King's College Hospital NHS
NHS Foundation Trust

NHS England

Review of pathway following sexual assault for children and young people in London - SUMMARY

The Havens, King's College Hospital London

On behalf of NHS England

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1. Executive summary

Children and young people who have been sexually assaulted or abused need medical care and support. At present, very few of them come to the attention of police, social care or health providers, and even fewer in the period soon after the abuse. It is thought that children and young people face a variety of obstacles in accessing care and support and that services and accessibility vary widely across London. This review sought to assess the service provision across London in order to better understand some of these obstacles. It explored national recommendations, international agreements, research and models of best practice for children who have been sexual assaulted. Based on the review findings, we have made recommendations aimed at improving the care and support provided to children and young people in London.

The review of the pathway for children and young people who have been sexually assaulted (October 2014 to January 2015) was led by Andrea Goddard, Emma Harewood and Lauren Brennan. The team interviewed nearly 200 stakeholders involved in the care of children and young people who have been sexually assaulted and reviewed available data from the Havens. The stakeholders included: 25 designated or named doctors for safeguarding children, 22 children's commissioning teams from Clinical Commissioning Groups (CCG) and Local Authorities (LA) and 22 CAMHS teams, as well as others from third sector providers, local counselling services, school nurses and designated nurses.

We do not have good information about the total number of children (0-17 years) being seen by health professionals following a sexual assault, in a variety of settings across London. We know that during 2013/14 only 2485 children under 16 years of age reported their sexual assault to the Metropolitan police. In recent study for the NCPCC, *Child abuse and neglect in the UK today*, Radford et al found that 9.4% of 11 to 17 year olds had experienced sexual abuse (including non-contact) and 1.9% had experienced contact sexual abuse in the past year. If this percentage is used to extrapolate the potential incidence of contact sexual abuse in London, it suggests there could be approximately 12,540 children 11 to 17 years of age in London who have experienced contact sexual abuse during the past year.

Commissioning

The review identified inequity in the services commissioned for children and young people in London following sexual assault. The Havens, for example, are not commissioned to provide medical aftercare/sexual health screening for children under13 years of age or counselling for children under 18 years of age. This differs from the services provided to adults and in effect means the most vulnerable members of society are currently receiving the least support from the Havens. There are also very few specific services commissioned locally in the London Boroughs for Child Sexual Assault (CSA). This differs from elsewhere in the United Kingdom (UK) and internationally where holistic, multi-agency services are provided.

The commissioning and provision of child and adolescent mental health services (CAMHS) following sexual assault were also found to be lacking. Like other recent reviews, this review identified significant issues with CAMHS accessibility, including strict access criteria and long wait times both

for assessment and treatment. Many stakeholders reported struggling to access support for children and young people as well as their families following sexual assault. It is thought that financial cuts to CAMHS providers over the past five years are in part responsible for this reduced accessibility.

The Havens

The Havens currently provide forensic medical examinations and immediate aftercare for all ages as well as follow-up medical care for those aged 13 and older. The physical environment at the Havens is not adequate and requires improvement for patients and staff alike. While the forensic decontamination requirements somewhat limit the choice of materials and objects, there needs to be a greater emphasis placed on creating more child-friendly spaces.

Currently it is sometimes not possible to arrange a forensic medical examination during the daytime for children under 13 years of age. These children are either jointly examined by a sexual offences examiner and a consultant paediatrician (out-of-hours rota only), or examined by a dual-trained sexual offences examiner. There is no daytime paediatric cover and currently only one dual trained examiner. When the dual trained examiners are not available, examinations are deferred until the early evening. This is another example of the inequality in service provision for children which should be addressed.

Following the forensic medical examinations, the Havens hand the care of children under 13 over to local paediatric and social care teams. The paediatricians surveyed report significant issues with the referral process and this should be improved as a matter of urgency. The Havens receive no information on the children they have referred or feedback on the outcomes from social care. The Havens do not receive feedback on their forensic results and rarely on case outcomes through the criminal justice system. A new child advocate role has been created at the Havens (starting in 2015). The advocate will liaise with local paediatric and social care teams to improve the handover of information and follow up on aftercare provision.

Young people aged 13 to 17 years may be referred to their local paediatric and social care teams as well as sexual health clinics for follow up, but they can also return to the Havens for aftercare. The experience of young people at the Havens appears to be generally positive with 90 – 95%, reporting that they felt safe, listened to and believed at the Havens. The handover of care for young people is already available from the Young Person's Advocates, although only 40% of young people seek this support. The Young People's Advocates have knowledge of some national and London wide services, but there is limited knowledge of the local community services available in all 32 boroughs. It would be helpful if the Havens could hold a London-wide directory of services.

About one third of young people who attend the Havens for forensic medical examination report a history of self-harm, up to 49% of young people in one London borough. The lack of counselling in the Havens and access to CAMHS support for this vulnerable group of children and young people should also be addressed as a matter of urgency.

Local follow-up

Medical follow-up for children and young people after the Havens, as well as provision of medical care for cases of historic CSA was found to vary widely across London. In some areas clinicians are seeing very few cases per year and are struggling to maintain their skills. Many would like to

continue seeing CSA but feel they need greater support. Some of these paediatricians report feeling isolated while others have already arranged for their CSA cases to be seen by colleagues with greater experience. In other areas paediatricians feel confident in their skills/knowledge, report being well supported and having good peer review; some are already providing CSA examinations on behalf of their colleagues in other London boroughs. Some significant issues identified were in relation to the screening and prophylaxis for sexually transmitted infections (STIs) (including the availability of "chain of evidence") and documentation of anogenital examination using a colposcope.

The majority of paediatricians would like more training and support provided to those who see CSA in London and would also like to see the Havens extend the services they provide. Nearly all thought the Havens should be able to offer all the necessary medical aftercare (including STI screening / prophylaxis) for children and young people following an acute assault and that flexibility was needed, with patient choice as the focus. The paediatricians reported mixed views on social care services for CSA. Many would like to continue seeing CSA cases and expressed interest in working closer with colleagues in networks or hubs.

Emotional support following CSA was found to be lacking, with children, young people and their families not currently receiving the emotional support they need. The paediatrician's reported difficulty accessing CAMHS and as such were referring children less. CAMHS reported their own issues regarding reduced funding, strict Tier III criteria and waiting lists for interventions of up to 6 months. The review also identified some holistic third sector services that support children and young people following trauma, exploitation and abuse. All these services were well received and research into outcomes is underway in some cases.

Similarly, police and social care report being stretched to capacity and lacking in the time needed to truly support and care for children, young people and their families following a sexual assault. Young people are reporting that this results in poor communication and process driven investigations.

Often the person with the best rapport to support children and young people in their local environment are frontline staff like youth workers, school nurses and third sector providers. However these staff report that they are often not trained or supervised in CSA and lack access to experts for advice in complex cases. It is important to note that the current child sexual exploitation (CSE) training includes identification of at risk children but does not support staff to work therapeutically with children post assault. Support for local teams from CAMHS and specialist CSA services should be developed.

London should develop as a centre of excellence and expertise in CSA. While some research is currently underway, more should be encouraged. London should engage with the wider national and international community to work towards improving the understanding of CSA, including its prevention, identification, management and prosecution through a child-friendly criminal justice system.

Research and best practice

This review has ensured the recommendations are in line with the principles set out in the United Nations Convention on the Rights of the Child (1989), the Children and Families Act 2014 and the

Council of Europe Convention for the Protection of Children against Sexual Exploitation and Sexual Abuse (also known as the Lanzarote Convention). Over the past thirty years there has been substantial progress in the way children are assessed and supported following CSA including not only their medical and psychosocial care but also their treatment by the criminal justice system. At the core, the system should be designed to fit the child rather than force the child to fit the system.

This review explored models identified as best practice internationally including the Children's House (Barnahus) in Iceland and the Child Advocacy Centre (CAC) in United States. These models were developed out of recognition that the criminal justice and medical / social care systems being used to help children following CSA were actually causing them harm. They redesigned their systems placing the child at the focus.

