

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

The Havens, Kings 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.

On average 400 children and young people attend the Havens each year for a forensic medical examination following an acute sexual assault. This number probably represents less than 5% of the children and young people living in London who have experienced contact sexual abuse in the past year and suggests there is a significant unmet need.

It was been estimated by the NSPCC study<sup>1</sup> that 9.4% of 11 to 17 year olds had experienced sexual abuse (including non-contact) in the past year and 1.9% had experienced *contact* sexual abuse in the past year. If this percentage is used to extrapolate the incidence of contact sexual abuse in London, it suggests there are approximately 12,540 children 11 to 17 years olds who have experienced contact sexual abuse during the past year. . During 2013/14, only 2485 under 16 year olds reported their sexual assault to the Metropolitan police, less than a quarter of the NSPCC estimate. (Although not all cases would be seen in the Havens, some could be seen by the local borough services or Rape Crisis Centres.)

### 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 under 13 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.

- **1<sup>st</sup> choice and long-term goal:** Children’s House (Barnahus) model x3-5 locations in London
- **2<sup>nd</sup> 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<sup>2</sup>. 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.

### Aim and Objectives

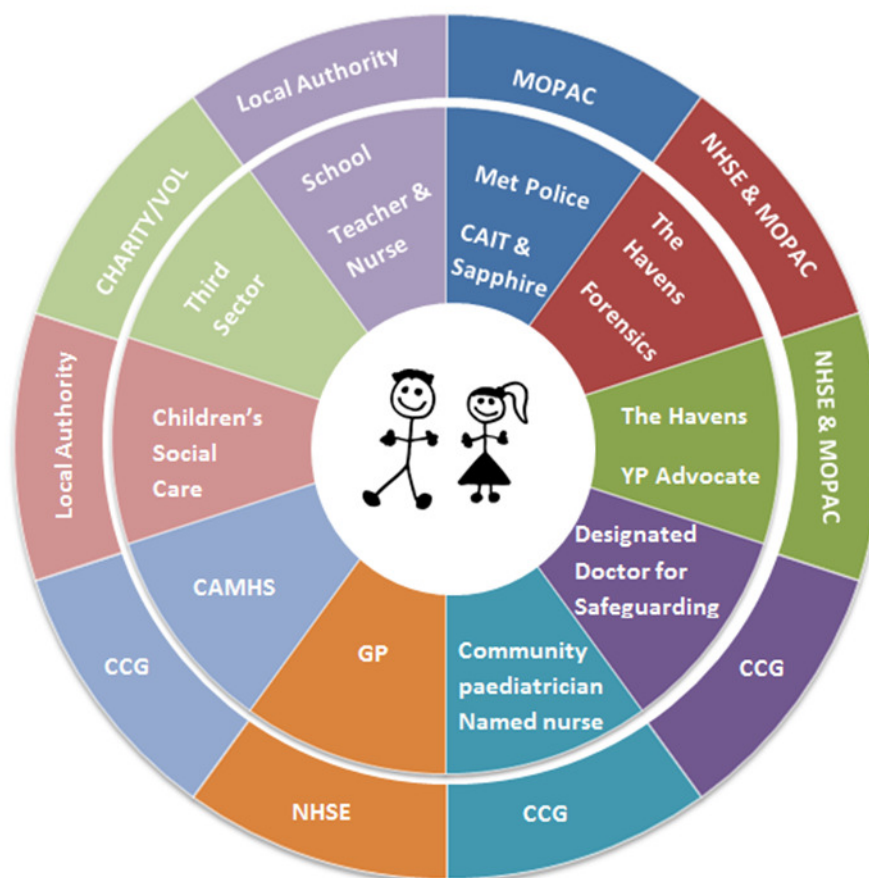
To deliver an options appraisal for the implementation of the NHS England Commissioning Framework for Paediatric Sexual Assault Referral Centre (SARC) Services as it would apply to London.

1. To undertake a detailed clinical mapping exercise of the current Paediatric pathway for cases of sexual assault.
2. To undertake a gap analysis of current commissioned services and the capacity of such services in all 32 London boroughs.
3. To identify commissioning and funding mechanisms for existing services.

4. NHS England has developed a Commissioning Framework for paediatric sexual assault referral centre (SARC); to undertake an options appraisal of potential paediatric models based on the principles set within.

### Scope

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 under 18 years of age. The review included pathways for under 13 year olds and 13-17 year olds. The project team engaged representatives from all providers and stakeholders below.



## 3. Methodology

This section describes how the review team carried out the review including interviews with expert providers, surveys, review of specifications and comparison to actual provision and structured interviews with Paediatricians, Clinical Commissioning Groups, Borough Commissioning leads for children, CAMHS, school nurses and the third sector.

