

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

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

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The Tavistock and Portman   
NHS Foundation Trust



Chanon Consulting

## i. About the programme of work and this report

This programme of work arises from national and local recognition of the need to improve health services for children and young people who have been sexually abused. This need is evident from high profile cases of child sexual abuse (CSA), recent cases of organised child sexual exploitation (CSE), the Government's *Tackling Child Sexual Exploitation* action plan<sup>1</sup>, the Tackling Child Sexual Exploitation Progress Report<sup>2</sup>, the report of the Children's Commissioner for England<sup>3</sup>, the Health Working Group report on Child Sexual Exploitation<sup>4</sup> and *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*.<sup>5</sup> The added focus on vulnerable children in the *Future in Mind* strategy provides a way for local areas to develop new ways to meet the needs of sexually abused children who are in need of emotional and psychological support, but who fall below the so-called 'diagnostic threshold' for Child and Adolescent Mental Health Services (CAMHS).

The Department of Health and Social Care (DH) commissioned a programme of work to explore how a more joined-up service could be provided to children and young people who are sexually abused, with a particular focus on case-management, services that address both the physical, emotional and behavioural needs of children, and other issues facing them, for example, poor educational outcomes, and substance misuse in relation to the sexual abuse.

To that end, DH selected three areas (North Central London, Rotherham and Birmingham) to develop and test new approaches for commissioning and providing services for these children and young people. There was no prescribed model for the sites to adhere to, but projects were expected to be based on an assessment of local needs which has reviewed existing services and baselines and reflects input/advice from the Clinical Commissioning Group(s) (CCG), Local Authority and public health department.

As part of this programme, DH also commissioned the Family Nurse Partnership National Unit and the Tavistock and Portman NHS Foundation Trust to support and lead the work with sites (with Chanon Consulting joining later as an evaluation partner and Claire Bethel from the Way Ahead Team contributing to the drafting of the report).

This report responds to that DH commission – it seeks to shine a light on the lives of children and young people who have been abused or exploited. It describes the local systems in the three sites in some detail in order for the reader to fully understand the complexity in each area (and their choices about their programme of work). It includes feedback from children, young people and parents who were interviewed for this work, and some reflections and learning points for the commissioners of the programme, the sites and wider audiences.

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<sup>1</sup> Department for Education, *Tackling Child Sexual Exploitation: Progress Report* (February 2017).

<sup>2</sup> HM Government, *Tackling Child Sexual Exploitation action plan* (March 2015)

<sup>3</sup> 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.

<sup>4</sup> 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).

<sup>5</sup> Department of Health, NHS England (2015)

The project took place between 1<sup>st</sup> 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; not all 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.

## ii. Acknowledgements

First and foremost, our thanks to the children, young people and parents who took the time to share their stories with us, so that we and others could learn from what went well, and how things could be better for others. We hope your views are described well in these pages.

Thank you too to the commissioners, professionals and managers from the three areas who contributed their time and expertise in the design, delivery and evaluation of their projects, and without whom none of this work could have taken place.

We thank the Department of Health and Social Care team for commissioning the work – their ambition to improve the lives of all children and young people shone through at all stages, and we are glad to have the opportunity to work with them.

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## 1. The Scale of the Challenge

**Imagine a childhood disease** that affects **one in five girls and one in seven boys** before they reach 18: a disease that **can cause dramatic mood swings**, erratic behaviour, and even severe conduct disorders among those exposed; a disease that **breeds distrust of adults** and undermines the possibility of experiencing normal sexual relationships; a disease that can have profound implications for an individual's future health by **increasing the risk of problems such as substance abuse, sexually transmitted diseases, and suicidal behaviour**; a disease that **replicates itself** by causing some of its victims to expose future generations to its debilitating effects.

### **Imagine what we would do**

As a society if such a disease existed **we would spare no expense**. We would invest heavily in basic and applied research. We would devise systems **to identify those affected** and provide services to treat them. We would develop and broadly **implement prevention campaigns** to protect our children.

**Wouldn't we?**

**James Mercy,**

**Centre for Disease Control, Atlanta<sup>6</sup>**

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<sup>6</sup> Excerpted from a commentary by Dr. James Mercy, a researcher with the Centre for Disease Control and Prevention: Mercy, J. A. (1999). Having New Eyes: Viewing Child Sexual Abuse as a Public Health Problem. *Sexual Abuse: A Journal of Research and Treatment*, 11 (4), 317-321.

## Introduction

Sexual abuse and exploitation 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 sexual abuse in childhood or adolescence is uniquely toxic and debilitating; few other adverse events are kept so concealed and bring with them the stigma and shame that so often accompanies sexual abuse.

It is perhaps these associations with stigma and shame that appear to have the greatest impact on how young people who have been abused or exploited see themselves in the world, and that drive subsequent vulnerability to their health and development. Yet we know that sexual abuse and exploitation are all too frequently accompanied by other traumatic events and experiences, such as family breakdown, violence and mental health problems. The compound and cumulative effect of multiple adverse childhood experiences (ACEs) can have very significant and long-lasting impacts on both physical and mental health throughout the life course.

## The scale of child sexual abuse

There has been a growing recognition by Government, the public sector and wider society in recent years of the scale of sexual abuse and exploitation (shortened to CSA, CSE and CSAE throughout this report) in children and young people, mostly prompted by emerging research. However, assessing the true scale of abuse remains an imprecise science. Finkelhor et al,<sup>7</sup> working with data from three US studies involving young people aged 15-17, identified a lifetime prevalence of sexual abuse of 26.6% for girls and 5.1% for boys. More recently, Kelly and Karsna's<sup>8</sup> conclusions are close to Finkelhor estimating CSA of 15-20% for girls and 7-8% for boys. This contrasts with a recent study in Wales identified that around 10% of the adult population had experienced some form of sexual abuse in their lifetime.<sup>9</sup>

The current prevalence research is focused primarily on child sexual abuse, with limited studies specific to child sexual exploitation (CSE). The Children's Commissioner for England has published reports in 2013<sup>10</sup> and 2015<sup>11</sup> focusing on CSE to identify prevalence and actions in relation to child sexual exploitation by gangs and groups and child sexual abuse within family networks in England.<sup>12</sup> These reports estimate that a minimum of 16,500 children were at risk of CSE in the year to March 2011, and that 12% or 450,000 children in England and Wales had been sexually abused in the two years to March 2014, with intra-familial sexual abuse most likely to occur around the age of nine (though this abuse is most likely to come to the attention of authorities in adolescence). In the latter case,

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<sup>7</sup> Finkelhor, D. Shattuck, A. Turner, H. Hamby, S. (2013) The Lifetime Prevalence of Child Sexual Abuse and Sexual Assault Assessed in Late Adolescence, *Journal of Adolescent Health*

<sup>8</sup> Kelly L. & Karsna K. (2017) Prevalence from: scoping paper on measuring the scale and changing nature of CSA and CSE. Centre for Expertise on Child Sexual Abuse.

<sup>9</sup> Public Health Wales (2016) Adverse Childhood Experiences and their association with chronic disease and health service use in the Welsh adult population

<sup>10</sup> 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

<sup>11</sup> 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.

<sup>12</sup> Children's Commissioner (2015), Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action. The Office of the Children's Commissioner's Inquiry into Child Sexual Abuse in the Family. Final Report

two thirds of the abuse was in a familial context. Despite this recognition of the scale of abuse, very few cases of sexual abuse (around one in eight) are ever reported to public authorities such as the police.

## The impact of abuse and need for support

The very high profile cases of organised and systematic child sexual exploitation in a number of local authority areas in recent years has shone a powerful light onto sexual abuse that takes place outside the home, the impact this has on the children and young people involved and what services might make a difference for them. An unintended consequence of these very high profile cases has been that there has been less focus on supporting emotional health and wellbeing following child sexual abuse within families.

### *Short/medium term impact*

Although most research focuses on the psycho-social impacts of sexual abuse, some children and young people can have physical injuries arising either from the abuse itself or from associated violence. All of the children interviewed for the Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Inquiry<sup>13</sup> reported experiencing physical violence, and nearly half had injuries that required attendance at an accident and emergency department. Some children have contracted sexually transmitted infections or had unwanted pregnancies as a consequence.

Between a half to four-fifths of children and young people who experience sexual abuse have some symptoms of post-traumatic stress disorder (PTSD), anxiety and depression.<sup>14</sup> Many exhibit self-destructive behaviours and/or experience substance abuse, and report feelings of isolation and stigma and difficulty in trusting others. For some, their abuse translates into sexualised behaviour and promiscuity, poor self-esteem, withdrawal, anger/aggression and disruptive behaviours.<sup>15</sup>

The traumagenic model (Finkelhor & Browne, 1985)<sup>16</sup> explains these behaviours in terms of four trauma-causing factors – traumatic sexualisation, betrayal, powerlessness, and stigmatisation. Whilst these traumagenic dynamics are not unique to sexual abuse, their conjunction in one event is what makes the trauma of sexual abuse unique. They alter children's cognitive and emotional orientation to the world, and distort children's self-concept, world view, and emotional capacity. For example, the dynamic of stigmatisation distorts children's sense of their own value and worth; powerlessness distorts children's sense of their ability to control their lives. Children's attempts to cope with the world through these distortions may result in some of the behaviours cited above. In some cases,

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<sup>13</sup> Children's Commissioner (2012), op cit.

<sup>14</sup> 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

<sup>15</sup> Dominguez, et al., 2001; Finkelhor, 1990; Kendall-Tackett et al., 1993; Walsh, Galea & Koenen, 2012) (Beitchman et al., 1992; 1991; Briere & Runtz, 1990; Dominguez, et al., 2001; Ernst, Anst, & Foldenyi, 1993; Ferguson, Horwood, & Lynskey, 1996; Finkelhor, 1990; Mullen, Martin, Anderson, & Herbison, 1994; Mullen, et al., 1996; Palmer, et al., 1999; Perry, Conroy, & Ravitz, 1991; Polusny & Follette, 1995; Putnam, 2003; Reiker & Carmen, 1986; Usher & Dewberry, 1995; Walsh, et al., 2012

<sup>16</sup> Finkelhor D. & Browne A. The Traumatic Impact of Child Sexual Abuse: A Conceptualization. Family Violence Research Program, University of New Hampshire, Durham. American Journal of Orthopsychiatry, 55(4), October 1985

disruptive and sometimes aggressive behaviours, and harmful sexual behaviour, arises as a consequence of the trauma in some young males.<sup>17</sup>

### *Long-term impact*

Sexual violence and abuse can also cause long-lasting harm; chronic child sexual abuse perpetrated by a close relative or other trusted acquaintance can have more severe long-term consequences than isolated incidents perpetrated by strangers.<sup>18</sup> A 2013 study by Fergusson et al<sup>19</sup> found that adults reporting historical child sexual abuse had:

- Increased risks of mental health problems in adulthood (ages 18–30);
- A greater number of PTSD symptoms, lower self-esteem and lower life satisfaction at 30;
- Higher rates of sexual risk-taking behaviours at age 30;
- Higher rates of doctor/hospital contact for physical illness at 30; and
- Higher rates of welfare dependence (ages 25–30).

In addition, the study established that the severity of psychiatric symptoms increased with the number of additional childhood traumas experienced. This is important because there is a growing body of evidence that childhood sexual abuse often co-occurs with other adverse childhood experiences (ACEs), including domestic abuse, parental mental ill-health and/or substance misuse, children being separated from birth parents, experiencing neglect and/or physical abuse<sup>20</sup>. Some studies that have taken into account other adversities found that CSA is still a powerful predictor of disordered psychological and behavioural functioning in adults.<sup>21</sup>

As well as the potential for a significant impact on mental health, sexual abuse in children and young people has the potential to have long-term consequences for physical health. When sexual abuse occurs with multiple 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.<sup>22 23</sup>

## 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 cases into CSA

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<sup>17</sup> Ghani, N. 2016, Now I know it was wrong: Report of the parliamentary inquiry into support and sanctions for children who display harmful sexual behaviour, Barnardo's

<sup>18</sup> 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

<sup>19</sup> 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

<sup>20</sup> 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

<sup>21</sup> Fergusson et al, op cit.

<sup>22</sup> Public Health Wales 2016, op cit

<sup>23</sup> 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



and cases of organised CSE, such as in Rotherham<sup>24</sup>, Manchester<sup>25</sup> and Oxfordshire.<sup>26</sup> Reviews of these cases have found that children and young people (particularly those from homes where there is the potential for multiple other adverse childhood experiences), need co-ordinated support to help them to get their lives and schooling back on track.

“What works” when intervening with children, young people and families in the aftermath of sexual abuse requires further research. However, being able to access abuse-specific interventions (as opposed to generic services) is critically important, with trauma-focused Cognitive Behaviour Therapy over 12 to 16 sessions recommended by NICE as one of the first line treatments that should be offered to children and young people who have been sexually abused and who are showing symptoms of anxiety, sexualised behaviour or Post-Traumatic Stress Disorder (PTSD).<sup>27</sup> Furthermore, children themselves have identified having an accessible, non-judgemental and non-directive approach as key, with trust and confidentiality being well-maintained.<sup>28</sup>

However, it appears that few children and young people obtain timely, evidence-based therapeutic intervention or support following sexual abuse. This ‘treatment gap’ was well described by the 2015 NSPCC (2015)<sup>29</sup> 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. At least another 55,000 clinical therapeutic support places would be needed per year to make sure all children received this necessary support. This would only cover young people who have displayed high level support needs including suicidal or self-harming behaviour following abuse’.*<sup>30</sup>

Clearly, not all children and young people will need intensive psychological support or therapeutic intervention - we know that between 20 and 40% of children who experience sexual abuse “will show no ill effect later in life”.<sup>31</sup> The Children’s Commissioner has proposed dedicated centres of support for sexually abused children that could deliver an appropriate initial response to the abuse.<sup>32</sup> 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.<sup>33</sup>

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<sup>24</sup> Jay, A. (2014) Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013)

<sup>25</sup> Coffey, A. (2014) Real Voices. Child sexual exploitation in Greater Manchester An independent report by Ann Coffey, MP.

<sup>26</sup> Blythe, M. (2014) CSE - Making a Difference. The impact of the multi-agency approach to tackling CSE in Oxfordshire

<sup>27</sup> NICE guideline on Child abuse and neglect, October 2017, paragraph 1.7.17 et seq [https://www.nice.org.uk/guidance/ng76/chapter/Recommendations]

<sup>28</sup> Allnock, D. and Hynes, P. (2012) Sexually Abused Children and Young People Scoping the Evidence Base, NSPCC

<sup>29</sup> 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

<sup>30</sup> Allnock D, Bunting L, Price A, Morgan-Klein N, Ellis J, Radford L. and Stafford A. (2009) Sexual abuse and therapeutic services for children and young people: the gap between provision and need: full report. London: NSPCC

<sup>31</sup> NSPCC Scoping report, prepared by Allnock, D. and Hynes, P. (2013) Therapeutic services for sexually abused children: scoping the evidence base (p5)

<sup>32</sup> Children’s Commissioner (2015), Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action. The Office of the Children’s Commissioner’s Inquiry into Child Sexual Abuse in the Family. Final Report

<sup>33</sup> Tabachnick, J. (2013) Why prevention? Why now? International Journal of Behavioral Consultation and Therapy

*Future in Mind*<sup>34</sup>, based on the last UK epidemiological study<sup>35</sup>, 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<sup>36</sup>. *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.