In Iceland for example, when a child discloses sexual assault, an appointment is made at the Barnahus. An interview is conducted by a specially trained forensic interviewer (with a background in child psychology) in a child-friendly room which is video-linked to an observation room. The interview is witnessed by the child's advocate, social worker, the defence and prosecution teams, with a Judge presiding. The Barnahus is effectively an outreach of the courtroom at that time and the recorded interviews usually suffice as the child's full testimony for court. The interviews are reportedly more successful in obtaining information with increases in the number of prosecutions and convictions for CSA. Because the interviews are usually completed within one to two weeks of the initial allegation being made, this allows the child to start therapy quickly, either at the Barnahus or locally. The recorded interviews are also used to plan therapy and medical examinations / aftercare can also be provided at the Barnahus.

The Children's House (Barnahus) and CAC models have been adopted/adapted into many different criminal justice systems and their effectiveness has been validated by numerous studies.

Themes identified in the London review:

- There are geographic variations across London in attendances for forensic medical examinations, not explained by differences in population size
- Handover to local services following forensic medical examination needs improvement
- Paediatric (and sexual health) assessment and review varies across London, there is a need for service reorganisation and greater support
- A significant percentage of teenagers report a history of self-harm at the time of forensic examination
- There is a sense of "normalisation" and desensitisation around sexual behaviours and assault among professionals and young people
- There is a lack of psychosocial support for children and young people at the Havens
- There are widespread issues with access to psychosocial support, including high CAMHS thresholds and lack of support for those who do not meet thresholds
- There is an overall absence of support available for parents and caregivers

- There is a lack of service flexibility and choice for patients and their families
- There is poor engagement with local borough services
- There is a lack of knowledge of available third sector services and how to access them
- There is a need to develop greater multi-disciplinary cooperation / information sharing and support
- There is a need for feedback, case and peer-review as well as research and knowledge dissemination

The impact:

The resultant long-term costs of the current poor service for children, young people and their families experiencing sexual abuse is likely to be significant. Costs to UK of child sexual abuse were estimated by the NSPCC study at £3.2 billion in year 2012 alone. Sexual assault and abuse rarely occur in isolation of other psychosocial factors. London is already investing in varied and isolated interventions which are not addressing the needs of all children and their families following sexual abuse. The potential negative outcomes include poor educational outcomes, enduring mental health issues, healthcare and police costs, sustained risk of repeated assaults and a cycle of sexual harmful behaviours. No change is not an option.

Recommendations:

This review recommends a significant change in the way cases of child sexual abuse are investigated and supported in London. The following options include a London implementation of international best practice as well as "quick wins" and local recommendations for NHS England/MOPAC and the CCGs and Local Authorities in each of the London Boroughs.

- **1st choice and long-term goal:** Children's House (Barnahus) model x3-5 locations in London
- **2nd choice and "quick win":** Child Sexual Assault hubs x 5-7 locations in London and Paediatric Haven Plus
- **Team around the worker:** Child Sexual Assault expertise for paediatricians, social workers, police and CAMHS teams and CAMHS supervision for frontline staff
- **Individual recommendations** for commissioners and providers in the pathway

2. Introduction

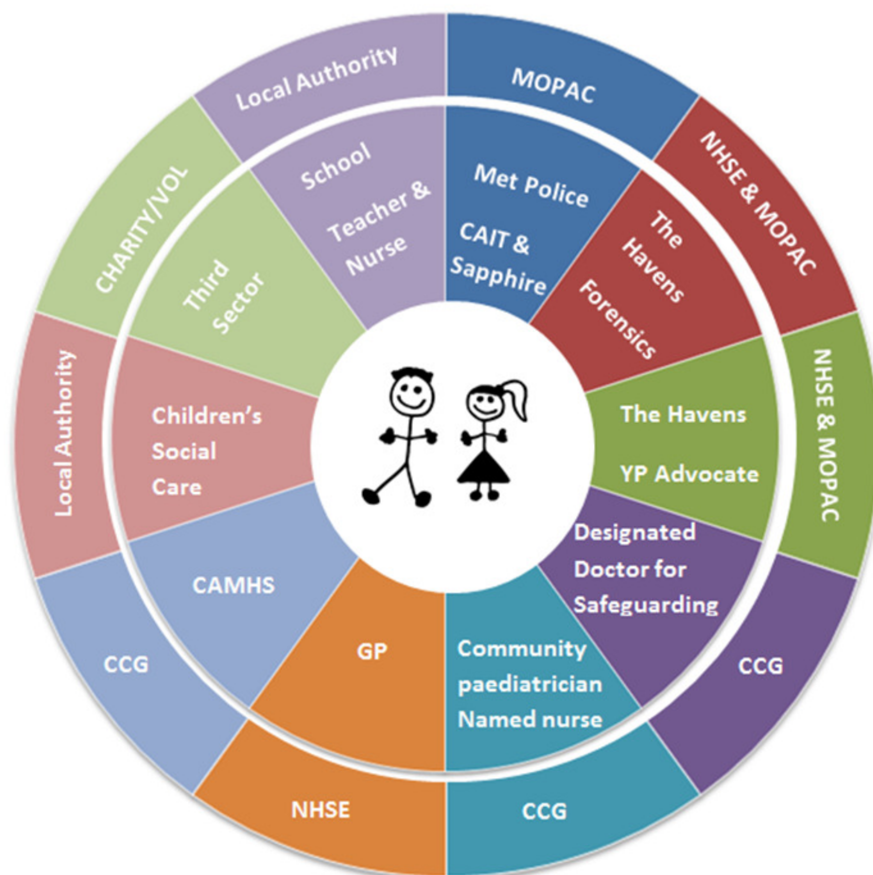
There is a silent epidemic of sexual assault and abuse affecting the physical and mental health of our children and young people as well as their families and loved ones. It has been estimated that 9.4% of 11 to 17 year olds have experienced sexual abuse in the past year alone (including non-contact offences). In London that's an estimated 61,470 children and young people, or roughly 1,860 per borough[1]. The same study found 1.9% of 11 to 17 year olds had experienced *contact* sexual abuse in the past year. If the percentage were the same for London, that would work out to approximately 12,540 children age 11 to 17. By comparison, ~350 children under 18 attended The Havens for acute forensic examination in 2013/14.

Children and young people who have been sexually assaulted or abused need medical care and support. At present, very few ever come to the attention of police, social care or health providers, even fewer in the period soon after the abuse. Many clinicians, agencies and organisations work hard to provide care to these children and young people. However, it is thought that children and young people face a variety of obstacles and that services and accessibility vary widely across London. The review sought to explain these obstacles to accessing the specialist services and follow-up needed to ensure children and young people get the help and support they need after disclosure of sexual assault and abuse.

The review was overseen by Dr Andrea Goddard, Consultant Paediatrician, Paediatric Lead for the Havens and Designated Doctor for Safeguarding Children and Young People for Westminster. It was delivered by Emma Harewood, Review Lead and Dr Lauren Brennan, Clinical Lead.

The Havens, part of King's College Hospital NHS Foundation Trust, was commissioned by NHS England (London) to review the existing services that help children and young people in these circumstances. This review focused primarily on patient care pathways in London and sought to identify barriers to accessing acute care at the Havens and the challenges in providing aftercare in local areas. The Havens are specialist centres in London for both children and adults who have been raped or sexually assaulted. They are based in Camberwell, Paddington and Whitechapel, and are managed by King's College Hospital NHS Foundations Trust, and commissioned and jointly funded by NHS England and the Metropolitan Police Service. Only Haven Camberwell and Haven Paddington currently see children under 13 years.

The scope of this review was a detailed clinical mapping including identifying all clinical, safeguarding and mental health pathways, understanding the psycho-social networks and links with social services and the third sector for children under18 years of age. The review included pathways for under13 year olds and 13-17 year olds. The project team engaged representatives from all providers and stakeholders below.