### 3.1: Analysis of Haven database data

The Haven database contains demographic details and selected information obtained from the police, patients, their parents, guardians and / or others at the time of the forensic medical examination. The data is entered into the database by the Haven administrative staff following the

examination. Data note: the NHS changed from Primary Care Trusts to Clinical Commissioning Groups (CCG) during this time period and some of the areas recorded in the Haven database do not exactly match current CCG areas.

### **Method:**

Selected data from the Haven database was extracted and anonymised before being provided in an Excel spreadsheet to this review for analysis. The data was imported and analysed in EpiInfo 2007 (a programme commonly used in statistical / epidemiological research). Data was analysed from 2004 through March 2014 (2004 and 2014 each contained incomplete data at the time of our review but all other years contained complete data).

As the population sizes vary substantially by London borough the review team created a “case rate” to allow more equivalent comparison of the Haven attendances by area. The Office of National Statistics 2011 census mid-year estimate data was used to estimate the population of children and young people under 18 living in each borough<sup>3</sup>. To create a comparison rate we totalled the number of cases seen between 2004 and March 2014 (“ten year” total). Only females were used in this analysis as they accounted for over 90% of Haven attendances. We divided that “ten year” total by the total of the number of females under 18 living in each borough in 2011 and multiplied it by 100,000 to create a comparison “ten year rate”. This rate is effectively the number of females under 18 per 100,000 living each borough who attended the Haven for forensic medical examination between 2004 and March 2014. It effectively normalizes the population variations across London to allow more equivalent comparison by borough.

### **3.2: Surveys and interviews**

To assess the services available for child sexual abuse (CSA) across London surveys of all stakeholders were performed. These included individual interviews, brief general surveys on Survey Monkey and structured interview questionnaires. Interviews were completed on:

- Haven staff from Paddington and Camberwell sites
- 25 designated or named doctors (covering 27 Boroughs)
- 22 CCG children’s commissioners (usually a Joint commissioning post with the LA)
- 22 CAMHS teams
- Third sector providers including: Brook, NSPCC, Rape crisis x4, MAC-UK, Red Thread, Kids Company and local Borough counselling services
- 2 School nurses
- 3 Designated nurses

The full surveys were either conducted in person or over the phone. Data from the paediatricians’ surveys was entered into EpiInfo or Excel for analysis. A quantitative and qualitative summary of the results is presented below.

### **3.3: Review of Best Practice in CSA**

International best practice was explored by searching the internet for models of care in different countries and by reviewing international reports, agreements and research. Contact was made with several centres via email, phone and site visits to further explore individual models.

## 4. Background

It is beyond the scope of this review to discuss the short and longer term consequences of CSA. However that CSA is associated with negative impacts on physical and mental health is not surprising<sup>45, 6</sup> 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<sup>7, 8, 9, 10</sup> 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<sup>11</sup>. 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<sup>12, 13</sup>.

Societal recognition and understanding of child sexual abuse (CSA) has changed substantially over the past thirty years<sup>14</sup>. We now recognise that it is much more prevalent than previously thought. It is estimated that sexual violence affects one in five children<sup>15, 16, 17</sup>. Around a third of sexual abuse is committed by other children and young people (varied research suggests one-fifth to two-thirds)<sup>18</sup>. 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<sup>19</sup>. 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 Nations 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 of 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. Key articles of the UNCRC specifically relating to CSA are listed in Appendix 1. 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<sup>20, 21, 22</sup>. The treaty came into effect in the United Kingdom (UK) in 1992. Since then 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<sup>23</sup>.

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"*<sup>24</sup>. 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,<sup>25, 26</sup> 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 advice 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.

## 5. Commissioning of sexual assault services in London

Sexual assault services for children comprise a mixed picture of medical, police, social care and third sector services. This review focused on the medical assessment and local medical, emotional and social follow up of children following a sexual assault. Each of these services is commissioned differently, with varying degrees of joint commissioning across the London Boroughs.

**Table 1: Summary of commissioning arrangements for children's services**

Service	Commissioner
The Havens	NHS England and Mayors Office of Police and Crime (MOPAC)
Met Police: CAIT and Sapphire teams	MOPAC
Children's Social Care	Children's Services in Local Authority (LA)
CAMHS – tier III	Clinical Commissioning Group (CCG) Sometimes jointly commissioned with LA
CAMHS – tier II and Early Intervention	Children's Services in LA Usually Jointly commissioned with local CCG
Third Sector	Usually combination of charity funded and MOPAC Occasionally LA commissioned
School nurses	Public health in LA
School counselling	School Head Teacher

## 5.1 NHS England

NHS England commission services for sexual assault as part of Health in the Justice System. The services commissioned in London are three sexual assault referral centres (SARCs) for adults, young people and children provided by The Havens, Kings College London. The SARCs are commissioned to provide forensic examinations following the disclosure of a recent sexual assault of a child or adult. Victims are seen up to 7 days post assault for collection of forensic evidence, depending on the assault type/site and in line with the Faculty of Forensic Legal Medicine (FFLM) guidelines.