## Local commissioning context

The public sector financial environment across England remains very tight, with all local authorities seeing continuing pressures on their budgets.<sup>37</sup> In the case of Rotherham, by the end of 2016 it had:

*[...] lost 33% of its spending power in real terms compared to 2010/11.*<sup>38</sup>

This is broadly in line with the National Audit Office estimate that local authorities in England lost roughly a third of their central government funding between 2010-11 and 2015-16, and a quarter of their total funding once council tax is included.<sup>39</sup> It is clear that the scale and nature of these reductions in local authority resourcing writ large are having a significant impact: on thresholds for access to children's social care; on access to children and young people's mental health services; and on access to other services, including those delivered by the voluntary sector.<sup>40</sup> We don't seek to make a judgement on the scale and nature of these cuts to services, but do find it difficult to imagine how services can effectively protect and support vulnerable children and families given such significant reductions in resource.

All three areas working through this project are facing significant financial challenges that have driven service and structural changes. As these projects were being designed and implemented, budgetary pressures from elsewhere in the system inhibited project development, leadership, implementation and sustainability. But it isn't all about the money, and many areas are still struggling to adapt to the changes to the NHS and local authority commissioning landscape brought about by the Health and Social Care Act 2012:

*[...] It's like we had to use this project to stitch the local relationships back together after the 2012 Act. This project couldn't have gotten started without doing that first (NHS Provider)*

*[...] public health is still so new in the local authority that we are still having to learn how to navigate around the system to get things done – it's just so different (Local Authority commissioner)*

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<sup>34</sup> 'Future in Mind: op cit. Department of Health, NHS England (March 2015) Chapter 6

<sup>35</sup> 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.

<sup>36</sup>Future In Mind, op cit, page 52

<sup>37</sup> Innes, D. and Tetlo, G. (2015) Central Cuts, Local Decision-Making: Changes in Local Government Spending and Revenues in England, 2009-10 to 2014-15, IFS and Nuffield Foundation

<sup>38</sup> Jay, A. (2014)

<sup>39</sup> Comptroller and Auditor General (2014) The impact of funding reductions on local authorities

<sup>40</sup> NSPCC (2016) Survey of professionals

## Summary of the challenge

The sexual abuse and exploitation of children and young people in England is not a rare and uncommon event. Rather, every single school classroom in England is highly likely to have children and young people in it who are currently being or have been sexually abused. Abuse of this nature is traumatic, both physically and emotionally, and whilst some more resilient children do recover without professional intervention, it is likely that the majority of children will need clinical intervention and support to help them recover. Those who disclose will also require some support to navigate what is often a highly complex set of services.

Because of the relatively low levels of reporting/detection of child sexual abuse discussed above, we can surmise that a relatively small proportion of children, young people or families is 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, particularly in the face of cuts to public sector funding for local authorities and others.

## 2. The DHSC commission and our approach

### Introduction

Following on from several serious and recent cases of organised sexual abuse and exploitation, it has become widely recognised that there needs to be a renewed focus on the health and wellbeing of children and young people who have been abused. The National Group on Sexual Violence against Children and Vulnerable People was formed to examine the lessons from recent inquiries, to shape the Government's response to all forms of sexual violence against children and vulnerable people and to set direction for local systems. The Department of Health and Social Care, NHS England and others have been encouraging leaders and systems to think differently about how local services can best respond to abuse, and *Future in Mind*, the key strategy for driving improvements in the mental health services for children and young people, included a focus on the aftermath of sexual abuse.

This programme of work was commissioned by DH to help move this thinking along. In recognition of the complexity of these systems, the Department sought out partners to understand more 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 joined-up service could be provided to children and young people who are sexually abused. The Department selected three areas (North Central London, Rotherham and Birmingham) to develop and test their own approaches for these children and young people – there was deliberately no specific model for them to adhere to. Rather, each area was encouraged to respond to a brief in recognition of their own context. Projects were expected to be based on an assessment of local needs which has reviewed existing services and baselines and reflects input/advice from across their systems.

The Department of Health and Social Care commissioned the Family Nurse Partnership National Unit and the Tavistock and Portman NHS Foundation Trust to support and lead the work with sites. The consortium has unique alignment of capabilities, including a strong focus on improvement, innovation and site support from the FNP National Unit, and almost 100 years of distinctive ways of understanding mental distress, mental health and emotional wellbeing from the Tavistock and Portman. This consortium worked with sites to refine their project ideas, offered clinical advice and mutual support across sites and undertook the evaluation reported here.

The Department supported each site's project with a grant, and provided funding to the consortium to undertake the national support and evaluative functions (a summary of the grants and how they were deployed can be found at the rear of this report).<sup>41</sup> The project proposals focused on children and young people who in the main had experienced CSA,

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<sup>41</sup> Funding was in most cases held by a local NHS provider organisation on behalf of project teams. Chanon Consulting was later commissioned by the original partners to provide additional expert advice to the project areas and to undertake an evaluation.

although Rotherham also had a focus on improving services for children who had been sexually exploited.

## Project governance

The Department of Health and Social Care selected the three sites and worked with them to develop their initial proposals in Q4 of 2016-17, and soon after that the Family Nurse Partnership National Unit/Tavistock and Portman NHS Foundation Trust was commissioned by the Department to support and evaluate the work (with Chanon Consulting joining later). The project was live during 2016-17.

The project has reported to the internal Senior Responsible Officer (the Director for Children, Young People and Families at the Tavistock and Portman NHS Foundation Trust). The partnership provided the Department with monthly updates on site progress through detailed highlight reports and frequent telephone and face-to-face meetings. All of the areas have varied their work from their initial proposals to a greater or lesser degree, and the partnership has kept the Department fully informed of these changes as the projects have matured and been tailored pragmatically to their individual local circumstances and what is achievable within the financial envelope, different local financial and system issues and time constraints.

## Our support model

A team led by the Family Nurse Partnership National Unit (and including the wider Tavistock and Portman NHS Foundation Trust and Chanon Consulting) was commissioned by DH to lead the work on their behalf, support sites to clarify their projects and to undertake an evaluation. Our hypothesis was that good project work of this nature comprises the following:

- Effective local leadership
- Effective local project management
- Clinical expertise and guidance (national and local)
- Co-production of interventions (locally) and evaluation
- Mutual learning, feedback and challenge

With this in mind, the project team focused on areas of strength and areas of challenge for each site, taking a flexible approach to support offered depending on local context, monthly progress reports and site feedback. Each area was supported to put its own local leadership and governance arrangements in place (if they were not already in existence) and a local project leader was identified and supported by the team throughout the programme. The team has provided clinical expertise in trauma and early intervention through workshops, site visits and telephone calls. Three workshops were held during the life of the project to bring sites together with a view to enabling them to act as critical friends of each other, to present and discuss their projects in a safe environment and to share learning, as well as to hear from leading experts on trauma-informed working and CSAE.

The project team held regular phone consultations with local project leads and visited each area several times to guide them in clarifying the scope of their work, provide expertise and challenge on how to strengthen their clinical offer, as well as how to address the system changes required to develop a CSAE pathway ranging from early intervention and support to higher threshold therapeutic support and statutory intervention where required. As time progressed, the team also focused in on how best to implement a trauma-

informed approach across services, clarification of the case-holder model, how sites can 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.

## Evaluation and support methodology

The project evaluation was led by Chanon Consulting in partnership with the project team. In order to accommodate time and resource constraints, the evaluation was conducted using an iterative approach to ensure that we had the ability to improve and adapt to the circumstances as the work programmes. Our site support work and evaluation were often conducted in tandem to ensure that we maximise the resource but also to minimise disruption for local participants. In order to do this work well, and to provide something useful to sites, we undertook a full scoping exercise of the existing systems in each site. Our evaluation aimed to take a preliminary view on the following headings:

- Scope the existing systems in each area to enable full understanding of complexity and challenge;
- Identify good practice within the three project areas;
- Evaluate the processes used by local project teams to deliver change; and
- Assess the potential for replication of outcomes in other areas.

Data collection has been undertaken through site visits, fieldwork data collection, interviews with project participants/leaders, interviews with children and families and collected thoughts from project workshops and presentations by sites. These activities were undertaken in three phases:

Phase 1 – development of project data collection template; and site visits to provide expert support to projects and to undertake data collection;

Phase 2 – face-to-face or telephone interviews in each of the three project areas with children and/or parents, the children’s social care commissioner, a statutory service manager and commissioned service manager and practitioners/keyworkers.<sup>42</sup>

Phase 3 – presentation of the interview data, overall evaluation analysis and authoring a report.

The experimental and pilot nature of the projects meant that, in some cases, commissioners have needed to carefully manage service user numbers, to ensure they would be able to offer alternative support for children and their families in the event that the project was not successful and/or when the funding ceased. This, together with the time frame for mobilising local systems and developing change programmes meant that numbers of participants were small.

Chanon Consulting have taken a highly collaborative approach to this evaluation - the three areas have been supported through the site visits and interviews to assess their own performance. This is critical to ensure that the sites themselves have confidence in the evaluation data, but also take some ownership over their outcomes. These insights have been cross-referenced by the independent evaluator and checked with interviewees for accuracy.

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<sup>42</sup> The discussions with practitioners, children and parents were aimed at drawing out personal experiences of delivering and receiving services. We anticipated that many people interviewed, particularly those receiving a service, would have

### 3. Clarifying the case-holder model

This section describes the three local authority areas prior to and after implementation of their respective changes. There is a particular emphasis on the circumstances in each area pre- and post-project development, supported by data from the evaluation interviews, the project self-assessments and the project progress reports submitted by each area.

As the projects progressed, it became clearer that DH was particularly interested in the development and application of case-holder models of non-clinical support for children and young people who have been abused, and for their families.

The case-holder approach is not a new one, but can be specifically important in cases of child sexual abuse and exploitation. The need for case-holding arises from the complexity of services that children, young people and families will need to navigate through, from immediate post-abuse medical assessment and treatment, to the criminal justice system, psychological assessment, social care assessment, voluntary sector services and others. Most professionals, and indeed the project team leading this work, find this system disorienting at the best of times. (The complexity of these systems is well-described in this report and elsewhere.<sup>43</sup>) Families who have experienced (and may still be experiencing) significant trauma will find this system complex and difficult to navigate their way through - and at a time of great stress.

As the project team began to work with sites to develop their projects, it became evident that not all areas had a clear or common understanding of a case-holder model in this particular context. To help clarify this (both within the local context and in the context of a nationally-commissioned project), a model for describing a local, trauma-informed, case-holder approach was developed, and time spent with local project leads and others to agree what it might look like in their context. The model hypothesises that the majority of children who have experienced CSAE (and who therefore may need some form of support to recover) are unlikely to meet the required high threshold which may exist in some places to receive a child and adolescent mental health or other support service. It is also hypothesised that the majority are unlikely to be a Looked After Child, on a Child Protection Plan or to be assessed as being a Child in Need. We can be confident of these hypotheses because:

- In a majority of cases significant amounts of time has elapsed between abuse and disclosure (sometimes years after);<sup>44</sup>
- Abuse is often disclosed to family members or peers and this results in either support within the family or the child being 'silenced';<sup>45</sup>
- Children's social care cases are often stepped-down if the perpetrator of abuse no longer has access to the child and if they have a protective parent - and they are therefore deemed to be safe.

Even with targeted efforts to improve identification and disclosure, there are likely to always be significant numbers of children who do not receive a children's mental health or social care-led safeguarding service following abuse.

The model below describes an approach to assessment of need and management of post-abuse support developed by Chanon Consulting in discussion with the sites. When children

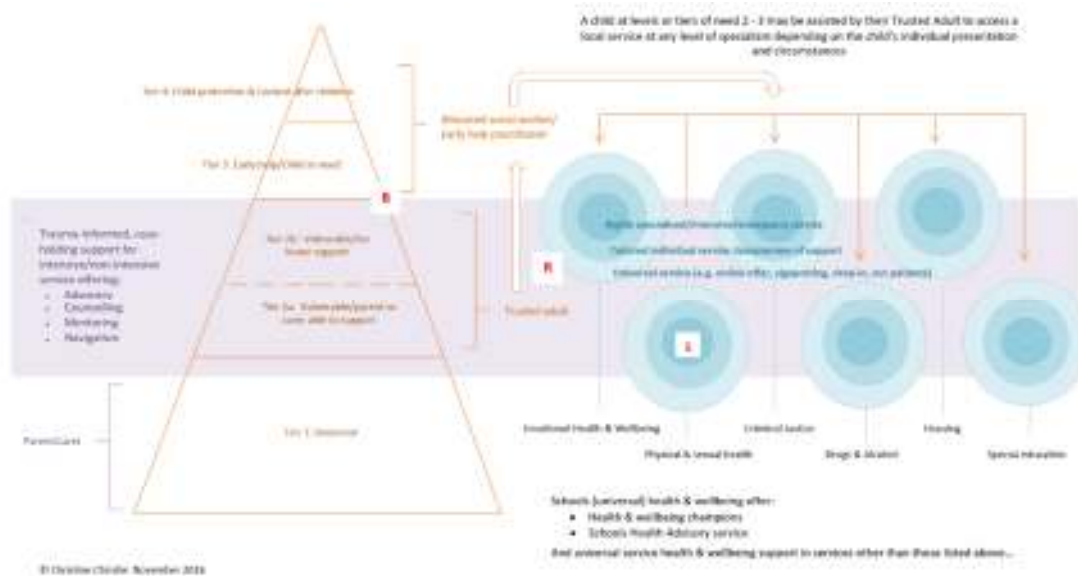
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<sup>43</sup> Goddard, A. Harewood, E. Brenna, L., Review of pathway following sexual assault for children and young people in London (March 2015)

<sup>44</sup> Allnock, D. and Miller, P. (2013) No one noticed, no one heard: a study of disclosures of childhood abuse, NSPCC

<sup>45</sup> Allnock, D and Miller, P. (2012)

and young people come to the attention of services as a result of suspected or known sexual abuse and exploitation, they should receive a holistic assessment of their needs, which must include their experience of other ACEs. Children not offered an allocated social worker, who do not reach the threshold for mental health services and/or whose family are unable or unwilling to support them, should be allocated a case-holder. The function of this role is to provide earlier intervention and support to help that child navigate/broker their access to other services, to advocate for them, to 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). 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.



All three areas have designed and implemented projects to ensure that children, young people and families are supported through their respective complex systems. Briefly:

**Rotherham (R)** – 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.

*Areas on the Diagram:* trusted adult service – CAMHS care pathway enhancement and attunement/attachment training and learning from police-led multi-agency CSE operations all Tier 2, 3 & 4 children.

**Birmingham (B)** – 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, and 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. This was anticipated to increase identification and referrals into children's social care or voluntary sector services.

*Areas on the Diagram.* trauma-informed training and library of resources – all children Tiers 1 to 4; Team-around-the-child Tiers 3 & 4 with some Tier 2 stepdown cases; consultation on a Tier 2 trusted-adult service.

London (L) - 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 (in this case, the advocate or CAMHS practitioner) to provide early emotional support, navigation into local services and liaison with the wider multi-agency network. The London model is described in the CSA Hub Toolkit<sup>46</sup>.