3. Background

It is beyond the scope of this review to discuss the short and longer term consequences of CSA. However it is not surprising that CSA is associated with negative impacts on physical and mental health[23,4] including for example sexually transmitted infection, pregnancy, anxiety, depression, suicide and self-harm, post-traumatic stress disorder, behavioural symptoms, drug and alcohol misuse and physical health problems. These have wider implications for the person, their family, and society at large[5,6,7,8] including costs (financial and otherwise) for treatment, due to loss of productivity from poor health, unemployment and also sometimes their own subsequent entrance into the criminal justice system, not to mention the impacts CSA can have on future interpersonal relationships[9]. The NSPCC produced a study attempting to estimate the costs of CSA. Their low estimate of the annual cost to the UK for CSA was over £1.6 billion, but their best estimate suggested it was closer to £3.2 billion. There is however some evidence to suggest that early treatment can help mitigate some of the morbidity associated with CSA[10,11].

Societal recognition and understanding of child sexual abuse (CSA) has changed substantially over the past thirty years[12]. We now recognise that it is much more prevalent than previously thought. It is estimated that sexual violence affects one in five children[13,14,15]. Around a third of sexual abuse is committed by other children and young people (varied research suggests one-fifth to two-thirds)[16]. The Children's Commissioner Inquiry found that of the 2,409 victims reported to them, 155 were also identified as perpetrators of child sexual exploitation[17]. This change in societal recognition has

prompted changes in the way the international community and individual countries identify, investigate, prosecute, treat and work to prevent CSA.

Twenty six years ago (1989) the United Nations established the United Nation's Convention on the Rights of the Child (UNCRC). This international human rights treaty changed the way the children (under 18s) are regarded. It formed the foundation for the development a more equal and just society for children. The UNCRC grants children fundamental rights and obliges ratifying nations to ensure that their government policies and practices incorporate and embody these rights. Progress and compliance with the implementation of the UNCRC is ensured via monitoring of non-governmental organisations (such as Save the Children) and by having governments report back to the UN on a regular basis. The UNCRC is the most ratified treaty in the world with only two countries currently outstanding[18],[19],[20]. The treaty came into effect in the United Kingdom (UK) in 1992. There have been a variety of legislative changes and policies created towards its implementation, including for example the Children's Acts (1989), Every Child Matters (2003), Children's Act (2004)and more recently the Children's and Families Act 2014[21].

Further international efforts to protect children led to the development of the Council of Europe Convention for the Protection of Children against Sexual Exploitation and Sexual Abuse (also known as the Lanzarote Convention as it was adopted in Lanzarote, Spain in 2007). A core principle is to design the system to fit the child rather than force the child to fit the system. The Lanzarote Convention *"sets forth that States in Europe and beyond shall establish specific legislation and take measures with an emphasis on keeping the best interest of the child at the forefront to prevent sexual violence but also to protect child victims and prosecute perpetrators"*[22]. It has been signed by all 47 Council of Europe member states to date and ratified by 35. The UK signed in 2008 but has yet to ratify. It is currently still assessing legislation and measures required for compliance,[23],[24] and has created an action plan against sexual violence and a Sexual Violence Against Children and Vulnerable People National Group. Among the requirements set out by the Lanzarote Convention for nations are the following protective measures;

- *Programmes to support victims and their families be established*
- *Therapeutic assistance and emergency psychological care be set-up*
- *The reporting of suspicion of sexual exploitation or sexual abuse be encouraged*
- *Telephone and internet help lines to provide advise be set-up*
- *Child-friendly judicial proceedings for protecting the victim's safety, privacy, identity and image be put in place*
- *Measures adapted to the needs of child victims, respecting the rights of children and their families be established*
- *The number of interviews with child victims be limited and the interview take place in reassuring surroundings, with professionals trained for the purpose*

The Lanzarote Convention is of particular relevance in the development and commissioning of child-friendly sexual assault services. The Convention not only requires countries to establish a child-

friendly criminal justice system which places the child at the centre process but also requires that countries ensure the medical and psychosocial needs of children and their families / carers are met.

4. Overall findings

This review sought to map the current paediatric pathway for cases of sexual assault, understand commissioning of those services and gaps in the pathway for children. This included paediatricians, CAMHS, police, the third sector and schools. The overall findings below are a summary of the detailed interviews and discussions with the stakeholders in the pathway.

4.1 Commissioning

NHS England and MOPAC commission the current sexual assault referral centres (SARCs) in London provided by the Havens, King's College London. However the services commissioned for children are not as complete as the adult package or in fact children's services in other UK SARCs. The Havens are commissioned only to provide forensic examinations for children, whilst they provide forensic examinations, sexual health follow-up and an advocacy service for young people. The Havens had already identified this issue and a NEW child advocacy role is commencing in early 2015.

In terms of immediate aftercare, the Havens are not commissioned to provide medical aftercare for children under13 or counselling / psychological assessment and support for anyone under 18 years of age. NHS England is aware of this gap and has commissioned this review to identify the ideal future sexual assault services in London for children and young people who have been sexually assaulted both acutely and in historic cases.

This differs from other centres contacted as part of this review in the UK and internationally, which are commissioned to provide holistic services for children and young people who have been sexually assaulted both recently and historic cases. These services will accept any child or young person who has been sexually assaulted regardless of the forensic window and are commissioned to provide a variety of services including medical examination, psychological assessment and support, advocacy, ISVAs and police interviews. More details can be found in the best practice section.

Clinical Commissioning Groups (CCGS) and local authorities (LA) have generally moved to Joint Children's Commissioning roles in the last year. This has resulted in a time of change in commissioning and in several areas a lack of local knowledge as new post holders commence. There are significant financial constraints both from CCGs and LAs, as well as two thirds of Boroughs currently retendering CAMHS and other children's services e.g. paediatricians, sexual health and school nursing. In some Boroughs commissioners are choosing to protect CAMHS from further cuts, whilst others are using retendering as an opportunity to drive further 10-20% cost savings. This is putting further pressure on services that have already faced significant cuts over preceding years.

Most children's services are generic and in only a few boroughs are services for child sexual assault specifically commissioned from paediatricians and CAMHS. The major differences are around CAMHS commissioning. The tendering process is shaping CAMHS provision to integrate tier II and III, with a stronger emphasis of early intervention and flow of children between the tiers. If this new service specification is deliverable within budget then it will improve the pathway for children. The

risk is that commissioners are asking providers to stretch resources too far and the resulting service will still not fill the gap for children with mild to moderate anxiety and trauma. However with waiting lists of up to six months and DNA rates of 25% it is clear that the current system is not working for children either.

4.2 The Havens – sexual assault referral centres

The Havens services were well received by the children and young people attending who have been sexually assaulted. The views of young people are being sought in an ongoing research study by the Department of Health/Havens. Initial reports suggest 90-95% of the young people felt listened to, safe and believed at the Havens. They reported being treated like an adult and feeling normal, not alienated. Their only criticisms were with regard to some staff members being "automated or patronising" and the lack of counselling for young people at the Havens.

"*The care I received was good and excellent, because they have given me my life, my future, back. They listened and they supported me and I am very glad that they were there to help me."* Young person attending the Havens

The Havens have clear processes and procedures, as well as a robust chain of evidence methodology. They also have crisis workers to meet and greet children and their families following a sexual assault, as well as an advocacy service for young people (over age of 13 years). Only 40% of young people choose to come back to Havens for their follow up, but this review felt that this was generally due to travel concerns rather than the quality of service or experience at the Havens.

The main concerns found regarding the Havens were:

Havens sites are not child friendly environments - The nature of being a service for acute forensic examinations means that the Havens are clinical and sparse. There is no child friendly furniture in waiting areas or access to a family room. There is limited access to play equipment because of the need for preservation of forensic evidence. The Havens are situation on acute trauma centre sites, due to the need to be near an emergency department and acute psychiatric support.

This is in contrast to paediatric SARCs elsewhere in the UK or Child House model seen internationally, where sites are based in community hospital/clinic settings or residential housing areas. These paediatric SARCs are equipped with medical examination suites of a forensic quality, but also have child/family friendly reception and waiting areas, family rooms and child friendly interview rooms. NHS England has plans for investing in refurbishment with child friendly furniture and a significant rebuild at one Haven site.