For children under 13 years disclosure of recent sexual assault always involves police and social services who usually accompany the child to the Haven. Following the forensic examination children are referred to the Designated Doctor for Safeguarding Children and Young People in their Borough of residence for all follow-up. Prior to this review NHS England identified a gap in the support for young children at the time of and following disclosure of sexual abuse and The Havens have been commissioned to offer a Child Advocacy service from 2015/16 – one post for London.

For Young People (13-17) the Havens are also commissioned to offer sexual health screening, other follow up and access to a Young Person's Worker to support them in the court process and referring onto local services such as CAMHS. Young people can be referred to The Havens by police and social services, or they can self-refer.

For both children and young people there is grey area for examinations which are outside of the forensic window but where physical trauma might still be visible and its documentation of potential use in a court case. For this reason the Havens are commissioned to offer some flexibility in referrals for examination. Children and young people who allege historic sexual assault (in the past months or years) are entirely dependent on local Borough/CCG services for health support – both physical and mental. This in turn is dependent on good working relationships between police and social services and their local health partners. Young people age 13 and over can receive medical care and support at the Havens for up to one year following a sexual assault.

For adults the Havens are commissioned to provide a full pathway of forensic examination, sexual health screening follow-up, advocacy and counselling. This service for adults is available for any acute sexual assaults requiring forensic examination as well as historic sexual assault up the one year after the assault. Adults can self-refer, or come via police or social care.

**Table 2: Summary of SARC services commissioned from The Havens by NHS England**

	<b>Forensic examination</b>	<b>Sexual health screening and treatments</b>	<b>Advocacy</b>	<b>Counselling</b>
<b>Children under 13 years</b>	Yes	No (referred to local paediatrician)	NEW child advocacy role in 2015/16	No
<b>Young People 13-17 years</b>	Yes	Yes Or local GU clinic	Yes Three Young People's Workers	No
<b>Adults</b>	Yes	Yes Or local services	Yes	Yes

NHS England does not commission CAMHS tier II or III services, but a recent report ordered by the House of Commons into children's and young people's mental health and CAMHS, describes insufficient capacity in CAMHS services. They note the significant impact these delays have on children and adolescents and call for NHS England to monitor and ensure adequate services are commissioned.

*"Young people and their parents have described "battles" to get access to CAMHS services, with only the most severely affected young people getting appointments; they also described the devastating impact that long waits for treatment can have."*

*"While demand for mental health services for children and adolescents appears to be rising, many CCGs report having frozen or cut their budgets. ....we are concerned that insufficient priority is being given to children and young people's mental health. We recommend that NHS England and the Department of Health should monitor and increase spending levels on CAMHS until we can be assured that CAMHS services in all areas are meeting an acceptable standard....." <sup>27</sup>*

## 5.2 Clinical Commissioning Groups

Clinical Commissioning Groups are responsible for commissioning most of the local services required for the long-term physical and emotional wellbeing after a child sexual assault, but these services are part of general services and not specified for sexual assault. These services include designated doctors and nurses, named doctors and nurses, paediatricians (community or acute) and CAMHS tier II and III.

Increasingly the CCG Children's Commissioning role is now a joint post with the local London Borough, and as such the Joint Children's Commissioner is also responsible for commissioning those services funded by the London Borough. These services include Early Intervention or Early Help services (including tier II CAMHS), children's social care, safeguarding teams, school counselling, school nurses. As 21 of the 22 Children's Commissioning leads interviewed were in joint posts, this section will focus on the role of the Joint Children's Commissioner.

### Commissioning Paediatricians

Of the 22 CCG Commissioning leads interviewed, most have generic specifications in place for community paediatric services including responsibility for long-term conditions management, fostering and adoption medicals, immunisation coordination and training. Only seven of the CCGs interviewed have sexual assault medicals and follow up services detailed in their specifications (examples detailed below). These service specifications varied and were not always consistent with current forensic examination guidelines or the service being provided (based on survey responses).

- Kingston CCG: Sexual assault (historic cases) – medical assessment and sexual health screening
  - Seen within 4 hrs and available 24/7
  - Facilities that meet the demands of forensic evidence collection
  - Expected to put in place an aftercare plan for all children and young people examined that will ensure they are supported to make a good recovery and prevent further health complications arising

- Lambeth CCG: Children will be seen for sexual abuse medical examinations, usually after a strategy meeting and police interview. Children are seen in the Centre for Child Health where there is a designated child protection suite and colposcope. In cases of acute sexual assault (<72 hours), children and young people may be seen at the Haven where forensic facilities are available.
- Sutton and Merton CCGs: Medical assessments for children who have been subject to long term sexual abuse – not acute
- Richmond CCG: Assessments of sexually, emotionally and physically abused children
- Barking and Dagenham CCG: Sexual abuse follow up clinics (SAFE) that accept referrals from Havens and following sexual abuse medicals completed by community paediatricians

Children's commissioning leads were only aware of pathways in four of the CCGs and yet the review found paediatricians had pathways in place in many more services. There was a general lack of knowledge amongst Children's Commissioners in this specialist area, with much of their focus at present on CAMHS and retendering services.