*Areas on the Diagram.* with a referral pathway via children's social care Tiers 3 & 4; but with potential in the future to consider self-referral which would make the service available to all children.

In summary, the different project teams interpreted the concept of case-holding in different ways depending on their existing local services, structures and systems. The projects usefully illustrate how the planning and commissioning of services to support children and their parents following abuse needs to be both strategic and operational, and to begin with clarifying the concepts and meanings prior to embarking on the work.

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<sup>46</sup> Child Sexual Abuse Hub Toolkit: a practical guide for commissioners and practitioners to establish a CSA Hub. NHS England (March 2017)

## 4. Service user evaluation

### Introduction

The Victim's Commissioner, Baroness Newlove eloquently described in her 2015 report, many victims of crime:

*[...] feel ignored, unimportant and confused* <sup>47</sup>

Some children and young people who have experienced CSAE will have this compounded by feeling a deep sense of shame that all too frequently prevents them from reporting what has happened to them. From the outset, all of the projects and our support to sites has sought to include the voices of children and young people in all of our work.

Our 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 of service users. This decision 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 is provided here relatively fully for two reasons: the voices of both the children and the parents serve as powerful reminders of the need, and the challenge to policy makers, commissioners and professionals to get service delivery right; and, although the number of respondents is small, the themes resonate with feedback from sexually abused children and their parents in other studies, and therefore carry more value than might otherwise be expected to be the case.

### Evaluation feedback from children and young people

For all of the children and parents whose feedback is presented here, the abuse occurred some time ago (as is generally the case) when the children were between 5 and 12 years old and, generally speaking, abuse was perpetrated by a family member (in one case the abuse was perpetrated by several males within a community). We present their views thematically to enable thinking about the wider implications of their experiences.

#### *Mental health and wellbeing*

Children and young people told us about the consequences abuse had on their mental health and emotional wellbeing. One child described feeling emotional whenever abuse was discussed:

*We talk about what has happened and me being emotional.*

For others, anger and sadness were the predominant feelings, and these feelings had a direct impact on their mental health:

*Depression, yes: and I have sad thoughts, but I try not to focus on it.*

*I've got PTSD as well, coz of my past and that. I think it was in December I was suffering a lot of panic attacks.*

Their sense of wellbeing also then had direct consequences for their lives, impacting on their behaviours and on their schooling:

*I have a lot of anger, which is me shouting and things at school.*

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<sup>47</sup> The Victims Commissioner (2015) The Silenced Victim

*I struggle sometimes to be good, I behave badly sometimes and sometimes it nearly gets me kicked out of school.*

*It really affected stuff at school, like me not doing okay anymore*

In answer to questions about what they felt they still needed help with, children focused on their struggles with their emotional wellbeing. One child described self-harm and suicidality:

*'My thoughts and my self-harm. I still have times when I want to self-harm myself and the thoughts in my head saying, "I don't want to be here". It's like the other day, I had a thought "I don't want to be here. I want to be killed" Obviously I didn't mean it but ....*

Some interviewees described children being bullied by other children as a direct consequence of their abuse experience. So, as well as carrying the burden of their abuse on their lives, the children and young people also described their worries about their peers, other family members and their home lives:

*At home, I do worry about my mum...*

*I'm being bullied severely on-and offline by friends in school*

*Her younger brother was bullied at school with the other children saying 'your sister's a crack head'*

For one child, her bullies were also her only friends, making for a complex internal world where she also in turn became a bully:

*She accepted being bullied and went along with behaviours and activities which she would not have initiated on her own, for the sake of feeling that she had friends (parent)*

The children and young people we spoke with highlight the impact their abuse had on their mental wellbeing, on their behaviour and on school performance.

### *What helps?*

We asked interviewees what services or which people had helped them. Some children described being helped by professionals from different agencies such as school mentors and CAMHS workers. However, when asked what sort of help is best, children said that it was to have a trusted adult to talk to:

*Probably to talk to someone and express your feelings.*

*Not, like, your parents, coz I find it hard to tell my feelings to my mum. Someone needs to be outside the family.*

Children were asked who they felt they would be able to talk to. They said it would need to be someone they had been able to get to know and trust:

*I find it hard to trust people. I don't mind who it is, but it depends on my being able to trust them or not. I find it hard to trust people. I don't know whether to tell them or not. I have to get to know them first.*

The consistency of the relationship is key – that the relationship is built carefully and not disrupted seem to be critical 'asks':

*I did have a mentor but she's on maternity leave at the moment. She comes back in May. I was really close with her and always talk to her about how I was feeling and stuff like that.*

*I had a CAMHS worker. He was helping me and then that was stopped because of it being too.... he put me on medication because of my depression which was helping and then obviously he was leaving. I didn't see him again.*

#### *Case-holding and keyworking*

The children and young people interviewed verified that case-holding or keyworking is important to them. Ideally children wanted to see the trusted adult (keyworker, mentor or advocate) once a week, if that was not possible, then at least once a fortnight. They said that when if saw a keyworker or mentor less frequently they felt they could not get to know the adult well enough to trust them. The interviewees were asked what help they would give to a young person:

*We would like to give them someone like [my keyworker] who comes in from outside, but sees them every week and then maybe they could start talking to them. Yeah.*

*I would definitely give them a keyworker to talk to and not keep it to yourself because it makes you even more worse inside and then obviously I would tell them .....to go and express it, even if you don't want to tell your parents, at least tell your keyworker or a teacher or a friend of the family part of it.*

In terms of what aspects of keyworking or case-holding children valued, they outlined their appreciation for advice, help with making decisions, listening to their feelings and liaising or advocating with their parent or teachers on their behalf. However, they also described their keyworker or mentor's role as being more than a 'sympathetic ear'. For them, support included providing boundaries and guidance for a child who is struggling to stay on track with their behaviour as a result of the harm they had experienced. A child volunteered the following information:

*I was really bad. Me and my friend kicked the door in and then everyone ran out from the school. I was always getting excluded. I was really bad and I got put on report. It's all because I was hanging round with the wrong people. I got some lectures from [my keyworker] and the teachers. And then I realised when I got to Year 9 I needed to stop doing that. So I hanged around with the right people. Now I'm doing good.*

#### *Parents*

*It's the one thing in life for me - to see my child back on track and being herself. I will do anything for her, she is my life.*

Several parents whose children have experienced sexual abuse participated in the evaluation interviews with us. However, only one family had received support directly from a service funded by this project for long enough to give a feedback on the service. All of the parents nevertheless provided very useful information about the challenges they have faced and the support they feel should be in place for their children and for themselves - some of which informed the design of the project in the area concerned.

On the whole, parents felt abandoned by the system. They highlighted the challenges of getting help from statutory services:

*Social services told me that we did everything right, they can't do nothing for me.*

However, the amount of pain the parents of abused children continued to experience was palpable.

*Yes it's very difficult to have a conversation without breaking into tears. That's no good for a child when you are trying to get him to come and confide in you, when mum is breaking down every time she's trying to have a conversation. And even dad... their dad is very strong, the children have never seen him cry before, and to see dad cry, that's a really big thing. So this one thing that has happened has now affected everyone.*

One parent described how the lingering pain of the abuse their child experienced continued within their relationship, and how this was exacerbated by not having more professional input:

*There's so much pain. Me and her, we live just together. Both of you passing the pain between you. You also want to shout but you don't want her to have the shouting.*

They talked in terms of their own inability and feelings of inadequacy in helping their child. In terms of counselling they said:

*She needs counselling. I can't do it on my own with her because she says 'you don't want to hear this'. Both of us don't want to say things that upset each other.*

Several parents described the challenge of having several services involved with their child:

*(A) needs one person to 'hold her' – not lots of people. And not short term, because the person needs to 'bring the child in' [build A's trust] so she is in a place that she can understand what's right and wrong [she is not to blame], about what happened to her, and about being able to carry on her life.*

*We had to explain our situation to three different workers. Then when the third worker was beginning to build a relationship, she was changed and we were given another worker. And I said "No, I'm not going through it all again. I am not willing to because I can't keep coming in this room every few weeks, breaking down and telling these people my life story. It's not right." So I think if you have a worker you should stick with that worker. They are on about confidentiality, well, if that was confidentiality.....half the office know about us.*

*The longest time a social worker held the case was 10 months – in a three year case. As C doesn't trust strangers, after the second one she just didn't want to know.*

Parents (and the children interviewed for the evaluation) all described children's struggles to contain outbursts of anger and violence. Parents talked in terms of their own inability and feelings of inadequacy in helping their child through incidents of both self-harm and attempted suicide; and all accurately attributed these to emotional struggles which parents did not know how to manage and avert:

*When she is kicking up and breaking things, what do I do? I might be a great mum but when she does that I'm bloody struggling.*

*Then when he was trying to kill himself, who do I ring if anything like that happens again?*

Parents described what they thought would help them in these circumstances. Parents highlighted practical support, activities and general support as being important:

*Somebody to be immediately, "Right, ok, keep calm..."*

*The best way I could help him, was to take him to kick boxing every night after school and stay there with him. People will think, "OK, what's that got to do with it?" Well, it had a lot to do with it because he had nothing to vent his emotions; he's got nothing to vent his anger; it was making him feel good about himself. He was learning how to protect himself which I think was a big thing for a boy who's been sexually abused.*

*I want them to get my child to understand it was not her fault and to get her to 'move-on'; get her to focus on other things [not dwell on it] – further her skills and get her to think about a career.*

*She is good in school. She is doing well. But what's happening is that [at school or at home] something stirs it up again and then she gets depressed. She needs someone to help her keep even. She gets 1-2-1 help at school.*

*My child and other children need activities to focus on*

*We could do with some support on how to help him. You are on eggshells because you don't know what's the best way to support him physically and mentally when he's so withdrawn and depressed*

*They need activities to focus on – things they're interested in to help them feel positive enough to explore the bad stuff.*

*I think it would be better if everything was dealt with in one place. Parents, like me, could have some counselling there. I should be able to have counselling at the same time at the same place because then it doesn't interfere with getting him back to school and disrupt his life even more than it already has been.*

Parents told us 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 has a very real impact on parents' ability to help their child do the things that made a difference to them:

*There's nothing now and it's affordability – because it was £20 a week... when benefits are dropping.*

*It costs me too much to travel across the city to the parent support group. It also takes a lot of time, getting the bus and walking.*

The family who received the case-holder approach described the centrality of the help provided by the case-holder although the service had been offered for a 6 month period and she felt that that would not be long enough. Parents were asked what they thought had been or would be, most helpful for their child.

*A child builds trust and then they can start to explore things inside. Then gradually they begin to say things about what happened and what they are struggling with.'*

*You know your child better than anyone, so you'll know when they start to get better. It's not like one time/one session or a few, and then she's better. Its stages that they have to go through.*

Parents were asked whether their child still needs help, and if so, what the reasons for this are. They said that their children had not been receiving support from the case-holder for long enough for them to comment on whether the child's needs are being met. However,

they spoke eloquently about the challenges they faced prior to the service being piloted and of how early intervention would have made a bigger difference:

*If they had started [counselling or therapy] when F was six, he would have dealt with it in a six year old brain and would have been able to manage it a lot easier now he's 14. Do you understand what I mean, when he's having his own puberty issues, his own feelings of ....girls, whatever....*

*The person who did the thing got help immediately. I understand why he needed help immediately, also needed to understand what he did was wrong. But there has been nothing there for F? I felt he was abandoned, but he was the victim!*

*The project psychotherapist has helped me to understand what was happening for a child and how to respond, how to manage herself [...] and the other children in the family. Has also given me the confidence to challenge [the other agencies]*

Another parent described an inadequate response, highlighting how episodic help can feel unfocused:

*They sent her on a two week holiday, to give me some respite. That was it. It was a bit like, "Well, I don't mean to be funny but my child's just been abused and you took her away on holiday for a week". Really. 'Right now she should be here with me and we should be working as a family unit to make sure she's OK but you sent her horse riding. I don't get that logic.*

A parent whose daughter had been abused as a young child told us about high thresholds for support and treatment:

*All these years I've been waiting for it to come out. Ten years for me to get anybody to take some notice and say, she needs some help. And it took her to want to kill herself for somebody to say, Right, OK she can have counselling and support.*

Some parents described the system as uncoordinated and that their children were not able to develop a trusting relationship, despite that being the key to their recovery:

*We had to explain our situation to three different workers. Then when the third worker was beginning to build a relationship, she was changed and we were given another worker. And I said "No, I'm not going through it all again. I am not willing to because I can't keep coming in this room every few weeks, breaking down and telling these people my life story. It's not right." So I think if you have a worker you should stick with that worker. They are on about confidentiality, well, if that was confidentiality.....half the office know about us.'*

Parents spoke about what has been really about the help and support their child has received by the case-holder:

*They've put us on this new programme where they involve the school and anybody else who would need to support us. So far the people who have supported us is the school and Barnardo's offering some counselling. Other than that we will have to see whether there is anything they can do for us as a family. There's no kind of support as a family anywhere else.'*

*The role of schools*

Parents were generally complimentary about the support their children have received from schools. Some of them relied on good teachers who can see the whole child's needs:

*There is a very good teacher at his school. I think the school do play a big, big part and if you've got a very good school with very good teachers, and they are very supportive and understanding, then that goes a long, long way.*

One parent described very positively the way that her child's school was supporting her child with flashbacks at school:

*She needs to get out of the class there and then, and they'll let her go and work outside without asking why. The parent also praised the way the teachers 'approach her if she's misbehaving in a slightly different way because any approach that's too heavy and she'll fly off. She's a very angry child at the moment.'*

In summary, parents and children have described clearly the impact that sexual abuse and exploitation had had on them and their entire family, the consequences it has had on their mental health and wellbeing, the services that they require, and some useful ideas on how these services could be delivered. They have identified what works for them (and what does not) – but overall they have 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. These thoughts have been integral to the planning, delivery and evaluation of the projects described in the next three sections.



## 5. Project evaluation – Birmingham

### The system and context

The Birmingham project was led by Forward Thinking Birmingham (FTB)<sup>48</sup> the mental health partnership responsible for providing services to 0-25 year olds across the city. FTB has worked in partnership with the three Voluntary and Community Sector (VCS) organisations who are currently commissioned to deliver services to children and their families who have experienced abuse: Barnardo's Amazon Project, RSVP (The Rape & Sexual Violence Project) and The Children's Society. From April 2018, local authority social work services will be delivered through Birmingham Children's Trust.

The Birmingham team identified significant challenges in their city that constrained their ability to offer a consistent, joined-up service to children and young people who have experienced sexual abuse, including:

- Children not being identified as having experienced CSAE or recognised as needing emotional support, and experiencing damaging life consequences as a result;
- Children only identified as having been abused after their unaddressed distress leads to anger and other behavioural issues resulting in poor school performance, re-victimisation or sexual exploitation;
- By the time a child is ready to receive support, they may no longer be using a service that can help them;
- Cases being prioritised mainly on the basis of risk eg of further sexual harm, leading to 'lower risk' cases waiting for up to six months for a service;
- Existing services are oversubscribed and provide an inconsistent response.

