those involved in this project, particularly to the staff and the children, young people and families who willingly gave their time to contribute to the evaluation, and to the Department for commissioning an important piece of work. There is no doubt that, although the project was welcome in the three areas, it took place during a turbulent time politically and financially, which made it difficult to get the traction needed to secure commitment from all the agencies concerned to the level of change required. One of the key requirements is for strong communication between services and agencies if case-holding is to be effective and children, young people and families delivered a seamless and holistic service.

For individual staff, one of the major challenges was the difficulty in implementing the changes needed when they were already under pressure and there was insufficient spare capacity to take on an additional and highly complex programme of work. Not all of the staff felt sufficiently supported by local leaders and some felt that this work was poorly understood. Ensuring that there is sufficient time to build the relationships needed and to develop a joint understanding of what support is required takes time. In undertaking similar work, local authorities need to be aware of the staff time that transformative change of this kind can take to prevent it being seen as a burden.

We know that timely therapeutic intervention can be critical to good recovery for children and young people who have experienced trauma – this project has helped to raise the profile of the needs of this vulnerable group and to develop a more trauma-informed and holistic approach to meeting those needs. However, the long delays in accessing specialist services and the rising pressure on Children's Social Care as well as a lack of understanding about the impact of trauma on children's lives meant that there was a tendency for services to leave families to cope unaided. There is therefore the risk of missing opportunities for earlier intervention and increasing the chance of their spiralling into crisis and developing more serious difficulties that could have been avoided.

Practitioners were generally not found to be knowledgeable about trauma-informed practice and to lack knowledge of what specialist services are available and effective, as well as their potential for providing support and improving outcomes. Training tools, including those developed for this project and the How-To Guide encapsulating the findings of the project, should be widely disseminated and easily accessible for a wide range of practitioners.

The trauma-informed case-holding model described in this report shows that it has potential – responses from the children, young people and their families were positive with clear appreciation expressed for the support provided and the relative ease with which they were enabled to understand what was happening and to access services. More needs to be done to test the model further, to examine its cost-effectiveness and to ensure that a wider range of staff across multiple agencies are trained to understand the impact of trauma and other ACEs. The response to children, young people and family's needs to be prompt, easily accessible, age-appropriate, continuous,

holistic and effective, with agencies working together seamlessly to deliver the best possible outcomes.

List of abbreviations:

ACE	Adverse Childhood Experiences
ALBs	Arms' Length Bodies
CAMHS	Child and Adolescent Mental Health Services
CSA	Child Sexual Abuse
CSAE	Child Sexual Abuse and Exploitation
CSE	Child Sexual Exploitation
DHSC	Department of Health and Social Care
FTB	Forward Thinking Birmingham
HWB	Health and Wellbeing Board
LSCB	Local Safeguarding Children's Board
RSVP	Rape and Sexual Violence Project
VCS	Voluntary and Community Services