Limited daytime access to the Havens for children - The Havens are limited by their paediatrician cover and only able to see children out of hours, unless a dual trained examiner is available at Haven Paddington or a paediatrician can attend ad hoc. Additionally the out of hours paediatric cover is provided by a rota of paediatricians who see anywhere from a few cases to twenty or thirty per year. Some or all of these paediatricians may be seeing non-acute CSA cases elsewhere but, for those not seeing many cases per year overall, there may be similar issues with maintaining skills as there are in some local Boroughs.

Discharge and handover to community aftercare - Concerns were raised about discharge and handover both from Havens and community/local professionals. There is some variation in handover processes between doctors and between the three Havens. When a verbal handover is attempted it can be a struggle to reach community colleagues, which can result in faxed handwritten referrals as the only method of communication. Community colleagues noted that these did not contain all the information they required, often they were illegible and they were not clear about the role expected of them.

There is also a gap in the aftercare with no counselling or psychological assessment by the Havens. Many stakeholders and children alike asked for emotional support in those first four – six weeks from experienced Havens staff.

Lack of knowledge of extensive local services in all 32 boroughs - The review identified that Havens staff do not currently have a complete knowledge of all the extensive services available in all 32 London Boroughs and there is no directory of services.

4.3 Paediatricians working in Child Sexual Assault

Children who have been sexually assaulted and report outside of the forensic window (48 hours to seven days) are generally seen for medical examination in the local paediatric clinic. These paediatricians may be hospital or community-based, and just under half see the child in a special CSA or vulnerable children clinic. The remainder of paediatricians see children ad hoc or refer to paediatricians in other boroughs. Usually children are seen quickly: within one week to one month after referral.

The caseload varied widely by borough, from 2-80 cases per year, with over half seeing <10 cases/year. This caseload is often shared between a couple of paediatricians, resulting in issues maintaining skills, competency and confidence in examinations. Most paediatricians are supported by a nurse or other doctor (usually another paediatrician, GUM clinicianor gynaecologist), but only a few have access to play therapists or clinical psychology.

While most paediatricians report feeling generally very or mostly confident in examining for CSA, 24% reported feeling only somewhat comfortable and would be happier co-examining with a colleague and 12% said they were not particularly comfortable or confident with these examinations (these doctors refer CSA examinations to colleagues).

The completeness of screening for sexually transmitted infections (STI) and management of the chain of evidence (COE) is very variable, with only half reporting screening for STIs in clinic (the rest refer to variably available GUM or other specialist services). Whilst two thirds of these can theoretically screen the mouth, genital area and anus if needed; this is not done routinely and screening is generally is guided by the reported history. This may be appropriate but it also may result in incomplete screening if not all of the abuse is known. In addition, there were several misconceptions about the need for STI screening in historical cases of CSA and some lacked awareness of STI epidemiology. There appears to be variance in the availability / provision of Hepatitis B prophylaxis and this should be further explored.

The availability of examination equipment varies between clinics; eight of the 25 paediatricians interviewed do not have access to a colposcope. These clinics generally see few patients per year and refer patients to colleagues if a colposcope examination is needed. Of those that do have a colposcope, 17% don't use it often and struggle when they need to do so. Only 70% have colposcopes that are able to video record the examinations; the remainder rely on still photographs as evidence. Consent and storage for intimate images was found to vary and should be reviewed, including the security of each storage method and consideration given to the creation of a Pan-London protocol. Peer review of intimate images is variable and many would like more support / review with and from peers.

Paediatricians were asked for their views on other services. When asked about social services teams, 48% had mixed experiences. The paediatricians thought social services lacked resources and experience to handle CSA cases and raised issues with a lack of skilled staff or high staff turnovers. When asked about CAMHS, their responses were highly varied from 12% very good/excellent to 44% poor; most struggled to access support. In general they felt that the criteria for acceptance into CAMHS services were too strict and referrals were often just not accepted or faced long delays. Some paediatricians felt that a lack of funding and resources were to blame. Some paediatricians refer children to local charities such as NSPCC or Barnardo's for counselling where these services are available; 60% felt they *could* access counselling or support for families from social services or the family GP.

The paediatricians were asked about their ideal model after being presented with a series of draft options. Three quarters thought the **Children's House Model** would be the best choice for London if it could be developed and thought this was the best choice for the child. This multi-disciplinary model has been identified internationally as best practice and provides all services for the child under one roof (including court interviews, medical and psychological care and social support). Most paediatricians had not heard about this model previously. Their second choice was the **hub and spoke model**, with medical examination for historic cases and aftercare for acute and historic cases provided in new community hubs. Paediatricians from surrounding boroughs could work sessions in the hubs if they chose; providing an opportunity to maintain/build skills and develop support networks. Safeguarding would either be provided by the hub or local services. Several commented that the Child House model should be provided in hubs to accommodate London's population and geographic distribution.

Almost all of the paediatricians thought the Havens should be more flexible and should expand the services they provide to children and young people. They were supportive of a **Havens Plus model** that included medical aftercare, such as STI screening, and thought that bridging counselling should also be provided at the Havens for all under 18 year olds. They would also like to see more training and support for those working in CSA.

Ultimately the paediatricians thought examinations should be done by those with the most experience but noted that skills need to be maintained more broadly as well. They thought the system should be flexible and take greater consideration of patient / family choice. They felt strongly that the Havens should provide bridging counselling for children and young people.

4.4 Police

The police reported concerns with access to social workers and the speed of the initial response after a child or other professional alleges a sexual assault. This can result in delays until the end of the school day, changing staff and the child needing to repeat their story several times. The feedback from young people as part of the DH/Haven study showed only 60-75% of the young people felt listened to and believed by uniformed and SOIT officers. This is considerably less than the 90-95% reported concerning the Havens. They also noted that communication from officers over to the lengthy period of the investigation and trial was poor.

Once a SOIT officer has been allocated, the ABE interviews take place in 20 suites across London, which are currently being refurbished for children and young people in 2014/15. Police were keen to maintain the large number of interview suites in any future model, due to transport issues for children and their families. Police officers from CAIT teams that were surveyed reported good access to ISVA's and intermediaries; there actual use was not assessed in this study.

A pilot is underway in London Borough of Kingston, whereby the cross-examination of a child will be pre-recorded prior to trial. This will largely avoid the need for the child to give evidence at the time of trial. This pilot is in some ways similar to the international examples of best practice (Child House and Child Advocacy Centre models) and suggests there is scope for further change within the UK system. Based on international experience, it is worth considering a broader review of the entire medical, social, investigative and criminal justice response to CSA and bringing it in line with the United Nations Convention on the Rights of the Child and the Lanzarote Convention.

4.5 CAMHS

This review found that CAMHS services have faced years of cuts with some reporting 19-76% cuts since 2010, resulting in some under resourced teams. For many teams the management focus is to meet waiting times for initial assessment and start therapy. This is often at the expense of softer, early interventions with schools, parents and the child's wider network. As CAMHS referrals increase, some services are raising their thresholds for tier III and requiring severe mental health conditions with a diagnosis. One CAMHS provider said *"Unfortunately it's no longer enough to have experienced a trauma like sexual abuse. We can only see children with a severe mental health condition requiring therapy. There are plenty of third sector providers offering support."*

Children and young people wait 2-11 weeks for an initial assessment which is then following by a further wait for therapy to commence and up to 6 months for some of the more specialist therapies such as psychotherapy and EMDR. There is currently no bridging counselling service from the Havens and many boroughs have 6 month waits for their own overstretched school based tier II counselling services. In summary the review has found inadequate resource for a child with emotional needs after trauma, and this relates as much to therapy for all types of trauma and abuse as CSA.

Young people had mixed views about CAMHS when questioned as part of the Department of Health/Havens research project. They reported waiting a long time for an appointment and struggling to cope in the meantime. Engagement was an issue with DNA rates 13-25% and several young people reporting the venue "depressing" or "feeling *embarrassed going in"*, however another said that *"CAMHS understood and listened to me".* The Young Person's Workers at the Havens

reported that young people often did not want to engage with CAMHS services as they found them too reflective and not practical enough.