#### *Existing services and systems*

In Birmingham, case-holding and keyworking are seen as interchangeable concepts. The worker should not change during the child's journey and the child can therefore build trust with an adult who engages and models a positive relationship and action. The keyworker should assist the child (and their family in some cases) to navigate through the system to get the services they need – aiming for this to be at the right time and at the right level of intensity. This relies on the keyworker correctly identifying need, including by helping to have the child's voice heard; challenging decisions on service access and waiting times - or finding alternative support services, often outside statutory services. However, the term itself is contested, with some people finding it focused on the system and not on the child:

*[...] the term 'case-holding' suggests being driven by processes rather than relationship; and that 'holding the child in relationship' would better describe the practice. (VCS provider)*

Prior to the project, case-holding only happened where a child or young person had an allocated social worker because their needs met the s17 (Child in Need) or section 47 (Child Protection) local thresholds.

Where a child or young person's needs meet the Early Help (EH) threshold, there can be an 'Early Help (EH) request for support'. This involves taking action to support a child,

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<sup>48</sup> Forward Thinking Birmingham was launched in April 2016. It is a cross sector mental health partnership led by Birmingham Children's Hospital, with The Priory Group, Worcester Mental Health Foundation Trust, Beacon UK and The Children's Society, commissioned to deliver mental health services for children and young people aged 0-25 in Birmingham.

young person or their family early in the life of a problem, as soon as it emerges, and ensures that agencies work together as soon as a problem emerges or a need is identified to ensure the child gets the right response, and the right services, from the right people at the right time. Early Help Panels, designed to give local practitioners the opportunity to discuss cases, identify blockages and agree solutions, have been set up across the city. However, service users still have to present themselves to each individual service even if they have been referred by another; this means that they are likely to have to repeat their story and have their needs assessed again.

Furthermore, when s47 investigations are undertaken, social workers are principally focused on short to medium term safety (whether the child is protected from harm, abuse or neglect), and as soon as the child is deemed to be safe from the perpetrator, the case is closed. There may then also be a referral for psychological intervention if the child is displaying signs and symptoms of distress which the professionals assess to be related to the CSA. However, as soon as the family is deemed to be 'safe', then children's social care withdraw and no-one holds the case or funds support.

There are existing VCS services responding to CSAE, but their view is that children with presentations that made them vulnerable to re-victimisation (or the beginnings of harmful sexual behaviour towards others) were not receiving a service from/funded by, children's social care, and even where they were eligible for a mental health service, there are no mechanisms in place to meet the whole child's needs. Providers commented that:

*'In consequence, there was a cohort of distressed families bouncing around the system often having been referred to all the services but receiving services from none of the services. The family bounces around until they sink into such crisis like usually disrupting school, re-victimisation (with missing episodes) or attempted suicide, but also, substance misuse or general offending or harmful sexual behaviour (HSB). Then they meet thresholds and get a reactive/crisis-led short term intervention (again).'*

This underlines the significant opportunity there is in case-holding models that can 'hold' a child or family, take a more rounded view of the services they require and not step away once immediate crises are resolved.

#### *Joint commissioning*

The Birmingham multi-agency safeguarding hub (MASH) is jointly commissioned. Birmingham is split into three areas, each with a CSE co-ordinator. The CSE and Missing Team Manager chairs initial MASE meetings and reviews are chaired by area Team Managers. The City has a jointly-chaired (LA & Public Protection police) commissioning group. Membership includes health services and the VCS. The intention is for the group to provide the strategic direction for the recommissioning of sexual abuse and exploitation provider services to begin delivery in April 2019.

The need for pooling budgets through a single commissioner remains an issue, particularly for smaller VCS providers. For example, a VCS childhood sexual abuse and exploitation support service receives its funding mainly from a local NHS Trust, with small amounts directly from two Government Departments and the local authority (and also from the local Police and Crime Commissioner). This funding pattern is precarious and makes the provider unstable, their future uncertain, and governance and oversight challenging.

#### *Referral and pathways*

From our limited time in Birmingham, we had a sense that reciprocal referral between the various agencies dealing with CSAE has, generally speaking, been effective. The working arrangements between agencies is built on informal relationships between individuals trying to support children and families, rather than a reflection of policy and/or planning. However, a theme from Birmingham (and indeed other areas) was the need for firmer information sharing protocols to avoid repeat assessments.

Reciprocal referrals between parents, the VCS providers, police, and the paediatric Sexual Assault Referral Centre (SARC) are good. There is a recently clarified 'emergency forensic pathway' to the paediatric SARC which includes advocacy and counselling (nine crisis sessions). However, there are few referrals between the VCS providers and schools, CAMHS or children's social care. In the absence of a case-holder model for children whose needs do not meet the various thresholds for service (or whose case has been closed by children's social care), there is no mechanism for joint working together or integrating work with the referrer or other non-specialist agencies. In relation to CAMHS, a VCS provider said:

*CAMHS needs to make the various referrals ... However, referrals into CAMHS go onto the waiting list (so the referrals never get made)*

The VCS providers felt that they needed to be part of the recognised referral pathway to children's social care. This would also address the issue of referrers being unaware of the specialist abuse and exploitation services available for children and their families.

Birmingham City Council is keen for schools to be fully engaged in the planning for any future case-holding development to ensure that the model is integral to the schools' existing pastoral care offer.

The Birmingham project team feels that their work has helped move thinking along on how a more accessible model could promote early identification and referral for sexual abuse; FTBs sustainability plan for their project includes further thinking on the development of a single front door, easily accessible through a single commissioned provider website. This is being planned as part of the re-commissioning of sexual abuse and exploitation services for the city.

#### *Accessing mental health services*

As is common across England, there is a waiting list for access to mental health services - now delivered in Birmingham by Forward Thinking Birmingham (FTB) 0-25, the commissioned partnership led by Birmingham Women's & Children's Hospital. It is built on 6 Levels (Universal, Universal Plus Partnership, Brief Intervention, Complex Care, Intensive Support and Inpatient Care) and 5 Pathways. One of the services delivered, Pause, is a sub-contracted service within FTB run by The Children's Society, which provides an Early Help Offer through Drop in, self-help support and workshops and is one of the Universal Plus Partnership levels of the FTB model. As a result of these newly-commissioned services, access improved over the duration of the project.

#### *Whole child's needs*

Meeting the totality of a child's needs following sexual abuse is a challenge, and this is as true in Birmingham as elsewhere. It has been recognised that the success of a child's counselling, for example, may well depend on the resolution of another issue such as difficulties at school, domestic abuse, parental mental ill health or poor housing. Another provider offering support for children who have experienced sexual abuse described the service as:

*[...] not being funded to provide the whole family service which would equate to Early Help. The service does not undertake a whole family or even child assessment. Families receive a referral as part of the plan based on the children's social care assessment. The service is commissioned as a 'counselling service for the child; there is a short (three month) intervention for the protective parent, however this can only be offered to selected parents.*

Similarly, the provider offering support to children following sexual exploitation is commissioned to provide advocacy for court cases only. So whilst these services are important to children and families, neither is providing a service that focuses on the whole needs of a family. The relationships the professionals develop to hold the cases between them are informal. There is no formal strategy/pathway or plan for managing a whole-child, or whole-family case.

#### *Recovery services*

The Amazon Project offers a counselling service for children and young people who have experienced sexual abuse or exploitation, but has limited capacity due to its small team of six workers, and has a waiting list of four to six months. The service is commissioned to provide each child with 26 sessions, to meet the needs of the child. There is a cost to extending the service (which is often doubled) and this cost is met by charitable funds.

The child sexual exploitation advocacy service is funded largely by the Home Office and Children in Need. The service provides two children's advocates for the whole City; and it can offer some group support to parents whose children have been abused and also offers training to build capacity in universal services to respond well to CSAE.

#### *Needs assessment*

The local Joint Strategic Needs Assessment (JSNA) should provide the framework for estimating prevalence of CSAE locally, and identifying the broader challenges faced by children and young people. There is a view that, as part of the JSNA, there should be an estimation of the number of local children who have experienced CSAE, as well as other adverse childhood experiences or events. In fact, even in its current format, the JSNA is unlikely to provide a sufficiently focused and detailed picture of CSAE for commissioning purposes. In consequence Birmingham has commissioned a separate CSAE needs analysis for the city.

#### *CSAE Strategy*

The current national focus on CSE has meant that there is a local strategy for CSE in Birmingham, specifically focused on gang-related abuse. CSA has always been seen as coming within the day-to-day focus of children's social care and has therefore not yet benefitted from a separate strategy or been differentiated from the abuse and neglect which social workers 'routinely' deal with. The result is that child sexual abuse and exploitation are dealt with separately at a strategic level and not joined-up operationally. There is a growing sense within Birmingham that this needs to change, and this has been given impetus by this project. The new strategy will be aligned to the Police CSE Strategy (which is also in development) and which has a focus on perpetrators. These new strategies will inform a unified CSAE Strategy for the city and the re-commissioning of the CSAE services – starting in April 2017 for the new services due to commence in April 2019.

## The Birmingham project

The timing of the project couldn't have been more fortuitous from a commissioning perspective – it coincided with preparations for the re-commissioning of the voluntary sector services for children and young people who have experienced sexual abuse and exploitation. In an unprecedented statutory and voluntary sector collaboration, the commissioners joined the project partnership with a view to supporting the projects and learning from them, in order to inform the recommissioning of the CSAE services. The result has been a successful collaboration which has been taken forward after this project ended.

The social care commissioners completed interviews across the landscape to inform their bid to DH for this project, and focused in on three areas for improvement/exploration:

- A case-holder model - team-around-the-child (TAC) CSA service;
- Child service user consultation on effective support following CSAE; and
- Training and resource development for professionals and parents/carers to enable early identification of CSAE.

These broad categories translated into the three interlinked project areas set out below.

### *Case-holding*

Barnardo's Amazon service were commissioned by the project team to lead the case-holder element of the Birmingham project. This provides support to children and young people aged 18 and under in the city who have been sexually abused. As the team got to work, they identified the following challenges:

- Local practitioners' frustration at being constrained to offer only supportive counselling; very often the success of their counselling relied on the other elements of the child's life being better managed or supported;
- Some children and their families were receiving no support following abuse;
- Where support was being offered, there could in some cases be up to 10 professionals involved, working in an uncoordinated way, with the child and their family having to navigate the different services;
- Children and their families were reliant on reciprocal referrals, with the accompanying requirement to repeatedly tell their story and be assessed;
- The majority of children were receiving no advocacy and other support to meet the whole child's needs;
- Service user feedback was that some additional support was needed to ensure that the support being offered was effective.

The project was designed to test whether providing a case-holding service could provide a whole child/whole family service in which the child and family have their additional support needs formally identified and documented, have a monitored support plan and receive additional support.

The project goals were to:

- 'Test-and-learn' from a case-holding service for a small number of families;
- Use an early help assessment to identify needs, and to share this assessment with other services;
- Develop an 'Our Family Plan' and meeting led by a lead practitioner to deliver the assessment and ensure continuity, ongoing review and accountability.

At the time the fieldwork was undertaken, 15 families had been offered the case-holding service, with around half of these families currently participating in the service.<sup>49</sup>

The local self-assessment and commissioner's view is that the project addressed the gap in care pathway for all levels of need. It is their view that the case-holder service has definitely improved the experience of services and the outcomes for the child and family, in that their needs have been met in the round. However, it became apparent that the case-holder service was highly resource-intensive as the offer was made to each individual in the family in all cases. In terms of time, where counselling for a child comprises a set of time limited sessions, case-holding for a whole family required working around their needs and navigation through the complex system of services, with individual family members progressing on their journeys at different paces. This has led the Birmingham team to query whether the case-holder model they have designed is cost-effective in the long-term. They will reflect on this in more detail as their retendering work progresses in the coming months.

The case-holder service worked for children, with young people being less inclined to have their whole family involved and having professionals talking to their parents about them. The older children are more likely to want to receive keyworking, counselling and advocacy from the CSE service provider.

#### *Promoting early identification of abuse*

RSVP were commissioned to deliver the second element of the programme - to promote early identification of sexual abuse and exploitation through resources and training for professionals and parents. There was a clear sense locally that professionals (and parents/carers) were still not identifying CSAE, lacked confidence in responding to it, were not knowledgeable about trauma-informed practice, or lacked of knowledge of specialist services available.

The aim for the second element of the project was to prepare universal service professionals (and eventually parents) with a sufficient level of skill and confidence to support children and young people who have been sexually abused. An evaluation of current training provision identified significant gaps, and a learning programme was developed and delivered locally by RSVP, alongside a directory of services available to families. At the present time:

- 819 professionals have been trained in early identification of CSAE as a result of the project, how and where to make a referral and in trauma-informed responses;
- The evaluation has led to the identification of a suite of resources for children and young people, and health care professionals;
- A set of 20 short training films are currently in development and will be shared on completion.

In addition to the areas of activity listed above, a website is under development that will form the single front door for children, their families and professionals to access commissioned CSAE services across the city. This element of the project has led to a better understanding of what skills each provider organisation has and better collaboration between providers. The partners are now ready to begin the detailed work of formalising their consortium partnership.

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<sup>49</sup> The families not receiving the service declined it on the basis of not requiring it, it not being appropriate to their needs or that they wanted counselling only at this stage.

### *Service user consultation*

The Children's Society Pause project was commissioned to capture the views of children and young people who have been sexually abused or exploited on what elements are necessary for an effective service, with a view to this supporting the recommissioning of VCS CSAE services described above. The findings of this work are quite stark, with children describing their initial contacts with social care, the police and CAMHS as *'unhelpful'*, *'unprofessional'* and having *'no empathy'*. Two young people stated:

*'CAMHS was shocking ... not tailored to the person'*

*'On first visit [with CAMHS] was asked "why [are you] here?'*

Perhaps unsurprisingly, one young person said:

*'I felt like I was repeating myself...all services need to work together sharing information before assessment'*

The combined feedback from children, young people and parents interviewed for this report will also inform the specification for the CSAE services to be developed later this year.

## Successes and challenges

In many regards, the project in Birmingham came at an important time for the city: it is in the early stages of recommissioning VCS services for children and young people who have been abused, and the project has enabled people in the system to re-establish relationships and to raise the profile of CSAE. It created an opportunity to accelerate the process of breaking down barriers between providers. Although the number of families who participated in the case-holder model was small, it has allowed for some significant learning about this approach that will support commissioning decisions in coming months. The density of practitioners trained in identification of CSA leads us to believe that there is a growing 'critical mass' of people in the city who can identify and support children and young people at the most challenging point in their young lives. Collaboration across the complex partnerships has been excellent, with this now translating into better relationships at a practice level.

There has been full agreement across FTB and beyond on key issues such as addressing CSA and CSE as one issue; that a child-centred, trauma-informed approach is critical; that seamless case-management should be the norm, and the re-balancing of services in favour of CSA (together with recognition that CSE can be re-victimisation from childhood CSA). There is very clearly an improved, more child-centred way of working, driven by 'what is best for the child' and a renewed focus on all sources of trauma, not just ensuring short-term safety.

The biggest challenge cited by the project team was the expectation that this project could be delivered within the time allowed (12 months from a standing start). The mobilisation of a complex set of partnerships (that were still bedding in within FTB), engagement at a variety of levels across the partnership, hearing the voices of families and involving them in detailed design work for a novel service, training of professionals and recruiting clients could reasonably be expected to take well over a year to do well, especially in the context of highly complex systems and limited leadership and management capacity.