### **Commissioning CAMHS tier III**

CCGs are responsible for commissioning tier III CAMHS services whilst the London Boroughs are responsible for commissioning tier II CAMHS services. Where children's commissioning posts are a joint role, this offers opportunity for integration and redesign of services. Commissioners reported that Tier III CAMHS services do not appear to be working. There are increasingly high thresholds to meet referral criteria, long waiting lists (up to a year) and high DNA rates of up to 25%. The exceptions were Enfield and Camden CCGs who reported that their CAMHS tier III was highly regarded.

In order to meet the criteria for Tier III services following a sexual assault, children and young people have to have a diagnosable mental health conditions such as severe anxiety, severe self-harm or post-traumatic stress disorder (PTSD). Many CCGs are aware that children and young people are falling through the gap in commissioned CAMHS services.

Most CCGs have chosen to protect CAMHS budgets from further cuts, conscious of the already low investment into CAMHS. One CCG did report a 20% cut for 2015/16, whilst other CCGs have described 10% cuts to provider block contracts that are impacting on services. For example where CAMHS is commissioned as part of a mental health block contract, providers can choose to make internal cost improvement savings to the CAMHS service. This has resulted in cuts to "soft" services for children and families, such as CAMHS support for the wider multidisciplinary team, support to a family pre-treatment, advice and guidance to frontline colleagues e.g. schools.

Two thirds of CCGs interviewed are currently out to tender with new specifications that integrate tier II and tier III services. Greenwich CCG is retendering CAMHS to include an early intervention, prevention and recovery based model. This ensures that those children or young people who do meet the criteria for specialist tier III CAMHS are offered tailored interventions such as talking therapies, peer support, counselling. And those that are assessed as needing tier III interventions will be provided an **interim support plan** (child/young person, family and school) during their referral to treatment time.



**Example of innovative commissioning:**

Greenwich CCG is retendering the CAMHS service from Oxleas Mental Health Trust to include:

- An **interim support plan** for the child/young person, family and school, during their referral to treatment time.
- **Training and support for professionals working with children who do not meet the Tier III threshold:**
  - Support on how to talk to children and young people who have experienced sexual abuse or have been sexually exploited to help them to manage their conflicting emotions regarding family members who may not have intervened to protect them, at an age-appropriate and/or timely point in their lives;
  - Support for the third sector commissioned to work with families
  - Training and case conference discussions to help professionals and parents manage more challenging and complex behaviours
  - Supporting young people with learning difficulties and challenging behaviour

Waltham Forest CCG has commissioned a service for children and young people who are borderline tier II and tier III. This service provides six weeks of intervention to determine if the child or young person need tier III or tier II. Unfortunately if a child is identified as needing tier III services, they then join the 18 week waiting list for therapy.

In Kingston CCG 40% of children did not meet the CAMHS tier III criteria in 2012/13. The CCG invested in more tier II support, developed clear pathways and referral criteria and established a single point of access. They are working with South West London and St Georges Mental Health Trust to create a similar flow of children between services across the tier II/III boundary

**Example of innovative commissioning:**

Kingston CCG has commissioned **Weekly Step Up and Step Down system** for children who are receiving CAMHS support. The tier II and tier III providers meet together to share cases and allow a fluid movement of children between services, with no need for the child to tell their story again.

Young people's engagement with CAMHS was an issue noted by several CCGs with 'did not attend' (DNA) rates high, in one case 25% of all appointments were not attended. Camden CCG is taking an innovative approach to this issue, investing in a three year project called "Minding the gap". Minding the gap is a young people's hub for 16-25 year olds that offers support for mental health as well as sexual health, drug and alcohol abuse. This will be in an accessible and non-stigmatised venue and will support the young people as they transition into adult mental health services. However, as with many innovative youth services, this still leaves a gap for children needing CAMHS support.

The only CCG that identified specialist sexual assault services was Wandsworth CCG. SW London and St Georges MH Trust provides a psychiatric nurse to work with children who have been sexually assaulted.

## **Commissioning CAMHS tier II**

CAMHS tier II is generally commissioned by the borough and the diversity of service name, provider and services are significant. For example services include: SAFE 0-18 (Ealing), Hear and Now (Redbridge), Families First (Islington), CAMHS early intervention (Lambeth). Children and young people following sexual assault and struggling with early signs of depression, anxiety or self-harm would be suitable for these services and can be referred by their GP or social worker. The knowledge of these services amongst the Children's Commissioners was limited in some cases but felt confident that the children's social workers would have a good working knowledge of local statutory and third sector services for children and young people.