The common theme from this review has been that children and young people need access to a variety of therapy and intervention options and shown the respect to allow them to choose the right one for them. Youth workers in the third sector describe the stigma still associated with CAMHS and the fear that it is part of the establishment. Young people often prefer to access local youth services where they can be more discreet.

The most common concern raised by CAMHS providers was that they no longer have the capacity to offer emotional wellbeing in schools and do not have the capacity to support and supervise colleagues in the wider multidisciplinary team e.g. school teachers, social workers, youth workers. This softer intervention and multidisciplinary working used to bridge the gap whilst waiting for therapy but this has been lost in many teams.

Additionally they are concerned that the family is being relied on to provide support where the family is seen as protective factor. However the parents/carers are not being supported or equipped to maintain stability for the child whilst coping with their own grief and shame. Only five of the CAMHS teams interviewed offer 1:1 therapy for parents.

Two suggestions from CAMHS providers included team around the key worker model and CAMHS in the Child House or Hubs. CAMHS should be key members of early intervention team and be able to offer 1:1 supervision and guidance to the key worker with whom the child or young person has established the best rapport - CAMHS experts as part of the **"Team around the key worker" model.**

CAMHS clinicians should offer all children who have been sexually assaulted an assessment. When the Children's House model was discussed they suggested a **CAMHS clinician in the Children's House** to offer assessment and short term therapy (4-6 weeks) and fast track referral with a "trusted assessment" to local CAMHS teams or local tier II providers for onward therapy/counselling as required.

4.6 School nurses

School nurses are key front line support and an important part of the choices of options for a child or young person. Those surveyed reported that still are commissioned to offer drop ins for young people and see children who have been sexually assaulted, although self-referral only and never referred by local paediatricians. Training and a helpline was requested by 60% and a local hub of CSA expertise by 80%. The "team around the key worker" model would be valid for school nurses as it is for youth workers.

4.7 Third Sector

Mapping the third sector providers as part of this review demonstrated a lack of knowledge amongst the Havens, local CCG commissioners and CAMHS teams as to the breadth of third sector providers in their Borough. There is no Directory of Service and no easy way for the Haven Advocate's to assist a child or young person in navigating the system. Some Borough Councils have useful information and the Havens provide a resource pack at discharge, but neither is as complete or as extensive as

the range of services available to children and their families from the third sector. Many of the third sector services are self-referral or peer-to peer referral only and running at capacity.

Third sector provision offer five types of service that could support a child or young person who has been sexually assaulted:

- advice and advocacy – helplines, practical advice and Independent Sexual Violence Advocates (ISVA)
- prevention – awareness raising, training and treatment of sexual harmful behaviours
- counselling/therapy for children and young people – counselling, psychotherapy, CBT
- counselling for parents/carers – 1:1 and support groups
- services for boys

The full range of services is described in detail in Section 13 and this showcases some great examples of innovative and bespoke services for these children and young people. However the services are not available in all Boroughs and are focused more in the Central, South and Eastern Boroughs in London.

The third sector organisations were keen to promote awareness raising and prevention as a recommendation. They advise training for signs of exploitation and how to respond to disclosure from a child, educating children in healthy relationships and sexual behaviours and advertising available services. They also recommended:

- All children assessed by a CAMHS professional at the Havens or CSA hub after a sexual assault
- CAMHS to offer early help, advice and supervision to the wider team around the child, working closely with children's social care
- Provision of enough ISVA's and ideally Child Independent Sexual Violence Advocates (CHISVA's) in London
- Integrated and holistic services in local and accessible sexual assault hubs or youth hubs
- Ensuring that there is choice as every child is an individual
- Supporting the parent to support the child – individual therapy available for parents and siblings if required
- "Team around the worker" model
- Havens Young Person's Worker or Child Advocate to support child or young person to identify a local key worker before they discharge them

4.8 Research and Best Practice

The **Children's House and Child Advocacy Centres** were identified as examples of international best practice. These models have been adopted / adapted into many different criminal justice systems and their effectiveness has been validated by numerous studies. The models are in line with the UN Convention on the Rights of the Child as well as the Lanzarote Convention and they embody the principles of child friendly justice including that:

- The child should be kept at the focus throughout the process and all efforts should be made to avoid re-traumatization by those responding to the child's allegation of CSA
- Parties involved should work in a multidisciplinary team and be accessible in one child-friendly place (social services, police, criminal justice system, medical care, psychological support and advocacy)
- Interviews of children should be performed by those specifically trained and kept to an absolute minimum
- Interviews should ideally be recorded and accepted as the child's testimony for court
- Medical examinations and treatment should be available to all as needed and coordinated with the multidisciplinary team
- Mental health support and treatment of the child and non-abusing family should start as soon as possible using evidence based treatments

Summary feedback and suggestions from stakeholders:

All stakeholders interviewed were asked for their suggestions for the ideal pathway for children who have been sexually assaulted and for their views on the ideal paediatric sexual assault model. The key principles for a London model include:

- Local Children's Houses or child friendly Hubs across London
- "Choice" for the child, young person and their family – everyone's response to child sexual assault is different
- CAMHS assessment and early intervention for all children and young people who have been sexually assaulted
- Improved communication between Havens/Children's Houses and local services in the Borough
- "Team around the worker" model – with CSA experts available to support and offer supervision to local frontline staff
- Support for parents to enable them to support their child
- Provision of child ISVA's
- Awareness and prevention of CSA in schools and in the national media e.g. mandatory reporting, national poster campaigns, advertisement of Havens services
- Engagement in research and collaboration with colleagues nationally and internationally

5. Conclusion

Services for children and young people should be designed around them, with their specific needs in mind. This review has identified that there is inequity in the services provided by the Havens to children and young people following sexual assault compared to care provided for adults in London, and children elsewhere. The Havens, unlike sexual assault services in other parts of the UK and

internationally, are not commissioned to examine historic cases of CSA, provide medical aftercare to children under 13 or counselling to anyone under18 years of age. Based on findings, this review recommends the Havens expand the services they provide to children and young people to include provision of medical aftercare and counselling for all ages. The Havens should be more flexible in the service they provide and improve the physical environment for children, their families and staff alike.

Medical aftercare and support for under13s and assessments and support for historic CSA are currently provided in the local community, where accessibility, experience and services can vary widely and in some areas is lacking. CAMHS and counselling follow-up is difficult to access and low referral rates suggest some teams have stopped referring. There are some highly regarded specialist third sector services but access to these is limited to certain boroughs. Often the people with the best rapport to support children and young people in their local environment are frontline staff like youth workers, school nurses and third sector providers. However this review identified that they are often not trained or supervised in CSA and there is a lack of expertise for them to access in complex cases.

Based on findings, this review recommends grouping existing services from local areas together into multi-disciplinary teams which could provide holistic care for children and young people. The review team believes that now is the time for the UK to develop their services in line with the UNCRC and the Lanzarote Convention.

- To focus the management of CSA in the UK on the child rather than force the child to fit the system
- To implement the Children's House model in several locations around London; providing friendly medical examination and long-term emotional/social therapy, as well as enabling a child centred court process
- To build on the expertise in CSA in London through strengthening links between health, police, social care and the third sector

6. Recommendations

This review recommends a significant change in the way cases of child sexual abuse are investigated and supported in London. The recommendations are based on the findings from this review, international best practice and make reference to key papers including the UN Convention on the Rights of the Child, the Lanzarote Convention, Working Together to Safeguard Children and the principles of Child Friendly Justice.

The following recommendations include a London implementation of international best practice, as well as "quick wins" as stepping stones towards the medium-term goal. There are local recommendations for NHS England/MOPAC and the CCGs and Local Authorities in each of the London Boroughs.

- **1st choice and medium-term goal:** Children's House (Barnahus) model x3-5 locations in London

- **2nd choice and "quick win":** Child Sexual Assault hubs x 5-7 locations in London and Paediatric Haven Plus

- **Team around the worker:** Child Sexual Abuse expertise for paediatricians, social workers, police and CAMHS teams and CAMHS supervision for frontline staff

- **Individual recommendations** for commissioners and providers in the pathway

A 3rd option (one paediatric SARC) or a 4th option (no change) are also discussed in this section, but are not the recommended model.