The team invariably had to spend a lot of time developing or establishing new relationships across a complex network of organisations and felt that this wasn't accounted for within the overall timeframe for the projects. Whilst this didn't enable in-depth, early discussions on important issues such as defining the case-holder approach, scoping the evidence or

designing different models, it did support a system-wide focus on CSAE, rebuilding networks and has built firm foundations for future development and change.

The Birmingham team has learned that the case-holder concept needs further design and testing work, perhaps with the development and testing (and cost benefit analysis) of more thoroughly tested and different models. (An advocacy-focused approach could have created a more flexible approach to ensuring that a child's entire needs are met by multiple organisations.) The team also have a stronger sense of the time required to market novel services (like case-holding) to a wider range of service users whose feedback will then be invaluable.

Birmingham Children's Hospital, who are responsible for commissioning children's mental health services, will be recommissioning VCS CSAE services in the financial year 2018-19 for a 2019/20 start. The VCS organisations currently offering services across Birmingham are keen to develop a provider consortium. They aim to put in place a single front door/single website, such as The Survivor Pathway<sup>50</sup> supported through aligned information sharing, recording, case-holding and performance management and reporting systems. The learning and feedback from the project will be used to explore the new CSAE service offer based on the model set out in this report. Building on the momentum achieved to date, the CSAE commissioning partnership is preparing two further bids for a part-time project manager to lead the development of a provider consortium and single-front door, and a further bid to DH for funding to develop a trauma-informed, case-holder CSAE service for vulnerable children.

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<sup>50</sup> The Survivor Pathway is a website offering easily accessible guidance for professionals and concerned others to the referral pathways for rape and any kind of sexual abuse or assault in the 5 regions of Bristol, Bath & NE Somerset, North Somerset, Somerset and South Gloucestershire. See: <http://www.survivorpathway.org.uk/>



## 6. Project evaluation – North Central London

### The system and context

The North Central London project has, from the outset, been embedded within a much wider and longer term programme of work that is accompanied by substantial funding from the London Mayor and NHS England (London) to improve the CSA care pathway in the capital. To that end, the London project team were engaged in this work before the DH-funded project was initiated, had a pre-existing project management infrastructure in place, and had undertaken other improvement projects (including a substantial review of pathways following sexual assault).<sup>51</sup>

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 (generally within the last seven days) where they can access forensic 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, and as discussed earlier, 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 which 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.<sup>52</sup> 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.

This particular model was recommended in the *Review of pathway following sexual assault for children and young people in London*<sup>53</sup> (The Goddard Review) and by the Children's Commissioner for England in *Protecting Children from Harm*<sup>54</sup> in 2015. The North Central London CSA Hub is anticipated to be the first step towards the development of a Child House model. This Hub part-launched in July 2016 ie: just as this project was getting underway and was fully staffed by November 2016.

The London project sought to respond to a particular set of challenges, where around 12,500 children and young people a year in London experience sexual abuse, yet only circa 4000 present to the authorities. Fewer than 1000 children are seen by paediatricians at the Havens or in local clinics and very small numbers access mental health support from CAMHS.

#### *Case-holding*

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<sup>51</sup> Goddard, A., Harewood, E, Brennan, L: Review of pathway following sexual assault for children and young people in London; King's College Hospital NHS Foundation Trust, NHS England (March 2015)

<sup>52</sup> 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, interdisciplinary and multi-agency co-located immediate (and in some cases longer term) response to child sexual abuse.

<sup>53</sup> Goddard, A. et al, op cit

<sup>54</sup> 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.

A key commonality across all case-holder systems is that the services a child needs are co-ordinated for/with them to enable navigation through a complex system. Whilst in other services this is undertaken by a single keyworker, the Hub approach proposed as part of the London project is similar to the Team-around-the-child (TAC)<sup>55</sup> model often used to support younger children. A Lead Professional is nominated to co-ordinate support from different services and disciplines.

The Hub brings statutory health & mental health services, and voluntary sector services together, with the early emotional support and case-holding elements commissioned through this project. Co-ordination is undertaken by a case-holder who becomes the single point of contact for the child or young person. This role is in parallel with that of the social worker (if there is social care involvement) who attends the initial CSA Hub meeting. The Hub team uses weekly team meetings to share information, reflect on individual practitioners' interactions with the child and family and to review/change the Hub care plan for the child. The team offers separate sessions with children and their parents and the advocate or CAMHS practitioner offer six sessions.

#### *Existing services and systems*

The North Central London CSA Hub, which builds on the services offered by the three London Havens (Sexual Assault Referral Centres), has been set up specifically to deliver a flexible two-way referral process between agencies. Children's social care already had systems and processes to respond appropriately to CSA, so the Hub team has been focused on developing robust reciprocal care pathways to support a good health service and police response.

Unlike the linear social care pathway, the Hub allows for the iterative characteristics of CSA cases (where children disclose, then often retract, only disclose later, or disclose incrementally). This means that a case can oscillate between levels of risk depending on the information available to the professionals at any one time:

*[...] the child disclosed and then retracted but was brought to the Hub anyway, introduced to the team and the visit allowed for a discussion with the protective parent about what support might be given to the child in view of the fact that the Hub assessment was that the abuse had taken place.*  
(Paediatrician)

Similarly, another family's case had been closed by children's social care on the basis that the mother was a protective adult. However, through continued engagement the Hub team became aware that the mother was convincing the child that their abuse was "made up" and that the child was "mentally ill". The protective parent withdrew contact with the Hub who then referred to the local MASH for further children's social care assessment and intervention. Had the Hub team not been there, the case would not have been re-referred to children's social care.

The service offers:

- Medical examination and documentation of injuries for children following CSAE, and immediate medical follow-up;

- Support for the ABE interview and advocacy to support children and their family who engage with the criminal justice process;
- Six brief intervention sessions focused on emotional well-being and mental health support for the child and their protective parent/carer.

As is common across all areas in this project, professionals described to us a picture of CAMHS under substantial pressure in London – many services have protracted waiting lists for treatment and one professional described CAMHS access as “idiosyncratic and unpredictable”. This makes prioritising the children referred by the North Central London CSA Hub a challenge, and is why time-limited CAMHS support is offered as an integrated element by the Hub.

The extent and complexity of the difficulties facing some of the children and their families is significant. Many children have experienced chronic maltreatment including sexual abuse and they have come through several adverse childhood experiences (ACEs) in their young lives already, making them particularly vulnerable to long-term physical, mental health and emotional problems.

The majority of referrals are for intra-familial child sexual abuse, and referrals have quadrupled since the Hub service started. The waiting time has increased to two weeks with the rise in demand. As demand increases, there will need to be a close monitoring of the waiting time/list.

#### *Whole child's needs*

The North Central London CSA Hub brings statutory health and mental health, and voluntary sector services together under one roof, and at the initial meeting the whole team meets the child and family. The minimum support offer is consultant paediatrician input, social worker engagement and support from a play specialist. The family therapist and the advocate sometimes do not need to be involved and are available if needed which gives the team flexibility.

Where the team cannot meet the entirety of a child's needs, they can identify them and make onward referrals. Similarly, the Hub helps to identify risks which makes it easy for children's social care to recognise the potential for, or actual harm.

The children are asked what they would like to have happen and who they would like to work with. This flexibility is essential and works very well in the Hub team, though this can add to the workload of specific professionals. The team have advocated and liaised on families' behalf with their MP, legal firms, professionals in closed communities etc.

#### *Care pathways*

Every assessment at the Hub starts with a discussion which includes the mother, the social worker, the paediatrician, the advocate and others in some cases. On arrival at the Hub, children are occupied by the play therapist whilst the meeting is taking place and any information from the session with the child will be fed into the meeting. This way of working can be really helpful particularly when the parent is very upset.

The Hub team describe access to the Hub as 'easy' - the team do not set any threshold for accessing the service and encourage referrals from which they can then assess a level of need. Referrals can only be made by a professional and the team have been advertising the pathway increasingly amongst professionals. All referrals so far have been from children's social care as part of a s47 assessment. After the s47 enquiry, if the sexual

assault happened outside of the family or the family comprises protective adults, then children's social care close the case.

#### *Trauma-informed work*

Trauma-informed work is ideally focused on identifying any trauma which lowers a child's resilience and addressing it before the child is further harmed. It starts from an understanding of the impact of different adverse experiences on the child, their parent and the family as a whole. The North Central London CSA Hub aspires to be a trauma-informed service with a focus on all the trauma in the child's life, not just the physical symptoms from the most recent sexual assault. Responding to this wider context involves open dialogue with family members about other adverse events in the life of the child and the family, which is a highly skilled intervention in itself.

The majority of intra-familial CSA cases are non-recent when they come to the attention of the Hub. The team assess the child's needs and also co-ordinates support from the different agencies. This is a short term team-around-the-child model designed to bridge the child and their protective parent/carer into longer term support.

The biggest challenge for this model is the short-term nature of the support the Hub provides. By its very nature, the Hub cannot offer long-term therapeutic intervention, and this means that the child inevitably has to experience a transition from the Hub to their local services, which represents a break in that important relationship which can be a hinder in recovering from the trauma of the abuse.

#### *Needs assessment*

The development of the North Central London CSA Hub was spurred on by the comprehensive assessment of needs of children and young people who have experienced sexual violence<sup>56</sup> and the Goddard Review<sup>57</sup> which identified gaps in care provided to children after sexual abuse and exploitation, including:

- waiting times varying between three CAMHS providers from 2-13 weeks for assessment and up to six months for intervention, with access limited to those with a diagnosable mental illness and no early emotional support;
- difficulties in navigating a complex system and finding local services, with some children who reported CSAE to the police not being in receipt of support from health professionals or independent sector specialists, and no case management approach before or after trial.

#### *Service user consultation*

Children, as well as adult survivors of CSA, have been engaged in the wider CSA transformation programme in London over the past year and a half. There has been an extensive programme of consultation on the development of the Child House model with more than 150 children involved through one-to-one meetings, CAMHS participant groups, youth parliaments, children in care councils, youth offending reparation groups and support groups for children identified at risk of CSE. Children, young people and adult survivors said that the service should:

- Feel safe, anonymous and comfortable;

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<sup>56</sup> 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)

<sup>57</sup> Goddard, A. et al, op cit

- Be in a building that looks like a normal place without a big sign;
- Be in a space that is creative and colourful;
- Have spaces and entertainment to cater for both younger and older children;
- Have staff that make you feel comfortable and at home;
- Be located in a place with good transport links; and
- Not be called the Child House or mention sexual abuse.

The themes that emerged have been taken into account in the development of the North Central London CSA Hub as much as possible within the limits of their current funding.

The decision that the CSA hub should operate from two sites to cover the whole sector, and the fact that children can choose which of the two clinics is more convenient for them regardless of their borough of residence, improves access for children, young people and their families. Additionally, although children initially access the service at the hospital sites at the time of medical examination, the six sessions of emotional support are offered at any location the CAMHS clinicians and Child Advocate are willing to travel to.

### *CSAE Strategy*

Each of the local authority areas in north central London has a CSE Strategy. There was an unmanaged care pathway (in the sense that children went to the Haven and then to CAMHS), however, the child and parent/carer navigated the process themselves and there was no professional coordination. This resulted in children falling through the net in the cases where the family was dysfunctional and/or the parent ambivalent. The Hub service existed prior to the project, but generally speaking with just the paediatrician undertaking the examination, with the health, mental health, and the voluntary sector staff joining them to provide a more holistic service.

## The London project

The London team had some significant advantages over other areas selected by DH for this programme of work - thanks to earlier funding from the Mayor of London and NHS England (London), relationships had already been developed across the complex systems, project leadership and infrastructure had been in place for some time, including the three well-established Havens which meet the needs of people of all ages who have been sexually assaulted or abused, a strategic view of services required was agreed and work was already underway to develop and implement the Child House model. This particular project nestled well into that existing programme in that it allowed case-holding and early access to support to be put in place and for lessons to be learned from it.

Despite these advantages, significant challenges remained including a lack of dedicated early emotional support for children who had been sexually abused, access to CAMHS was constrained (limited to those displaying diagnosable mental illness), where access criteria were met, waiting times for CAMHS services were too long and there was no clear mechanism to manage the cases, with young people and families left to navigate the system themselves and find local support services.

A case management and advocacy service was commissioned from Solace Women's Aid (0.8 WTE) to enable initial needs and risk assessment, support for children and families to navigate the pathway and to work closely with children's social care when appropriate. Additionally, the project also funded early support for mental health and well-being needs through having two part-time (0.5 WTE band 7) CAMHS practitioners in place to enable early CAMHS clinical assessment, support for families and to identify appropriate long-term emotional and mental health support for the child or young person including:

specialist CSE risk management, sign-posting to local services such as school counselling or tier II services, short-term therapy or long-term therapy. This support was offered across two clinics in two separate locations (St Ann's Hospital in Haringey, and UCLH).

This approach allows for flexibility, enabling one-to-one sessions between a parent and the most appropriate person (for example, a paediatrician if the child has medical needs). The new Hub has enabled early intervention and support to be offered. This is a significant change:

- a) The multi-disciplinary team meeting before the clinic includes paediatrics, CAMHS and [third sector] advocacy. The team work through an agenda which looks at all the current and referred cases and plans action on each;
- b) The meeting enables the team to identify any gaps already being experienced or in the child's plan, and address them; and
- c) All the practitioners attend and contribute to the meeting.

This significantly reduces the risk of a child 'falling through the net' as there is a shared view of who is taking the lead, who else needs to contribute and what gaps there may be in the care of an individual.

This represents a significant departure from the original service in which lots of agencies were involved in a case but had limited contact with each other, where families were in effect their own case-holder and there was limited clarity on which professional was in the lead. This meant that the child and family had to keep repeating not only the description of the abuse, but also the progress on the case.

#### *Successes and challenges*

As a result of this project, 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 offered for the child and their family, regardless of whether they have a diagnosable mental illness;
- Case-holding, led by the Hub team who can then refer onto the right long-term support if required;
- Follow up after six months to ensure that children and families settle into long-term support arrangements;
- Joined up services for all children up to the age of 17, including for boys and young men.

Of the 337 children who reported CSAE to the police in North Central London between July 2016 and February 2017 (ie: a 7 month period), 144 attended the CSA Hub, compared to 141 for the whole of 2015. The Hub team believe that this increase is due to increased awareness as a result of the CSA Hub advice service. Children have been able to access immediate emotional support from the Hub: in total, 82 children and 49 parent/carers accessed the CAMHS service at the clinic, 31 children have been supported by the advocacy service since it commenced in July 2016, 30 mothers/foster mothers have received support from the advocacy service, 30 children/young people supported by a CAMHS Clinician at UCLH since July 2016. 18 children received therapeutic intervention, and in 12 cases the CAMHS clinician provided liaison work and case management, 21 children were supported by a CAMHS Clinician at St Ann's clinic since November 2016. 13 children and their parent/carer received therapeutic intervention and 3 children as one-off appointments. In five cases, the CAMHS clinician 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.<sup>58</sup>

This change to the system has removed barriers to accessing advocacy and CAMHS support and improved multi-agency and professional co-operation. Additionally, outcome measures were trialled including trauma symptom checklist for children, strengths and difficulties questionnaires and goal-based outcome measures. An outcome tracker has also been developed with the aim of undertaking further work on evaluation.