Most boroughs provide an Early Help or Early Intervention service with a Single Point of Access (SPA). The SPA takes all referrals and a Social Worker or Family Support worker triages the referrals into early help services, children's social care or refers into CAMHS tier III, school counselling and other agencies.

The services are holistic, supporting the child and their family with 1:1 sessions, family therapy, parenting support, group work and in some cases cognitive behavioural therapy. Usually the services are provided in a school or home environment, offering up to six months of intervention. These professionals are used to supporting a child and family after abuse, neglect and violence – but do not currently have the support of specialist in sexual assault. They would benefit from access to child sexual assault experts locally to provide supervision and expertise. One possibility for the future would be for Havens Young People's Workers to refer directly into the SPAs. This would not only help facilitate their support but would also build links to the Havens for these services.

Some boroughs employ CAMHS staff directly in their Early Intervention teams, for example: Barking & Dagenham, Hounslow, Ealing and Southwark. However, with London Boroughs facing significant financial cuts in 2015/16, this CAMHS provision is at risk, with one Joint Children's Commissioning already planning to cut investment into the CAMHS team in 2015/16.

## **Commissioning school counselling**

Joint Children's Commissioners interviewed were only aware of school counselling being available in the following boroughs: Tri-Borough (Kensington & Chelsea, Westminster, Hammersmith & Fulham), Ealing, Kingston, Merton and Sutton. This counselling was funded by the borough or third sector e.g. Comic Relief in Merton and Sutton.

However schools also directly commission school counselling from education funds using national providers such as Place to be or Kids Company. School counsellors are easy to access with relatively short waiting lists of up to 6 weeks but, like Early Help services, they do not have access to sexual assault expertise for supervision and advice.

## **Commissioning school nursing**

School nurses have a role to play as a potential key worker for children looking for emotional support following sexual assault, particularly as they are a mainstream and accessible service. All

Joint Children's Commissioners confirmed school nurse "drop ins" were still part of the specification for services, with only one CCG reporting a likely change with 2015/16 service redesign. Educational mentors were also mentioned by several CCGs as other potential key workers for young people.

Bexley CCG commission school nurses to run CASH clinics (contraceptive advice and sexual health clinics). This means that a young person who has been sexually assaulted, could be referred by the Havens or others for sexual health follow up in CASH and then see the same school nurse in their school for emotional support.

Hounslow CCG will be retendering their school nursing service in line with the 2014 National School Nursing specification. This includes pathways for emotional health and wellbeing as well as a domestic violence pathway covering forced marriage and rape. If these pathways are successful they could be adopted by other CCGs.

### **5.3 Local authority**

The London Boroughs hold the commissioning responsibility for several parts of the long-term emotional and social support of children and young people following a sexual assault. The services include Early Intervention or Early Help services, children's social care teams, safeguarding teams, school counselling and school nurses. As mentioned in Section 5.2, most London Boroughs now have a Joint Children's Commissioning lead across CCG and Borough commissioning teams, with shared responsibility for the commissioning of children's services.

The only exception identified in this review was Hillingdon, which still runs a separate CCG and Borough commissioning of children's services. This is leading to challenges in the commissioning of mental health services, with the borough commissioning CAMHS input into its Early Intervention teams whilst the health commissioned CAMHS service has long waiting lists and offers minimal early input. There is an opportunity to develop a joint commissioning approach to CAMHS tier II to optimise investment.

A general theme from the boroughs was that there are huge pressures on the funding of services and each borough is taking a different approach to commissioning CAMHS and early intervention. Some boroughs are choosing to protect children's early intervention services and CAMHS. Others are cutting the already seriously underfunded CAMHS by 20% in 2015/16 on, placing CAMHS service provision at further risk.

## **6. The Havens – sexual assault referral centres (SARC)**

### **6.1 Havens Services**

The Havens accept referrals of children and young people who have suffered a recent sexual assault for forensic examinations. Those aged 13 and over can also be seen at the Havens for up to a year following an alleged assault. Referrals can be made by the police, young people themselves or third parties on their behalf including other professionals/agencies. All children under 13 must be accompanied by either the Child Abuse Investigation Team (CAIT) or Sapphire Team from the Metropolitan (Met) Police.