Implementation of these recommendations will need to involve co-commissioning across borough and stakeholder boundaries. This review sets out the outline model, but local redesign with all stakeholders, including children and their families, is recommended. Implementation will involve NHS England, MOPAC, Clinical Commissioning Groups, Local Authorities, Public Health, Office of the Children's Commissioners as well as health, social care and third sector providers.

Governance needs to include multi-agency co-commissioners such as local authorities, CCGs, MOPAC, NHS England and London-wide agencies.

6.1 Option 1: Children's Houses for London

This option for NHS England, MOPAC, CCGs, Local Authorities and the Criminal Justice System to consider is based on the international best practice. The model includes the whole pathway for the child from disclosure or suspicion of sexual assault/abuse, through investigation, medical examination and onward emotional support. This model is holistic and child centred, seeking to integrate the current system of individual services from all stakeholders.

This option establishes 3-5 Children's Houses across London providing services to all children and young people under 18 years of age following child sexual abuse. Services would be provided from a purpose built "Child House", ideally in a residential area and will include:

- medical examinations

- recorded interviews, accepted as court evidence and carried out by specifically trained providers

- sexual health screening and follow-up

- advocacy support for court and practical issues

- CAMHS assessment and counselling for 1-2 years

The goal would be for the same model that has been identified as best practice internationally. Children reporting a recent assault, historic abuse or preliminary interviews for suspicions of child sexual abuse will take place at the Children's House. Children presenting acutely following sexual assault may require forensic medical examinations and additional support at nearby emergency

departments. These may take place in the Havens or possibly in a Children's House either with site staff or a floating team. Forensic interviews for children and young people would be conducted by professional forensic interviewers (preferably with backgrounds in child psychology) at the Children's Houses. The forensic interview would be conducted as soon as possible, ideally within a few weeks of the allegation being made and would suffice as the child's entire testimony for court (including evidence-in-chief and cross examination).

The child and their family would then be able to start therapy immediately at the Children's House (with a different CAMHS counsellor from the interviewer). All medical aftercare would also be provided at the Children's Houses.

This model would require a change to police and court processes. This review acknowledges the recent investment in ABE suites in 20 locations which would not be required following full implementation of the Children's House model. The benefits of adopting this model (based on outcomes in Iceland) include court process completed in 2 to 4 weeks for the child, a reduction in drop-outs or withdrawal of statements and an increase in the number of cases prosecuted and convicted.

6.2 Option 2: Child Sexual Abuse Hubs and Havens Plus

Child Sexual Assault Hubs and spokes – "QUICK WIN"

This option establishes Child Sexual Abuse Hubs in seven locations with spokes out to local Borough services. This model builds on existing good practice in boroughs and creates "virtual teams" of child sexual assault experts in local areas. This model recognises the need for local paediatricians to see enough cases to maintain their skills, be supported by colleagues, work in teams and have access to multi-disciplinary support. Services would be provided for cases of **historic child sexual abuse** and be provided from an existing health premises in boroughs. Services will include:

- medical examinations from local paediatricians
- sexual health screening and follow-up from local services
- Safeguarding
- advocacy support from local Independent Sexual Violence Advocates (ISVAs)
- CAMHS assessment and counselling for 1-2 years from local CAMHS provider
- Outreach and support for local frontline staff

The model requires local experts to take the lead in child sexual assault on behalf of colleagues from neighbouring boroughs, creating networks across paediatrics, GU clinics, ISVAs and CAMHS teams that are not currently in place. Similar models of multi-disciplinary team work have been successful in MASH and MARAC work. Stakeholders interviewed as part of this review have expressed an interest in being local leads and are keen to maintain expertise.

The Hub would act as a local resource providing advice, training and supervision to frontline staff such as school nurses, youth workers and third sector providers. Hubs would also liaise and work with the Havens. Children and young people who attended the Haven for forensic medical

examination could return to the Havens or attend the hub for their medical aftercare and support at their preference.

Paediatric Havens Plus – "QUICK WIN"

This option provides services to all children and young people under 18 years of age following an **acute sexual assault**. The Havens continue to provide all acute forensic medical examinations for children and young people but expand the services for under 13s (at Haven Camberwell) to include semi-acute medical follow up and add bridging counselling for all ages. This option would remove the existing inequity of services provided by the Havens to children and young people as compared to adults. It would also help ensure that all children and young people are provided with appropriate medical follow up (including STI screening and prophylaxis) as well as psychosocial support.

Services would include:

- Forensic medical examinations and immediate medical aftercare
- Sexual health screening and follow-up
- Safeguarding and liaison with local teams / services
- CAMHS assessment and bridging counselling
- Option to record court interviews (in new child friendly suite)

This will need to be provided in a purpose built, child friendly suite at Haven Camberwell, for which funding is already available. Services for young people (13-17 years old) would remain available at Haven Paddington, Whitechapel and Camberwell, including follow-up 1 year post assault. Services for children under 13 acutely assaulted would only be available at Haven Camberwell with Paediatrician cover in the day and on call overnight. Medical follow up for under 13s could be either at the Haven Camberwell or in a local Hub. Short-term psychosocial support could be provided at any of the Havens sites, until handover to local CAMHS team.

6.3 Option 3: Paediatric SARC

A final option is for one Paediatric SARC for London for all acute and historic cases. This model is seen in smaller cities across the UK and provides services to all children and young people under 18 years of age following an **acute OR historic sexual assault**. Services would include:

- forensic examination following acute CSA
- medical examination following historic CSA
- sexual health screening and follow-up
- CAMHS assessment and bridging counselling
- option to record court interviews

- development of outreach, education, training and research in relation to CSA to become a single centre of excellence

This would need significant investment in one purpose built, child friendly suite in central London as none of the current Havens have sufficient capacity or space to extend. The SARC would provide services for up to 1000 children and young people per year, which is x2.5 more than the current Havens service. All children and young people would travel to this one central location for assessments and follow-up.

The Havens would continue to provide care for adults following sexual assault but all children and young people would be seen at a new Paediatric SARC. Paediatricians from local areas would be able to work some sessions at the new SARC to maintain skills and build networks. This would develop as a single centre of excellence for London.

6.4 Option 4: No change

The Havens currently provide forensic medical examinations for children and young people under 17 years, but only those aged 13 or over are provided sexual health follow-up. No counselling is provided to children or young people at The Havens. Currently each of the 32 CCGs and Local Authorities commissions paediatricians to undertake medical examinations, sexual health services to provide GU clinics and CAMHS providers to offer tier III intervention or tier II counselling. This review has found these services to be variable and disjointed, resulting in an unclear pathway that is not child centred.

6.5 Options appraisal and recommended models:

	Pro's	**Con's**
Children's House	• International best practice • Child focused, holistic service • Faster court process with potential for improved prosecution outcomes (benefit for child and society) • Medical examination and follow-up standardised • Long-term emotional support with no waiting	• Dependent on collaborative commissioning • Significant investment by all stakeholders in buildings and staffing • Travel time to one of 3-5 Child Houses
Child Sexual Abuse Hub and spoke	• Child focused, holistic service • Local hub of expertise to support frontline staff • Medical examination and follow-up standardised • Streamlined services with potential for reduced access times into CAMHS	• Dependent on collaborative commissioning • May require reinvestment into CAMHS in some boroughs • Travel times reduced to one of five to seven centres
Paediatric Haven Plus	• Equitable services for children of all ages • Provision of bridging psychological	• Cost for additional medical and psychological support in Havens • Travel time to Haven

	support • Continuity of medical care • Good use of new Havens paediatric space(already funded) • New staffing investment only	Camberwell for forensic and medical care for under 13s
One Paediatric SARC for London	• One centre of expertise in London acute / historic • Option for local paediatricians to in-reach and maintain experience • Potential for academic centre of research	• Potential loss of paediatric experience in Boroughs • Significant investment in new building and staffing • Travel time to one centre for all appointments for up 1-2 yrs • Support not integrated with local borough services
No change	• No action required	• Lack of medical and emotional support for children and young people • Continued inequity of service for children and young people