The key success of the North Central London CSA Hub has been the provision of a Team-around-the-child support service for children and their families. Children now do not have to repeat their story as professionals involved with the child work together. In addition, the Hub has generated a much more multi-agency response amongst the wider services. A range of factors have contributed to the success of the project; these include:

- The agencies which seconded staff to the Hub team have provided good support to those staff. The staff brought their professional networks and knowledge about other services which can be accessed by children and families;
- The Hub team have 'contained' children and their families in relationships, which has encouraged the traumatised individuals to reach out for help to process the trauma and re-develop or develop resilience. This has included role modelling for children and their families the linking of services (school, social care, community organisations) in their lives as a means of support;
- The team routinely work outside the usual boundaries of their discipline e.g. making home visits, working in the community and keeping an open mind about what a child or parent might be experiencing, what they need help with, who is or was involved in the abuse (and in the support);
- The Hub team have kept a focus on all the participants in every case – the child, the family and wider community and the professionals.

#### *Issues arising and key learning*

As previously outlined, this project was not working from a 'standing start' as was the case in other areas - existing local relationships, a 12 month preparatory period, commissioner engagement, support for the project, strong leadership and a dedicated project leader were all critical to the success of this work. The next challenge for North Central London is to implement the Child House model as recommended in the Goddard Review.

A significant constraining factor has been the lack of a shared IT system for case management within the Hub. Each of the team members can only access their own agency's IT system, and the team will need to think carefully about how this challenge can be overcome.

The Hub's case-holding role can be challenging to maintain. The team provide children and families with only brief interventions. This is necessary because the Hub only offers six sessions after which the child is referred back with active support and shepherding to their local area. This also fits with the CPS Pre-court therapy guidance.

#### *Exit plan*

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<sup>58</sup> Future in Mind, op cit, page 53.

The participating CCGs have agreed to fund the Hub for the financial year 2017/18; the piloting of the Child House is due to start in 2018. Within the Child House pilot, longer term therapy, up to 2 years, will be possible with a range of trauma-informed interventions on offer, including NSPCC's 'Letting the Future In', trauma-focused CBT, EMDR<sup>59</sup> and groups for young survivors.

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<sup>59</sup> Eye Movement Desensitisation and Reprocessing (a form of psychotherapy used for the treatment of psychological trauma)



## 7. Project evaluation – Rotherham

### The system and context

The project in Rotherham was undertaken in the context of serious and significant challenges across the public sector system. These challenges are documented fully elsewhere, but comprise the recent history of serious CSE, including the conviction of several perpetrators, the deficits subsequently uncovered across the system, the placing of the Local Authority into special measures in 2015 (and control passed from elected members to five government-appointed commissioners) and the slow recovery of the system from a period of turmoil and change. In this context, it is understandable that support for children, young people and their families who have been sexually exploited has been a major focus for the Rotherham project.

A new multi-agency system has been in place in Rotherham since 2016 to tackle child exploitation. The innovative EVOLVE team is one of the first of its kind in the country – comprising social workers, a CSE specialist nurse, a Barnardo's project worker, a children's social care operational manager, business support staff and police officers – all working together in one place. The aim is to provide 'wrap-around' support and protection to children and their family. The EVOLVE team operates from recently-opened, dedicated premises that were designed especially to help put children, young people and families at ease, and includes police interview rooms, medical examination room and spaces for young people to relax. Barnardo's also delivers an outreach service into schools and specific localities, a specialist CCG-funded child psychotherapist operates as a mental health pathway lead liaising with both child and adult mental health services and consulting into VCS and LA projects. Rotherham 'Rise', 'Grow', 'Swinton Lock' and 'YWCA' projects also support adolescents and young adults. The Sexual Assault Referral Centre (SARC) supports children and young people in relation to the assault. All of these services support those who are, or may become involved in court proceedings. They also support those who are not ready or are unwilling to enter the court process.

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.<sup>60</sup>

#### *Child and Adolescent Mental Health*

It is widely recognised and commented upon that CAMHS services in Rotherham (and indeed in all areas supported through this programme of work) have been under considerable strain, particularly (though not exclusively) from rising demand. During the project, the tier 3 CAMHS delivered by the Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) was being re-structured and staff were being recruited to the new structure. As a consequence of all of this, CAMHS thresholds were very high, making it a challenge to be responsive and flexible as set out in the Casey Report of 2015.<sup>61</sup> These factors are especially important when providing services that are sensitive to children who have experienced CSAE, where engagement can be difficult and symptoms not immediately

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<sup>60</sup> 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

<sup>61</sup> Casey L. CB, Report of Inspection of Rotherham Metropolitan Borough Council (2015).

obvious or present. Work was undertaken to improve access to mental health services, specifically for children who have experienced CSAE, through the development of outreach and 'in-reach' consultancy, for example.

It was in response to these challenges that a 'fast-track' care pathway for a CAMHS response to CSAE was conceived as a key element of this project. In addition to support, it was planned as a capacity building resource, providing liaison and specialist case-specific consultation to other professionals and teams. The service was designed to support the statutory CSE outreach team, EVOLVE, and the wider partnership, through joint surgeries with social workers and consultation to the 'Scorpio' police investigation. Children going through the court process as a result of CSE would be supported by EVOLVE or a Local Authority Social Worker (or both). The service would therefore also provide support around court proceedings.

#### *The local area context*

Case-holding in Rotherham during the project has comprised a 'Lead Professional' model - a practitioner who co-ordinated services for a child in the Common Assessment Framework system. There is recognition that a child or young person needs more than co-ordination of services, and that a relationship which includes counselling, mentoring/advice and advocacy/support to access other services can be important. Such a service could be more personal, is based on a growing trust between the child and the adult supporting them and it requires staff to work outside strictly defined, designated roles.

#### *Joint commissioning*

Services for children and young people in Rotherham are not jointly currently commissioned from pooled budgets across the NHS, local authority or other funders. Rather, services are co-located and integrated at the point of service provision i.e. separately commissioned services work collaboratively. For example, a child or young person may have an allocated social worker in the EVOLVE service whilst at the same time having a keyworker in GROW or Barnardo's.

Children who meet the children's social care threshold all have an allocated social worker who is their case-holder. Children and young people who meet the early help threshold (and those who do not but are considered vulnerable) also get a case-holder service offered by Barnardo's Reach Out and funded externally.

Barnardo's uses a model called the 'Four A's' for tackling child sexual exploitation which comprises:

- Access: Services provide a friendly and welcoming environment. Children can refer themselves and information or free phone numbers are widely available in local areas.
- Attention: Children are given a key worker who supports them throughout their time with the service and are offered one-to-one work, counselling, drop-in support and group work sessions.
- Assertive Outreach: Staff visit areas where young people gather. After identifying those at risk, frequent text messaging, mobile calls and home visits are used to create and maintain contact.
- Advocacy: A range of services are needed to build a protective network around children. Staff help children get access to the services they need and advocate for them when relationships with other services break down.

This provides a trauma-informed case-holder relationship for those children who have been sexually exploited. There is no limit to how long a child can receive a service for - a year is the norm, with some children using the service for longer. As one person told us:

*You work with the child until they don't need support anymore* (Rotherham professional)

There has been pressure from the commissioners to put a time limit on cases or to close cases. This has its origins in that mainstream statutory social workers, and those in the children's social care specialist CSE team, carry caseloads of 30 whilst the specialist Barnardo's workers carry a caseload of eight.

#### *Reciprocal referrals*

We found that there was a good level of referral between services, with step-down and step-up clearly happening. This is supported by the fact that Rotherham has one of the better MASHs in England – in 2017, Ofsted inspected and rated the MASH positively.<sup>62</sup> The early help 'front door' has recently been merged into the MASH, but is not fully embedded yet. The complex cases that have been uncovered in Rotherham have been a driver for the step-up process because they uncover new issues for the child as the case progresses and very often this means that the level of risk or degree of identified abuse rises.

#### *CAMHS access*

There is a cohort of children and young people who are being referred to CAMHS who do not meet the threshold and who have then waited months to receive an assessment for a service which they then do not get. This delay is extremely unhelpful to the child (and parent). There has also been a recognition that there needs to be a pre-CAMHS offer in the form of case-holding where this includes counselling expertise or in the sense that the practitioner or parent supporting the child is sufficiently skilled up/confident in supporting a child. There is also a concern about the lack of therapeutic support for young people transitioning out of children's services at the age of 18.

#### *Whole child's needs*

From our limited time in Rotherham, we found the case-holder or keyworking system introduced in recent years for children who have experienced CSE to be effective in meeting the whole child's needs. This is remarkable given the recent and to some extent continuing scrutiny which Rotherham has been under – in these circumstances, staff can be scared to be flexible and adaptable and instead can default to the 'safest' path.

#### *Care pathways*

There are appropriate care pathways for all levels of need. The early help offer is proactive and of high quality and any of the agencies can bring a case to the CSAE Panel. Barnardo's currently work with young people/adults up to the age of 24 years where the child or young person is a care leaver, has disabilities, is an ex-service user or is a young mother. A bid has been submitted to assist with reviewing transition pathways from children's to adult's services for survivors. There is also discussion about longer term support for adults.

There is a review underway to understand whether a specialist team holding all the CSE cases should be put in place, or if CSAE should be 'mainstreamed' with social workers holding the case with support from a children's social care specialist CSE team worker.

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<sup>62</sup> OFSTED (2017) Monitoring visit of Rotherham Borough Council children's services

Early help can comprise a Reach Out group intervention e.g. if a school or youth club identifies an issue with sexting, children hanging around with peers or adults about whom there is unease about their involvement on CSAE or sexual bullying. Prevention (primary & secondary i.e. to avoid re-victimisation) takes the form of capacity building in the community and interventions for vulnerable children. Barnardo's Reach Out uses 'Real Love Rocks'<sup>63</sup> and Chelsea's Choice'<sup>64</sup> with sessions afterwards to pick up referrals resulting from children and young people disclosing CSE. Reach Out provides training and support to professionals facilitating identification of CSAE and support for children and young people. They also provide training for the statutory sector e.g. police, health staff and children's social care, and businesses such as, hotels, licensing staff and licensed premises and taxis. Reach Out supports Rotherham's CSE Champions scheme where each agency has a CSE Champion within their organisation to ensure that the CSE message is cascaded, raising awareness of what to do when CSE is suspected and to provide support to the multi-agency CSAE response.

#### *Trauma recovery*

By the end of the project, it was still not easy for children and young people in Rotherham to access help for recovery. They were able to self-refer, but a specialist service such as CAMHS in particular was under-resourced to meet need so that very few children will receive a service, and those that do so receive it because they have an assertive and persistent keyworker/advocate or social worker. The Harmful Sexual Behaviours (HSB) service is only funded to provide for 20 young people in a year (though in practice, this is extended through 'good will' and needs to be commissioned fully to enable a sustainable service to continue in the long run).

#### *Needs assessment*

The Rotherham Joint Strategic Needs Assessment (JSNA), like many JSNAs did not adequately reflect the challenges of CSAE. This has changed significantly and a clear assessment of need, focused on CSE was undertaken by the University of Salford with Rotherham Metropolitan Borough Council in 2015, which identified vulnerability in specific communities such as the Roma community, living predominantly in the Eastwood area of the town.<sup>65</sup> This is supported by problem profiling, although limited resourcing for the police has meant that the problem profiling could better be described as an 'intelligence assessment'. A free app has just been launched for staff from all agencies to use to record and send intelligence relating to CSAE to the police.

#### *Service user consultation*

The Voice and Influence Partnership was established to enable access to children, young people and families who wish to participate in consultation activity. Consultation with children and their families is robust and contributes to the needs analysis. Whenever a service is reviewed, developed or re-commissioned, the commissioner is in a position to access a range of children and young people (including those with disabilities, from BME backgrounds) who have been trained to participate in roles such as recruitment, service design and service satisfaction/outcomes feedback.

#### *CSAE Strategy*

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<sup>63</sup> <http://www.barnardosrealloverocks.org.uk/>

<sup>64</sup> <http://www.alteregocreativesolutions.co.uk/chelseas-choice/>

<sup>65</sup> University of Salford and RMBC (2015) Needs Analysis Report following the Sexual Exploitation of Children in Rotherham

Historically, and unexceptionally, there has been a split in how agencies approach CSA and CSE. The Rotherham CSAE Strategy is called Fresh Start. It maps all of the local services available to support children and young people. CSA has been tackled by following the statutory child protection pathway, and there is now a move to better understand the connection between neglect and CSAE. This is part of the review and discussion about whether EVOLVE should exist as a specialist unit with social workers holding the cases; or whether CSE cases should be 'mainstreamed'. There is also a review of the high number of children and young people in the 'Looked After Child' population who have experienced CSE.

## The Rotherham project

As with the other areas, the Rotherham project comprised several nestled sub-projects based on their local assessment of what would make the most difference in a relatively short period of time. The project was overseen by a steering group comprising Assistant Director in Public Health, the CSE manager, the Post Abuse Support Service Co-ordinator, a CCG mental health commissioner, a CAMHS senior manager and a senior public protection police officer. The steering group reported into the CSE sub group of the LSCB.

As described above, there was a relatively high bar set for children and young people to access mental health services in Rotherham. The Casey Report also identified this as a key challenge for Rotherham:

*[...] the child and adult mental health services which have been targeted for the most significant investment have a very high threshold for referral: in other words, they are services for the most vulnerable people with acute and immediate needs.<sup>66</sup>*

A key, strategic aim for this programme of work was to address this by linking the existing CAMHS service, the newly formed EVOLVE team, and social care; identifying other key stakeholders involved in working with survivors of CSE; developing a direct and responsive referral route into CAMHS for assessment and onward CAMHS support; and developing a transparent CAMHS pathway across the system that was visible and accessible by both young people and professional stakeholders.

This service redesign was intended to allow CAMHS to change the way they deliver services to children who have been identified as being sexually exploited.

A senior CAMHS practitioner was commissioned by the project to work within the developing CSE pathway to bridge the gap between CAMHS and the EVOLVE team. Under the guidance of the CSE pathway lead (the lead psychotherapist) the CAMHS practitioner accepted referrals for initial mental health assessments (including mental health risk assessments), and brief therapeutic work, directly from the local authority. They also picked up initial assessments concerning CSE in the usual way from the CAMHS allocation meeting. They worked closely with the specialist CSE social workers as well as with other providers of CSE support such as Barnardo's, co-ordinating care from a mental health perspective and taking part in joint work with both social workers and therapists.

During the period when the CAMHS worker was mobilised (between August 2016 and March 2017), 55 cases were offered consultation at the point of referral into the service, and of these 55 cases, 14 were offered direct and on-going CAMHS intervention. The CAMHS worker also offered liaison into 80 cases where young people were brought through the

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<sup>66</sup> Casey, L. (2015) Report of Inspection of Rotherham Metropolitan Borough Council

risk assessment process by professionals where there were concerns about young people's vulnerability to CSE. This formed part of a review of all cases in Rotherham (not necessarily new cases of CSE)

The project has supported a trauma-informed approach: by helping individual parents and professionals to understand the mental health issues the child is struggling with, it has shortened significantly the waiting time for children who have experienced (or are at risk of) CSE to access CAMHS intervention and it has enabled organisational understanding of the approach through the CAMHS psychotherapist contributing at governance levels e.g. to the EVOLVE team. It has led to improved communication and mutual learning across the system, and has built capacity within the system to support children who have experienced CSE.