### **Services available for children and young people include:**

- Forensic medical examination (where required)
- Paediatric support for examinations on children under 13 year or as required for 13-18 years e.g. not Gillick competent, learning difficulties
- Emergency contraception and post-exposure prophylaxis
- For 13 – 17 years: sexual health follow up by nurses and doctors and advocacy support from the Young Persons Worker
- For under 13 years: NEW child advocacy role starting Jan 2015
- Provision of statements for police and court purposes
- Advice and training to police and other professionals
- Safeguarding (with multi-disciplinary team support)

### **Forensic examination**

Children and young people arriving at the Havens with the police, social worker or parent/carer are met by a crisis worker and examining doctor(s) / forensic nurse examiner. The crisis worker role is to settle the child and parent/carer and offer some preparation for the examination to come. Crisis workers at the Havens are supplied from a rota of professionals with other day jobs in health and social care (for example: social worker, teacher, commissioners) which brings breadth of experience to the team. However, aside from the training provided by the Havens, most have not otherwise been trained to work with children and don't necessarily have the skills of a play specialist to put the child at ease. Following discussion with Haven staff, there are varying opinions as to whether the crisis worker is there for the child or the parent, or in fact this is the role of the Havens Paediatrician. Several in the team raised their concerns about who was there to look after the parent in the physical examination stage of the forensic examination and interview process.

For those under 13 years, a joint examination is carried out by a sexual offences examiner (SOE) and paediatrician (or a dual trained examiner if available), with a Crisis Worker to support with sample collection. This model allows for comprehensive clinical examination and attention to the needs of the child but perhaps with less emphasis on the needs of the parent. One Haven Paediatrician said "they are both patients" and they both need emotional support through the examination process. In some local clinics where examinations for child sexual assault take place play therapists are available to support the child through the process, leaving the nurse to support the parent/carer. In the Surrey SARC the sample collection is all completed by the sexual offences examiner (SOE), leaving the nurse and paediatrician (if present) free to support child and parent/carer.

When a Paediatrician is required, it is not always possible to undertake an examination 9-5pm as on-call paediatricians are only provided out of hours. At Haven Paddington there is daytime provision for single examiner forensic examinations with dual trained staff. The dual-trained SOEs are supported by the Haven Paediatricians who provide peer review of each case in a timely fashion. However Haven staff noted that many children who disclose sexual assault during the day often have to be booked in at 6pm for an evening examination, which is not ideal in terms of the lateness for the child and the delay to collection of forensic evidence. The sooner someone can be seen for forensic examination, the greater the chance that biological evidence can be recovered if present.

For young people 13-17, the examination is carried out by the SOE or forensic nurse examiner (FNE) and nurse or crisis worker. A paediatrician is requested to be present where there are concerns about the young person's needs, for example: a young person with a learning difficulty.

All children and young people who attend the Havens for forensic medical examination are discussed in a multi-disciplinary safeguarding team meeting (with support from Kings College Hospital NHS Foundation Trust). Referrals to other services are discussed and further action taken if deemed necessary by the team. Young people age 13 and over can attend the Haven for medical aftercare and support following sexual assault, regardless of whether they had a forensic medical examination at the Havens.

### **Child friendly environment**

A significant issue noted with the Havens sites is that the environment is not child or young people friendly. The clinical environment and waiting rooms, are sparse and clinical due to the need to maintain easily decontaminated environment. While there are some limited facilities for distraction techniques during examinations, it is not possible to have many toys and play equipment due to decontamination requirements. Wipeable books and Aquadoodle are most commonly used, as well as projected images for the ceiling.

The Havens are currently investing in refurbished child-friendly furniture in the waiting areas and examination suites of all Haven three sites in London. The Paediatricians have planned the changes in consultation with play specialists, service users and staff across all three sites.

Non-acute cases of child sexual assault who do not attend the Havens generally have their examinations carried out in paediatric outpatient departments or clinics which tend to be bright, airy and colourful, with access to a variety of toys for preparation for and debriefing after the examination.

The SARC in Surrey has a welcoming homely environment, with a lounge style waiting area for follow up and historic cases, an adult and a children's forensic waiting area with wipeable toys/play equipment and kitchen for children and adults attending. They have also just invested in a "*V-pod Anxiety and Pain Management*" system which is a digital tool that fills the forensic examination room with an interactive world of bubbles and games to engage the child and examiners alike. The child, parent and medical staff can all wear the 3D glasses and engage together in the fun activities, with no chance of contamination of the evidence by toys or books. This distraction technique can be useful during the examination stage but some paediatricians have raised concerns over its use during the intimate examination stage. There are concerns about encouraging a child to disengage during the intimate examination.

### **Support after the Havens**

Children under 13 years are referred to their GP (with parent's consent), children's social care team and Designated or Named Doctor (as directed by Borough). The Haven team hands over all responsibility for medical follow up and community support to the Borough team. This review has identified significant variance in the responses to these referrals by Borough teams (see Section 7).

Young people 13-17 years have some choice regarding who is informed of their sexual assault and the Havens refer onto social care, GP, paediatrician and others accordingly. All 13-17 years olds are offered support by a Young Person's Worker and a follow-up appointment at the Haven or a referral to a young person's service at a local Genitourinary Medicine (GUM) clinic for STI screening and counselling. The initial follow up visit is usually arranged 7 – 14 days after the alleged sexual assault and includes a risk assessment. The young person is contacted by someone from the Havens for a welfare check within a few days of the examination. This can be the nurse, the young person's worker or the paediatrician.