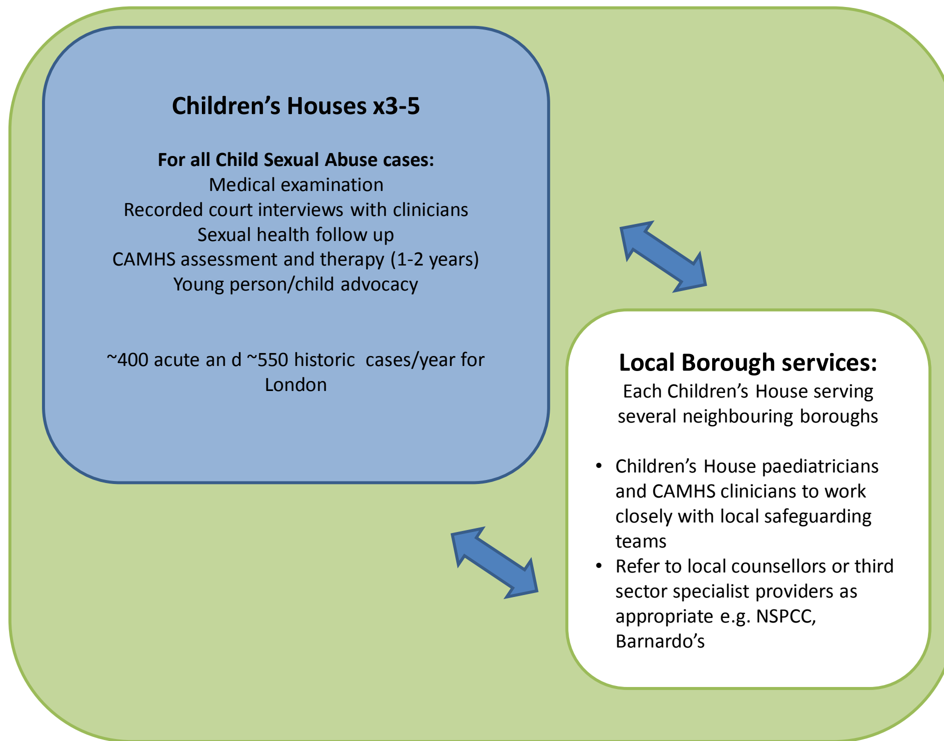
This review recommends the Children's House model should be the vision for the care of children and young people following acute and historic sexual assault in London and the UK, in line with the Lanzarote Convention, the UN Convention on the Rights of the Child and in line with the principles of child friendly justice. London could start with a pilot of 3-5 Children's Houses.

However in the short-term this review recommends the establishment of **Child Sexual Abuse Hubs** during 2015/16, with hubs fully in place by 2016/17. NHS England will work with MOPAC, Crown Prosecution Services, CCGs and Local Authorities in these collaborative commissioning plans, starting with a launch event in March 2015.

This review also recommends NHS England and MOPAC commission **Paediatric Havens Plus** as an immediate solution to the current inequity of service.

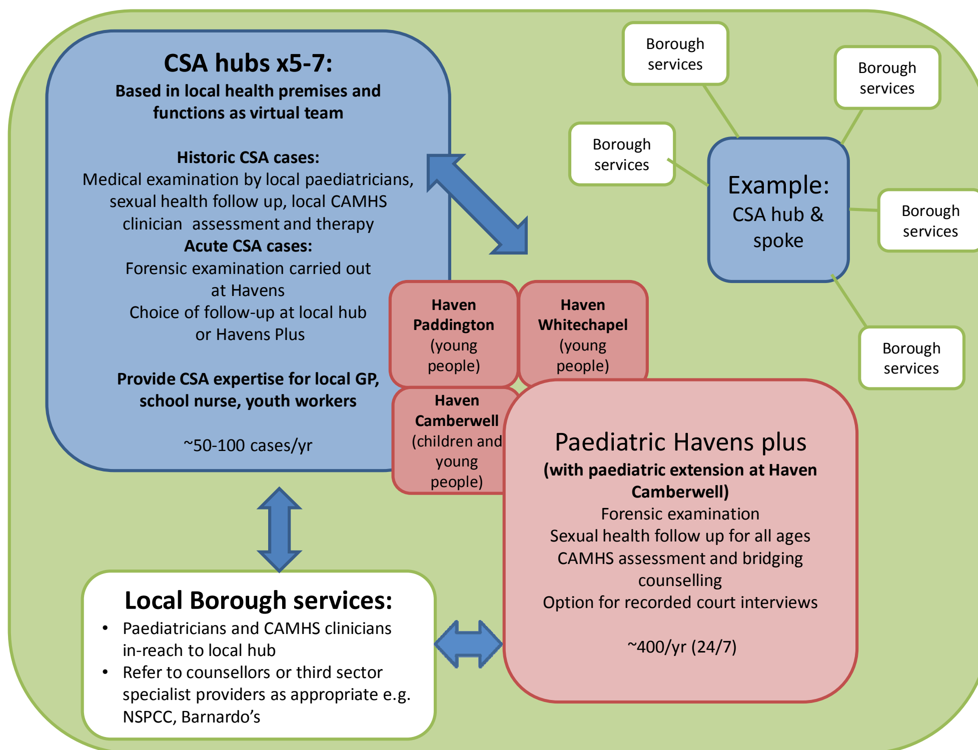
1st Choice – Children's Houses for London

Children's House model – 3-5 sites

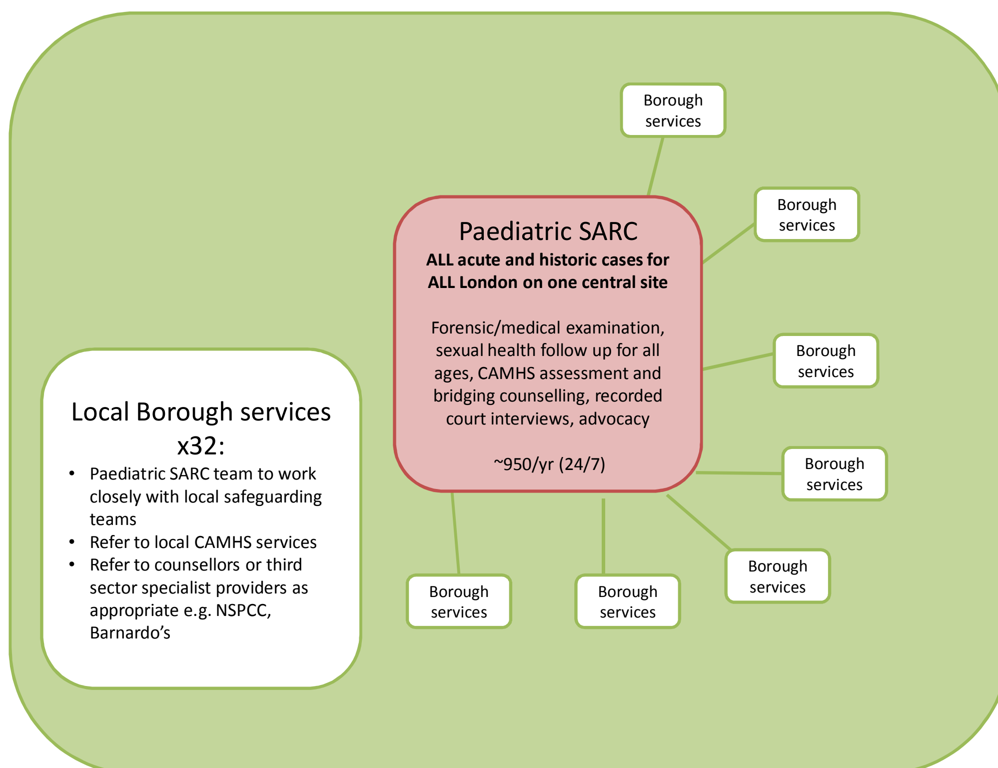


2nd Choice – Child Sexual Abuse Hubs and Paediatric Havens Plus

Child Sexual Abuse Hubs – 5-7 sites



3rd Choice – One paediatric SARC for London



Proposed timeline:

Issues were identified with the services in London for children and young people following sexual assault several years ago and this review was commissioned to examine those concerns. As such the recommendation is for a short implementation timescale.