The Jay report highlighted the strengths of the Rotherham LSCB training programme, including its focus on training in attachment theory for a range of professionals in Rotherham. The Casey report highlighted the importance of understanding the generational impact of CSE both upon the current and upon future generations. There is a growing body of evidence that supports the view that trauma in early childhood can have significant impacts, not just on the child, but on future generations too.<sup>67</sup> Parental bonding, attachment and attunement to an infant are critical protective factors against future ill health. The Chief Medical Officer for England has stated that

*[...] those who suffer multiple adverse childhood events achieve less educationally, earn less, and are less healthy, making it more likely that the cycle of harm is perpetuated, in the following generation*<sup>68</sup>

There was a recognition, based on earlier training, feedback from service users and staff, that practitioners would benefit from further training in child development and attachment needed to develop and use attachment and attunement to interrupt the negative impact of CSAE on the next generation. There now exists a cohort of young adult survivors of CSE in Rotherham, many of whom are now parents. Whilst the local FNP service undertakes invaluable work with vulnerable teenage parents, many of the historical cases of CSE are out of the age range for the service and have several children, some of whom had been taken into care previously.

In response to this, the project team commissioned the Northern School of Child and Adolescence Psychotherapy (NSCAP) to deliver 10-week intensive training courses to improve practitioners' observational skills, raise awareness of the seriousness and importance of relationships at the different stages of child development and give practitioners greater confidence in working with and understanding infant development and neuroscience, and thereby improve their ability to work with the parents to improve attachment between them and their children. The training has been commissioned and the first 10 week course has commenced, but further evaluation of this element of the work is not possible at this stage.

The final element of the Rotherham programme focused on learning the lessons from a complex police investigation of CSE in the Roma communities in Rotherham. As mentioned earlier, the needs assessment had identified particular vulnerability in these communities, and in March 2016, just as this project was beginning, the Police and RMBC had launched Operation Scorpio to look at this in detail. The local CSAE partnership had undertaken

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<sup>67</sup> Champagne, F.A. (2015) Epigenetics of the developing brain. Zero to Three

<sup>68</sup> Durkan M. Field, F. Lamb, N. Loughton, T. (2013) The 1001 Critical days: The Importance of the Conception to Age Two Period. Cross party manifesto

several complex multi-agency police-led operations in response to a developing picture of suspected widespread CSE within local black and ethnic minority communities. The enquiries had all been structured under the themes of *prepare, prevent, protect* and *pursue*. In each case, the enquiry commenced as a police intelligence gathering operation, which subsequently developed into a multi-agency response.

The local team commissioned an independent review to identify learning from Operation Scorpio for future operations and to provide the multi-agency senior leadership team with sufficient information to make informed decisions about the future of the ongoing enquiry and step-down from the enquiry for the affected communities.

The reviewer examined documentary material, undertook interviews and focus groups, and held a multi-agency learning event for professionals. Extensive consultation with members of the affected communities were also undertaken. The review author, Maggie Blythe found that there is:

*[...] a strong approach to tackling CSE in Rotherham.*

The report found that stronger governance and leadership at a strategic level is required, that working with and engaging with communities is key to tackling 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. Subsequently, an action plan has been developed to address these challenges and which specifically supports and has been approved by the Rotherham Local Safeguarding Children and Adults Boards.

#### *Successes and challenges*

As a result of the CAMHS pathway enhancement, Rotherham now has a dedicated CSAE CAMHS therapist who is contributing from a trauma-informed perspective at an individual client level, as well as in support of other professionals (and their direct work with clients) at a multi-agency operational level (e.g. membership of the governance board for EVOLVE and input into children's social care and public health commissioning) and at a strategic level (input into the JSNA and CSAE strategy). The therapist also provides case consultation for keyworkers which means that some children who may have been referred to CAMHS no longer need to be - their worker can undertake the work with support. There is now a much clearer, much more effective local pathway into CAMHS, or CAMHS support for the parent or keyworker, and for children who have experienced CSE - children are accessing CAMHS much more quickly than previously.

The attachment/attunement training has been popular and is fully booked. Previous evaluations from this provider's work suggest Rotherham can expect participants to continue their learning, change the way they manage their workloads/deal with stress and focus on transferring their learning into the workplace.

The learning obtained from the Operation Scorpio review has supported integration of the police into the local CSAE partnership and re-confirmed the partnership's child-centred approach, highlighted challenges in perspective and agenda across the system and has led to the development and implementation of an action plan.

Challenges have accompanied these successes - the programme of work in Rotherham got off to a relatively slow start. There were multiple factors associated with this, not least the significant challenges within the system from the very high levels of scrutiny taking place by appointed commissioners overseeing the work of a local authority in 'special measures'. We make no comment on this process or its outcomes, but do recognise that, at the time,

there was a significant reduction in freedom to act and a sense of stasis brought about by the additional scrutiny. Recruitment of the CAMHS therapist funded by this project took an unavoidably long time, chiefly as a result of recruitment timelines and restrictions on employing temporary staff. Significant challenges remain within the system – there were very real resourcing issues in CAMHS at the time the project was undertaken. . Since reorganisation of CAMHS locally and the adoption of a consultation model, starting with the Child Sexual Exploitation project and then widening to the whole of the service, waiting times for initial assessments have dropped below national average, and access to CAMHS has improved significantly.

Similarly, the commissioning of the attachment/attunement training was delayed by local processes, with approvals for procurement and tendering of the training taking some time due to the impact of procurement regulations, which required input from the project leadership to progress. The local project leadership has stated from the outset that a longer period of analysis, planning and mobilisation before project delivery would have yielded a better and more sustainable project.

#### *Exit plan*

The Rotherham team has, from the outset, sought to ensure that a trauma-informed approach is embedded across the system, and this is well reflected in each element of the programme. Funding has been identified to retain the new CSAE therapy post and maintain the new CAMHS pathway for children and young people who have experienced CSAE (and for the parents and staff supporting them). Funding to scale the attachment/attunement training is being explored locally, based on the excellent quality of the learning to date and its uptake. The Operation Scorpio review has led to development of a multi-agency action plan which is being implemented in Rotherham. This has underpinned a shift in police commitment to multi-agency, assertive outreach approach and enhanced support for children and young people.



## 8. Reflections and learning

Overall, this has been an important programme of work. Not only has it shone a light on the challenges children, young people and families face after abuse, but it has also helped us all to reflect on the complexity of the service systems around families, and just how difficult this can be to navigate, even for professionals.

Each area has delivered a significant programme of work to begin to address some of this complexity. They have done so in a relatively short period of time, as we have described how elements of this work are being sustained in each area after the projects ceased being funded on 31 March 2017.

This final section sets out some of the reflections that span all of the projects, with the aim of identifying key learning from these systems that can be applied in a wider context.

### Reflections on the system

#### *Raising the profile of CSAE*

There can be no doubt that, whilst starting from very different contexts and baselines, each project has further raised the profile of children, young people and families who have experienced sexual abuse and exploitation in their respective areas. Their needs for immediate care and treatment, post-abuse support and system navigation are now well-known in each area, and this has manifested itself in clear plans for deeper needs assessment and profiling where this has not already taken place, with a focus on this assessment informing or shaping future commissioning plans.

#### *The 'treatment gap' persists*

As described above, timely access to therapeutic intervention can be critical to a good recovery for many, if not most children. The fact remains that this treatment isn't readily available to most - CAMHS access remains a significant challenge - with tight access criteria and frequent long waits. People below what are perceived to be high thresholds don't routinely receive any service at all, particularly the early intervention that could prevent problems escalating into problems in adolescence or late life. One clinician vividly described this to us:

*CAMHS thresholds are an enormous challenge. For example two sisters who had been vaginally and anally raped by their father and one of whom had set herself on fire as a result of the abuse, were refused a CAMHS service. This is not acceptable. Do these children have to be dead before they get a service!*

#### *A 'safe keeping' gap also exists*

Children's social care can provide a vital service to families to keep children safe and supported at a challenging time. However, we have described a landscape here (which supports what is reported extensively elsewhere<sup>69</sup>) where CSC is under pressure from rising demand and reducing budgets (according to DfE analysis).<sup>70</sup> For children who have been sexually abused, this means that CSC will often step cases down when the child has a supportive parent in place and is safe.

#### *The 'Coping Conundrum'*

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<sup>69</sup> ADCS (2016) Safeguarding Pressures Phase 5

<sup>70</sup> Department for Education (201f) Children's services: spending and delivery research report by Aldaba and the Early Intervention Foundation

These high thresholds for both CAMHS and social care represent what we call the ‘coping conundrum’. Many children who experience abuse are being kept safe by their parents following disclosure, and because they are below threshold to receive a CAMHS service are unlikely to receive significant levels of intervention from the public sector. These families are, in some cases, just about coping, but as a consequence, they are not receiving intervention that could mitigate emotional, behavioural or mental health problems that may arise later in life. That is not to say that many families can and do cope, and do support their children through a traumatic event. Although case-holding can support some families, it cannot entirely replace early therapeutic intervention to bolster resilience. We can assume though that low resource families, with low service provision and limited or no support will struggle.

#### *The scale of the challenge and the response*

Early in this report we have described some of the prevalence data for CSAE that shows just how significant the scale of sexual abuse is in England. Most professionals do want to do the best possible job, and even when under considerable pressure will ‘go the extra mile’ to support families. However, in a time of limited resources, we think that local authorities should have a renewed focus on the entire range of sexual abuse that occurs in these young lives. They should take a public health approach to this challenge (and to looking at all adverse childhood experiences) by estimating the local prevalence from the best available national data, adopt a case-finding approach, as in other areas of medicine, and hold themselves to account for the outcomes achieved.

#### *Look at totality of adversity*

As we described earlier, experiencing sexual abuse and exploitation can have a devastating impact on the health and wellbeing of a child. There are few other experiences that are accompanied by the stigma and shame that so often accompanies this form of abuse. However, sexual abuse and exploitation are but one form of childhood abuse and adversity, and we know that the compound effect of experiencing multiple adverse childhood experiences plays a significant role in determining resilience, and physical and mental health later in life. We think that as well as focusing on CSAE, that there needs to be a ‘place-based’ approach to looking at adversity in childhood in the round, with a particular emphasis on this (and leadership) from public health.

#### *National policymakers can help*

The DH focus on CSAE through the commissioning of this work has been welcomed across the three areas. It offers a strong signal that whilst CSE has been a major focus in the last few years, all forms of child sexual abuse are important. We think that this focus should continue beyond the life of this programme, learning the lessons from some of the most successful government policies of recent years e.g. the teenage pregnancy strategy, which has yielded a hugely significant reduction in the number of conceptions in the last 16 years (over half the number at the outset). We surmise these lessons to be: the importance of having good data; a rigorous cross-government focus; some additional resourcing to deliver support to the system; and a focus on ‘what works’. Leadership, and investing in, and understanding a longer term sustained approach is required to deliver culture, system and individual change.

## Reflections from children and families

### *The role of stigma and shame*

Perhaps unique to child sexual abuse, the stigma of sexual abuse and the shame experienced by children and young people in its wake hangs like a pall over the lives of many families in England. These factors are critical in whether children disclose their abuse and seek support, either from within their family or from professionals. Some think shame to be a key factor in a perpetrator's developmental experiences, and it is clear that far from being peripheral to treatment of abused children, recognising and understanding shame is critical to a successful treatment journey for children post-abuse.<sup>71</sup>

### *Case-holding has value*

We have described here the complexity of the systems that exist to support families after abuse has been disclosed. It is no wonder that families find this almost impenetrable, do not understand why they have to repeat their stories time and again and do not get access to the services that they would want (and in a way that fits in with their lives). It is immensely difficult to navigate through this complexity, and case-holding can help with this. However, there are doubts from this project about whether case-holding can be delivered in a cost-effective manner, and the resources for it cannot be taken from services already under pressure such as CAMHS. Indeed, case-holding cannot be a replacement for therapeutic services where they are needed, and further work is required to properly implement single assessment, single point of contact, information sharing, consistency of support and a trusting relationship.

### *The burden on parents is significant*

Because of the 'coping conundrum' we describe above, many families do not receive any form of support or intervention. We know that a great many parents are resourceful, but in the context of an abuse disclosure, parental resilience will take a knock, and this coupled with multiple other strains in their lives will create situations where some parents will not be able to support their child. Even where parents are resilient and have some skills to cope, the stress of listening to a child's story can be overwhelming. One parent described a situation where they were in receipt of very little help:

*There's so much pain. Me and her, we live just together. Both of you passing the pain between you. You also want to shout but you don't want her to have the shouting.*

Good support for parents is vital to the recovery of their children, and to bolstering resilience in the whole family, and case-holding can provide this, though the questions about cost remain.

## Reflections about commissioning case-holder models

### *Prevention, detection and early intervention are under pressure*

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<sup>71</sup> Nathanson DL Understanding what is hidden. Shame in sexual abuse, *Psychiatr Clin North Am.* 1989 Jun;12(2):381-8, Feiring, C., Taska, L. S., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attribution style. *Developmental Psychology*, 38, 79-92

The detection of CSAE is everybody's business – from the NHS and social care through to sports clubs, schools and the retail sector. But certain public services can play a key role in detection, prevention and early intervention, particularly those public health services commissioned by local authorities, including sexual health services and others. Health Visiting, School Nursing and the Family Nurse Partnership programme are public health services that have reach into many homes and lives that other services do not reach, and as such are uniquely placed to intervene early where CSAE is suspected or disclosed. It is clear that these services are being reduced significantly by reductions in the funding government provides to local authorities to deliver public health services (the public health grant), and that these reductions will continue for the foreseeable future.<sup>72</sup> This will undoubtedly undermine efforts to reach into vulnerable families, and makes effective early intervention and prevention all the more difficult.

#### *The CSA/CSE continuum*

The statutory definition of child sexual exploitation clearly states that CSE is a form of child sexual abuse. Accompanying this statutory definition is a significant focus on CSE in recent years at a national and local level. Publications such as *Putting Children First*<sup>73</sup> have further shone a light on CSE, and resources have been focused on mitigating its impact on children and families.

In some cases the notion of separate CSA and CSE commissioning (and service provision) is breaking down – following a period of intense focus on CSE, the projects have served to raise again the needs of children and young people who have experienced abuse within their families. This is to be welcomed, as the needs of these children and young people overlap significantly and a whole host of services provided for one group could be appropriate for the other. Areas seeking to develop a more structured approach to case-holding should build this on the existing CSAE infrastructure.

#### *Making the case for investment*

In the context of cuts to the public health grant, and pressure from rising demand and reducing resources across a range of other public services, each area now has to make a clear case for investment. An analysis of the case for investment in local case-holder models was not included within this programme of work (nationally or locally), but there is some evidence emerging from one area (Birmingham) that the case-holder model as implemented there is costly and might not have a long-term, demonstrable business case. The Birmingham team will continue to think about this in their sustainability plan for their project, but it does seem that most areas will struggle to implement case-holding without additional resourcing. Further work on the business case for investment in these models would be welcomed by local authorities and others.