The Young Person's workers also undertake risk assessments and provide emotional support to young people as well as signposting to other services. When they identify safeguarding risks they chase police and social care teams to ensure actions are taken. Young people are seen again at subsequent medical visits (or otherwise as indicated). They are also offered telephone advice for up to one year if required. The service from the Young person's worker vary between sites with one offering support three to four times a year and the other three to six weekly appointments if required. Most young people only attend for 1-2 appointments, with the young person advocates supporting 150 young people each year.

Currently only 40% of young people choose to come back for follow up with a Young person's worker. Young person's workers reported difficulty in making contact with young people.

Following discussions with the two Young Person's Workers currently in position, their knowledge of local borough and pan-London services varied, with no borough level directory of services at the Havens. The Haven leaflet provided at discharge contains useful information about the key national or London services such as Brook, NSPCC, Kids Company and Rape Crisis, for self-referral or referral by the Havens. Feedback from third sector providers was that they rarely receive referrals from the Havens. They would like to be more actively involved and would prefer a verbal clinical handover. Currently there is a real missed opportunity for the Havens to be the specialist provider holding the knowledge pan-London.

### **Havens case tracking**

This review has undertaken case tracking of 80 children and young people seen at the Havens between April and June 2014 to identify to whom they were referred and the outcome of the referral.

The cases of 24 children **under 13 year olds** were reviewed and all but one were referred to social care, local paediatricians and their GP as per Havens policy. The remaining child was not formally referred as the social worker accompanied them to the Havens. However 15 of the children were not seen by the paediatrician for medical follow-up, with five of the paediatricians assuming that the referral for information only with no action required. The very small number referred to CAMHS were seen quickly in 3-6 weeks; and four children were referred to the local GUM clinic.

**Table 3: Case tracking outcomes for under13 years olds seen at the Havens between April-June 2014**

<b>24 children</b>	<b>Not referred</b>	<b>No of children seen</b>	<b>Outcome</b>	<b>Referral made but not seen</b>	<b>Outcome</b>
Paediatricians	0	9	Seen in 2-12 weeks Referred to CAMHS (1) or GUM	15	Assumed for info only (5) Referred to GUM, social worker or children's nurse
Social care	1	20	Seen in 1 day to 1 week Social care assessment and case closed (13) Case open (7)	4	Reviewed referral and closed case
CAMHS	21	3	Only 3 referred to CAMHS Seen in 3-6 weeks		

The cases of 56 young people **13-17 year olds** were reviewed. Young people attending the Havens are consulted about who the Havens refer to and as such only 40 of the 56 were referred to local paediatricians and their GP. A higher number were referred to social care due to safeguarding concerns. Of the 40 young people referred to the local paediatrician, the majority were not seen by the paediatrician for medical follow-up, with 12 attending GUM clinic or Havens. Two paediatricians had assumed that the referral was for information only with no action required. Social workers remain active in 19 cases and a small number have been referred to specialist CSA provision. CAMHS were referred very few young people from the Havens and of those that were referred only one met the tier III criteria.

**Table 4: Case tracking outcomes for 13-17 years olds seen at the Havens between April-June 2014**

<b>56 young people</b>	<b>Not referred</b>	<b>No of children seen</b>	<b>Outcome</b>	<b>Referral made but not seen</b>	<b>Outcome</b>
Paediatricians	16	4	Seen in 2-12 weeks Referred to child protection nurse or social care	33	Assumed referral was for info only (2) Follow-up arranged at GUM/Havens (12) Referred to child protection nurse (3)
Social care	9	31	8 cases now closed 19 cases remain open 4 cases declined social care input And 4 were referred	16	Referrals reviewed and no social worker allocated or follow-up needed (10) In two cases the

			onto Barnardo's, NSPCC, Empower and Respond		young person could not be contacted
CAMHS	51	5	3 seen by Tier III or IV 2 referred onto local services e.g. school mentor and counsellor	0	

Fewer than 40% of young people chose to return to the Havens for their follow up and received a follow-up appointment with the young person's workers. The Young Person's Workers attempt to make contact with all young people regardless of if they plan to return to the Havens for medical aftercare, with varied success. Few children are referred to CAMHS from the Havens, most likely as interventions are generally at the forensic examination stage and it is difficult to determine longer term emotional support needs at this early stage. Future recommendations should include some CAMHS assessment in the Havens in the first 4-6 weeks.

### Identifying child sexual exploitation

The Havens have a role in spotting the signs of Child Sexual Exploitation and ensuring that young people attending the Havens for forensic examination after a rape are suitably supported for secondary prevention. Several Havens team members described cases where young people return to the Havens on several occasions following alleged sexual assaults. The Havens currently use a risk assessment tool as part of their initial forensic examination and at the Young Persons Worker first assessment and report any concerns to children's social services.