2015/16	• Child sexual abuse hubs developed from collaboration of existing services and co-commissioning • Paediatric Haven Plus established including building of child friendly suite and recruitment of additional staffing • Local redesign workshops for future Children's House model • Pilot of Children's House model in one locality
2016/17	• Child sexual abuse hubs established covering all London Boroughs and additional staffing commissioned as required • Children's Houses co-designed, consulted on and tendered across London
2017/18	• Children's Houses established in London covering all boroughs

Commissioning implication:

Option 1 - Children's House: This will require collaboration across boroughs with existing commissioners contributing staff/services to the model. There will need to be a local agreement of the vision for a Children's House model and shared capital investment in a purpose built Children's House. In most boroughs this will require significant investment in CAMHS services and some investment in access to medical examination and follow-up. Boroughs may like to invest in existing third sector specialist services to work alongside their Children's House. This model would require a change to police and court processes to establish the Children's House model for interviews.

Component of sexual assault service	Existing commissioner	Cost Implication
Medical examination - historic case	CCGs	Some investment
Recorded interviews by CAMHS clinicians	MOPAC (currently SOIT officers)	Move to CAMHS
Sexual health screening and follow-up	Public health (local authority)	Some investment
Advocacy support	50% home office & 50% local authority/charity	No change
CAMHS assessment and counselling	CCG	Significant investment
Child House Building	Existing health and police buildings	Capital investment

Option 2 – Child Sexual Abuse Hubs and Paediatric Havens Plus

Child Sexual Abuse Hubs: This model would require collaborative across boroughs as the Hubs would cross borough boundaries. Local hub geographies will need to be agreed. There should be minimal cost as these services are core contracted services in paediatric and CAMHS services specifications. There would need to be service level agreements for clinicians to provide services on behalf of neighbouring boroughs. Recommendations for specific boroughs in each hub can be found in the **Appendix** or boroughs could use existing strategic partnership groupings.

Paediatric Havens Plus: NHS England/MOPAC investment in extension to Havens Camberwell to create child-friendly forensic suite (including interview facilities) and additional practitioners at Haven Camberwell to provide sexual health follow up for children under 13years, daytime paediatric forensic coverage and CAMHS/counselling for all under 18s.

Component of sexual assault service	Existing commissioner	Cost Implication
Forensic examination at Havens in child friendly suite	NHS England	Capital investment
Follow-up of acute cases at Havens plus	NHS England	Staff investment

Medical examination - historic case	CCGs	No change
Sexual health screening and follow-up	Public health (local authority)	No change
Advocacy support	50% home office & 50% local authority/charity	No change
CAMHS assessment and counselling	CCG	Recurrent Investment
Child Sexual Assault Hubs (estate)	Existing health and police building	Potential capital investment

6.6 Training and supervision

Team around the worker

This model complements the models above, with the establishment of mechanisms and capacity for expert health providers to support local community and third sector staff working with children and young people. This review has identified that the person best placed to support a child or young person following sexual assault is different for everyone and that choice is essential. But sometimes the person that the child builds rapport with (social worker, school nurse, youth worker) does not feel equipped to support them. The “team around the worker” model ensures that there is expert advice, training and supervision available from the Child House, the Child Sexual Assault Hubs, Havens or local CAMHS teams.

This review also recommends that there is sufficient investment to establish the **Team around the Worker** in all boroughs.

6.7 Specific recommendations for commissioners and providers

Joint Children’s Commissioners

- Commission sufficient CAMHS services to meet the needs of children and young people who have been sexually assaulted ensuring that services remain in place or are re-commissioned for:
    - CAMHS as part of early intervention teams
    - Capacity to offer pre-therapy support to the child’s wider network e.g. school, parents, social worker
    - CAMHS training and supervision for the frontline staff from other agencies e.g. Hope for Children and Families programme (pilot)
- Co-commission existing or enhanced Paediatrician and CAMHS services in CSA hubs or Child Houses with local boroughs
- Review the extensive range of specialist CSA third sector provision available across London and commission third sector services as local prevalence of sexual assault determines

The Havens

- Strengthen links between the Havens and local borough services

- Provide awareness raising of risks of CSA and services available to schools and youth services
- Provide advice and support to local borough services and CSA hubs/Child Houses
- Always discharge a child to a local named lead that has agreed to take overall accountability for the child's onward medical, social and emotional needs
- To maintain an up to date Directory of Services for CSA
- Review referral and discharge processes, documentation and referral routes
- Increase training
- Increase service provision and flexibility - as per Havens Plus model

Paediatricians

- To establish local CSA hubs to consolidate local caseloads and expertise
- To ensure STI screening, prophylaxis and treatment are provided as indicated
- To review Chain of Evidence and intimate image protocols
- To strengthen links with the Haven paediatricians and local colleagues for research, peer review, training and support

Police and CPS

- To strengthen links between police, social services and schools, with a review on the process and timeliness of reporting
- To review communication with children and families in the pre-trial period
- To review outcomes of the Section 28 pilot in Kingston and international best practice, with a view to considering the Child House model in London
- To pilot the use of the paediatric interview facilities at Haven Paediatric Plus
- In the interim to ensure intermediaries are available during the interview process, especially for young children
- To review ongoing research outcomes for methodologies used by the third sector including messy play, writing, storytelling and art to help explore what happened
- To ensure formal feedback or review on ABE interviews by police supervisors or peers
- To provide feedback to the Havens (and others as appropriate) on forensic examinations and case outcomes

Social Services

- To consult paediatricians early in the process and include them in strategy meetings
- To discuss all cases where CSA is suspected with paediatricians to consider medical needs
- To strengthen ties with police, CAMHS, medical and other providers
- To provide feedback to referrers on assessments and progress

CAMHS

- To offer guidance and advice to the child's existing support network in pre-trial period. E.g. parent, social worker, school counsellor, mentor or others already involved
- To offer all children who have been sexually assaulted an assessment and triage into tier III or tier II services. This assessment and support could be in a Haven or local CSA hub
- To ensure early support is available before therapeutic interventions start e.g. strategies for coping with feelings, emotional resilience and symptoms that impact on daily life – such as night terrors, flashbacks, self-harm
- To offer support to parents and siblings in conjunction with the child's therapy
- To offer choices to young people of where to be seen including: outreach on street, home visit or clinic based care
- To consider youth based settings for CAMHS interventions e.g. Mind the Gap in Camden or the Well Centre in Streatham
- To offer 1:1 supervision and guidance to the key worker with whom the child or young person has established the best rapport - CAMHS experts as part of the **"Team around the key worker"** model

Third Sector

- To develop services in London targeted at supporting families and carers
- To develop services in London targeted at boys
- To work with local commissioners to support the development and promotion of local CSA hubs, ensuring integration of medical, CAMHS, police, schools, counsellors and local third sector services
- To strengthen links with Havens to encourage attendance by young people who have been sexually assaulted

Appendix : Suggested Child Sexual Assault hub locations

The following are some suggestions of locations for Hubs based on existing paediatric services in the local areas, CAMHS providers and transport links for children and their families. This review recommends that local joint commissioning discussions review options with local teams to agree on optimal groupings and locations.

- **Northeast London**– possibly located at Barts (Royal London) or in Chadwell Heath and covering Newham, Redbridge, Waltham forest, Barking and Dagenham, Tower Hamlets and Hackney
- **North London**- possibly located UCLH and covering Barnet, Enfield, Haringey, Camden and Islington
- **Northwest London** - possibly located at St Mary's Hospital and covering Hillingdon, Hounslow, Ealing, Harrow, Brent, Hammersmith and Fulham, Kensington and Chelsea and Westminster
- **Southeast London** – possibly located - at King's College Hospital, Lewisham or Croydon - and covering Southwark, Lewisham, Greenwich, Bexley, Bromley and Croydon
- **Southwest London** - possibly located at Lambeth or Wandsworth, and covering Richmond, Kingston, Sutton, Merton, Wandsworth and Lambeth

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