#### *Seeking support and system mapping*

Commissioners working towards implementation of a case-holder approach in their local areas will be best placed if they do this by building from a coalition of the willing, but whilst necessary, this is unlikely to be sufficient in and of itself. They will 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 recent legislation), HWB and

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<sup>72</sup> Public Finance (2016) Public health funding cuts 'put children's health at risk'

<sup>73</sup> Putting Children First: our vision for excellent children's social care. Department for Education (July 2016)

other structures that hold their local systems together. They will need time and permission to do the work well, and to start with rebuilding relationships across what is a fractured public services system.

Many people who became involved in this programme of work were struck by the complexity of the systems they were operating within, but also how few people had a clear view of the totality of services that could be offered to children and young people who have been sexually abused or exploited. Some areas undertook some form of service mapping to help them to establish a clear sense of which services exist and for whom, and whilst this is incredibly useful we know from prior experience that such system maps can become out of date every quickly. They will need constant tending to keep them refreshed, and will need systems in place to enable sharing of new information across an area. The idea of single online portal for this kind of information is attractive and being tested in Birmingham (and has been introduced elsewhere), and is something other local authorities should explore.

#### *Defining the work from the outset*

As set out elsewhere in this report, as we progressed through the early stages of this programme of work, it became evident that there were very different concepts of case-holding both within the individual areas and across the whole programme of activity. This is partly due to the very significant variation in contexts and service landscapes across the areas, but is also because the concept of case-holding was not well-defined early in the programme. Each area did arrive at a better definition of their work and their model as time progressed, and from this we have learned that it is important to understand the system well (enough), but also getting started with the work can help to further iterate to model and learn.

Had there been more time, the sites have clearly stated that they would have spent considerably longer developing their model with their local stakeholders and services users, developing clear driver diagrams that mapped out the logic of the approach they wished to take. Other areas taking up the challenge of implementing case-holding would do well to take heed of this, take their time to develop granular definitions of their model, but also not get too bogged down in understanding complexity – iterating their model and understanding what has changed (and why) is a good way to progress work at pace.

#### *Setting realistic expectations*

Although DH developed a Memorandum of Understanding with each area at the beginning of the financial year, it became clear that ambitions were high from the outset, and that a considerable amount of time would be required to mobilise local systems to get projects up and running, which had not been foreseen at the outset and therefore factored into the programme. The sites have done good work, much of which is now being sustained at least in the current financial year, and that is to be applauded. All teams reflect that projects of this nature need considerable amounts of time to mobilise systems and to define the work well before embarking on delivery of a service. This is important learning, if we are to embed and sustain successful approaches for addressing CSAE. We would add our view that starting with small numbers of families, and then capturing, learning and acting on continuous feedback is the best and most realistic means of developing and delivering a service that is likely to lead to a sustainable improvement.

## Reflections on the workforce

### *Capabilities for a case-holder workforce*

From our discussions across each separate system, and with the local project teams together, we got a very strong sense that the capabilities for undertaking the case-holder role successfully very much mirror those required to be undertaken by any form of assertive outreach work seen in assertive community treatment, the Family Nurse Partnership or indeed the many advocacy and keyworking services that exist in the VCS. These workers will need to be open, non-judgemental, resilient and tenacious, capable of forming strong trusting relationships with traumatised children, young people and their parents – many of the stories they will hear will be extremely distressing, and children and young people will be on a disclosure journey which sometimes leads to withdrawal of initial disclosure and occasionally challenging behaviour as a result of their trauma.

Focusing on existing strengths and resources that exist within the child, family and community can help to engage families and to become partners in their own treatment.<sup>74</sup> They will need a degree of freedom to offer respectful challenge to professionals and their decisions, and a knowledge base about trauma, shame, stigma, relational working and motivational interviewing. To retain them and further develop their skills and confidence, they will require access to high quality clinical supervision to provide emotional containment, prevent burnout and to ensure that boundaries and a focus on outcomes, are maintained.

### *The wider workforce*

All LSCBs have a statutory role in enabling the training of people who work with children, mostly in the form of evaluating training and/or ensuring that it takes place. LSCBs do think about CSAE as they discharge this function, and from our work during the year of the project and subsequently, we think that a stronger focus on the emerging evidence around ACEs would strengthen provision of training and awareness of the cumulative effect of multiple ACEs on the life course. LSCBs also have a critical leadership and influencing position which is key in leading, driving and sustaining culture change in both policy and practice to, in turn, enable an earlier and more responsive child-centred service to be provided and sustained.

### *Supervision for professionals*

We know that clinical supervision is a key tool to enhance the practice of health and allied professionals providing 1:1 support to children and young people affected by CSAE. It is an essential part of ensuring appropriate support, ensuring competence, improving quality of care and enabling new professional insights to be gained.<sup>75</sup> With this in mind, we question whether high quality supervision is available to the majority of professionals working with children who have been sexually abused or exploited, and LSCBs should satisfy themselves that people working with vulnerable and traumatised children have access to frequent, high quality supervision.

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<sup>74</sup> Jones-Smith, E. (2014) *Strengths-Based Therapy: Connecting Theory, Practice and Skills*

<sup>75</sup> Hines-Martin, V., & Robinson, K. (2006). Supervision as professional development for psychiatric mental health nurses. *Clinical Nurse Specialist*

## Reflections on leading this work

### *Recognition of need and national action*

We are immensely grateful to DH for its commissioning of this work. It has shone a light on the lives of children, young people and families in the aftermath of sexual abuse and exploitation, the complexity of the services they need to access, the gaps in the systems and what more we can all do to address them. We value the contribution from the DH team who have steered the work over the year, their support, insights and expertise. Their approach, to test some of the key features of case-holding, but also to enable wider impact eg through workforce development, has helped us all to understand the complexity of the systems and what it takes to deliver change in complex systems.

### *Setting the pace is important*

From the outset we have collectively set high ambitions for this work, and this has helped local systems (and the national leadership) to keep focus on the work. We welcomed the challenge of delivering this complex work in under 12 months and the focus on action. Our view is that the project has been worthwhile and has delivered and will continue to deliver improved services for children and young people. The scope of any future work should be framed in terms of the complexity described in this report. Setting a longer time horizon and deciding from the outset which features are deliverable within a year are key pieces of feedback from all sites for us to learn from in future projects. We also hope that any future work would mobilise the national leadership early in the programme, ideally before sites are selected.

### *Agreeing definitions*

Developing the concept of case-holding model was more challenging than was fully understood at the outset of this project. Each area had its own context, complexity and focus and a stronger focus from the outset (including at bid stage) on defining case-holding, the problems it was seeking to address and which features might be tested would have been well spent.

### *Mobilisation*

Most of the professionals involved in the programme have been clear that mobilisation of this kind of work takes a lot longer than expected. We collectively think a two year timeline would have been more realistic, and would have enabled the development of very clear agreed case-holder models at the outset, their position in the system, small scale testing of key features and some form of analysis of costs and benefits.

### *Limited management capacity*

Most sites focused their DH funding on front line service delivery, training to build capacity or on work that will help them to build and learn for the future. As a consequence, most of the project teams and leads did this work on top of their already busy 'day jobs', with no additional leadership capacity or back-fill to cover the time spent on this work. As a result, some of these projects were led mostly on good will alone, and whilst this has delivered useful learning for their systems we do think that a more sustainable approach to leading projects needs to be considered should these sites progress with this work in the future.

### *Leadership*

Effective leadership is key to any successful change programme. This project would have benefited from stronger strategic engagement at all levels in view of the significance of the work and the system changes required. It was not always obvious to us that senior leaders

were connected and engaged with the significance of this work. Providing an earlier trauma-informed case-holder support to children and young people affected by child sexual abuse and exploitation requires system as well as practice change, and we have seen in this project that effective leadership is required to make the changes, unblock the barriers, ensure the resourcing, training and partnership work are in place and that the lessons learned are explicitly gathered and used to strengthen services.



## ANNEX A - Case studies

From the many case studies submitted from sites, we have included a small sample below that describe the challenges faced by young people who have been abused, and how the projects have supported them.

### *Case study 1*

A 14 year old girl originally from a Sri Lankan family drank bleach in a suicide attempt in December 2016. She was admitted to hospital in one area (the same local authority area as her GP surgery). However she and her family live in a different area which created initial confusion about which of the two local authorities had responsibility for the child. Responsibility was taken by the borough in which the child lives, but there was then a delay in the child receiving therapy because CAMHS are linked to their local GP service where the child lives. CAMHS services passed the case between them several times trying to decide who would take responsibility, but because the CSA Hub family therapist was in place therapy was started with the child immediately thereby bridging this gap until the right longer term service could be put in place.

The child disclosed to the Hub family therapist that she was afraid of what her father would say when he discovered her online activities. She had been subjected to online sexual grooming by a man who had got her to agree to fly out to Australia. Her sister had overheard the arrangements being made for her to get her passport and meet him, and alerted her mother.

The Hub team identified this as CSE and potential child trafficking, made the decision to break confidentiality (although with the child and parent's consent) and contacted children's social care and the police. The children's social care assessed the child together with the CAMHS service, though CAMHS concluded that as the child had taken the bleach to avoid facing her father, the issue was about parenting skills and this being the case they felt that they could not offer any helpful support to the child. Children's social care decided that the parents were just not setting good boundaries for the child (re the online communication) so they gave some advice and closed the case

However, the family were supported by the Hub therapist and had access to a service that otherwise would not have been in place. The team's role included advocating for families in order for them to navigate their way to the most culturally (or otherwise) appropriate local service support.

### *Case study 2*

In this case the child was sexually abused by the father in a family from a closed religious community. The police did not pursue the case because the offender/father fled to another country. Children's social care visited the family home and spoke about the father as the abuser openly in front of the other children. The mother was extremely upset about as she did not want the children to talk about the abuse in this closed community (her fear was it would result in the family being ostracised, and she was concerned about the ongoing impact on the children). Following this the abused child went missing and one of her siblings set her pyjamas on fire.

As a result the mother did not want to have any children's social care involvement and sought help from this team, requesting support for a referral to a specialist, religious-based voluntary agency.

### *Case study 3*

The team receive a relatively high number of referrals of children who have been trafficked from outside of the UK and sexually abused/exploited. In the majority of cases these children are significantly more distressed and disturbed than the host country children.

In this case a child was trafficked from Albania and anally raped by a man. She managed to escape from him and was found on a bench in a park by a member of the public. The child was terrified and so disorientated she did not know which country she was in. The woman provided overnight accommodation for the child in her home and the following day took her to a hostel. The hostel staff contacted the Police and children's social care. The Local authority took the child into its care.

The child was referred to the team, who offered care commencing with a 'history-taking' session attended by both the lead paediatrician and the family therapist. This allowed the child a choice of adults with whom she could potentially bond. In this case the child reached out to the therapist. The family therapist offered the child immediate therapy and at the same time referred the case to the local CAMHS service. The family therapist and CAMHS practitioner can offer a child six sessions after which the case is transferred to the child's local CAMHS.

Each child reacts to trauma differently, this child needed to talk it through repeatedly to process the nightmares and flashbacks. The child said:

*Here I can be myself. Anywhere else – like when I am talking to the social worker or the foster carer or the Home Office person or school, I have to be careful what I say.*

The child was placed with a dark skinned Somali Muslim foster carer as a cultural match based on the child being Muslim. The colour difference raised questions at school and the potential for bullying amongst the child's peers. The Family Therapist helped the child to construct a narrative to manage the other children's curiosity and protect herself.

The child revealed that she had fallen into the hands of the trafficker as a result of her efforts to avoid a forced marriage. After six sessions the family therapist will support transition for the child to the Camden CAMHS.

#### *Case study 4*

A visit by NSPCC Childline to a primary school prompted a 10 year old Sudanese girl to disclose that she had been sexually abused. The abuser was the child's 21 year old cousin. The school called the police and children's social care, who made the referral to their local CAMHS. However the child was allocated a male psychotherapist and when she was not able to talk to him her case was closed on the grounds that 'the child refused to engage'.

The team were able to engage the child. This was important to understand and support the child in managing the tensions of holding to the truth of her disclosure in the face of the wider family's rejection, and her shrinking from feeling responsible for 'sending the perpetrator to prison'. The team were able to assist the child through the police prosecution. They were also able to support the mother and her daughter as a family unit to cope with the crisis and develop some post abuse/disclosure resilience in the face of being ostracised by their family and community. The six sessions provided by the team provided the emotional space and modelled accepting support from others which can prevent the child and the protective parent from becoming isolated and spiralling into dysfunction.

#### *Case study 5*

A 12 year old girl was already receiving services from her local CAMHS when she was raped at a party. As a result of the rape the child was referred to the team. The child disclosed to the family therapist that her sister was very violent and aggressive to her in the family home and that to avoid being victimised she walked the streets at night, encountering individuals and situations which exposed her to sexual abuse and exploitation – such as the party at which she was raped.

This needed a psychological assessment. The Hub team shared the information with the child's CAMHS, however they did not feel able to make a referral to children's social care on that basis of information which had not been disclosed by the child directly to them. The Hub team made the referral instead. Included in the referral was the fact that the child had revealed a cohort of obsessive compulsive disorders, such as not being able to enter cafés or buses.

Children's social care drew up a Parenting Agreement which the parent's signed requiring them to constrain the sister's behaviour and protect the 12 year old. The team undertook a follow up visit with the family.

#### *Case study 6*

A mother was alleging that her husband was not only very violent towards her, but that he had also sexually abused the couple's five year old daughter. The mother was seeking to exclude the father from contact with the child through the legal system. The local CAMHS was not prepared to engage with the child to make an assessment of the likelihood of the abuse (CAMHS does not readily engage until after any court proceedings have been completed).

The case was referred to the team. The mother refused to allow a physical examination of her child. The family therapist was nominated to undertake an assessment of the child and opted to do so by assessing the child with her mother for three sessions and then with her father for the following three sessions. The team experienced some tension in this case as the mother was extremely compelling and the team were cautious about facilitating contact between the child and the father.

The therapist was able to establish that the child had a very good, warm and open relationship with her father; that there were no indications of abuse having taken place and that the overwhelming stressor for the child was the tension between the parents. This manifested for example when a session started in the company of one parent and the pair were joined by the other parent. In such a scenario the child was unable to engage with the second parent. Similarly in representing herself, the therapist and her parents in play, the child positioned herself and the Therapist together, but in a central, separate position with the parents on either side, facing each other. The Hub team has offered a follow-up assessment to be reassured that the assessment was accurate.

## Annex B - Summary expenditure by project

### London

CAMHS clinician (1.0.wte)	£58,725
Child Advocate (0.8 wte)	£31,275

**Total** **£90,000**

### Birmingham

Project Management	£25,973
Case-holder model	£37,120
Training packages	£26,907

**Total** **£90,000**

### Rotherham

Project Management	£20,000
Project Scorpio	£10,000
Attachment & Attunement training	£10,000
CAMHS service	£50,000

**Total** **£90,000**

**FNP NU/Tavistock**

Site support and clinical advice	£40,000
Project management	£7,000
Project evaluation	£17,500
Workshops	£2,500
Final report writing	£5,000
Senior management oversight	£3,000
NU/Tavi support, finance, admin	£5,000

**Total** **£80,000**

\*It is important to note that project costs and headings varied significantly due to differences in local models and how project management costs were allocated. London did not charge any project management or staff management costs as these were contained within the CSA hub. London focused some funding towards sustainability of posts whilst awaiting the local CCG decision to continue funding.