Brook & BASHH launched "*Spotting the Signs - A national proforma (CSE)*" in summer 2014<sup>28</sup>. This will allow sexual health professionals to use a standardised approach to pick up on the warning signs of child sexual exploitation. It has been designed to be integrated into sexual & social history taking frameworks and provides questions to help practitioners identify a young person's circumstances or behaviours – including non-verbal signs. Other tools such as the Brook Sexual Behaviours Traffic Light Tool are also available to start conversations with young people<sup>29</sup>.

### Voice of the young person

***"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

This review could not seek the views of the child directly, but early feedback was sought from the Department of Health/Haven research study "Outcomes and Experiences after Sexual Assault of Young People through the Havens" which is currently in progress. The first 89 young people (aged 13-17 yrs) to have been interviewed shared their thoughts about the police, The Havens and then CAMHS services if referred. Nearly all, (90-95%), of the young people felt listened to, safe and believed at the Havens, but this dropped to 60-75% when asked about the uniformed police and SOIT officers. Many participants described positive experiences of care for victims of sexual assault.



The research team think that anxieties about being blamed or judged may prevent adolescents accessing services following sexual assault.

The young person's views were reviewed and some themes identified were:

- Young people were worried about attending the Havens in case people thought they were lying or they were in the wrong
- The majority of young people felt safe and believed at the Havens
- One young person said *"After seeing everyone I felt normal and not alienated"* and another said *"Everything was just right – I was treated like an adult"*
- Two described the team that saw them as judgemental and another found the young person worker who saw them was *"automated – saying the same thing each time"*
- Five young people requested access to counselling, that is offered immediately and ideally available at the Havens. One suggested group counselling with people who have experienced the same thing – this is a model that is used in STARS service in Surrey and for adults at the Havens
- One young person suggested it would be ideal to have a centre for young people who have experienced rape to go to and have 1:1 counselling/support from experts

### **Local support for children and young people after the Havens**

This review sought to map both the provision of local services and understand the gaps and the needs of children and young people post sexual assault. Overall the loudest message to come from this review is that in fact every child is different and needs a unique set of services to support them, for a unique length of time and in a place of their choosing. Choice is essential. Services should be provided by someone with whom the child or young person has a rapport in a venue that is accessible and not stigmatising. In order to provide the best support possible a joined up knowledge of all the local services is essential.

There is a need to consider different services for boys and girls following a sexual assault due to the different nature of their emotional responses. Girls tend to internal their stress, struggling with self-harm, anxiety, eating disorders. They often prefer counselling and talking in a place of security and safety. A Barnardo's Study<sup>30</sup> reviewed the needs of boys following child sexual exploitation and found that boys may react differently from girls, and in such a way that professionals may not be aware that they are displaying symptoms of abuse or suffering the after effects. For example, males may self-harm by getting into fights, which may not be recognised as a method of self-harm. Likewise, criminality may be a particularly common response to trauma for boys. Professionals also found that young men are more likely to express their anger externally and be labelled as 'aggressive', 'violent' or an 'offender', whereas girls are more likely to internalise their distress.

The primary issue with local follow up after the Havens is that no one is currently taking responsibility for ensuring children under 13 and their parent(s)/carer engage with services. One

Young Person's worker said "Community paediatricians do not follow up children or take a lead in coordinating the community response – so who is??" The Havens has developed a new child advocate role to follow-up on the aftercare and support for children under 13 years, starting in January 2015.

The Young Person's workers noted that they do not currently have the capacity to provide an outreach service to the young people in local, non-stigmatised venues. The Young Person's workers also reported that sometimes they are unable to find a key worker to refer onto in the Borough. This review has found that there are a multitude of other support options available for children and young people, from school counsellor to youth worker, and early support worker to third sector charities. A key recommendation to come out of this review is to review current protocols and consider the capacity and skills needed in Havens Young Person's workers and new child advocate role to meet the needs of the ~400 children and young people seen each year on average at the Havens

### **Summary of issues raised with regard to the Havens by Haven staff, Commissioners, third sector parties:**

Issues with the current Haven service have been raised by both Haven team members and other stakeholders, with some suggestions for improvement including:

- Several stakeholders reported poor discharge information and handover to borough services from the Havens. They expressed concern that this could lead to delays and children and families not being offered appropriate services
- The lack of professionals in the community taking accountability for the child or young person at the point of discharge from the Havens
- Lack of capacity in the Havens to provide outreach support in the Borough for children and young people
- Limited access to paediatric forensic appointments in the daytime (dual forensic examiner role currently at Haven Paddington only)
- Havens team reported time wasting with double faxing of referrals from Havens to social care and paediatricians, but they could be emailed from nhs.net to gcsx.gov emails
- Small numbers of < 13 year olds seen each month raise competency issues for Haven paediatricians assisting with acute forensic examinations. Small numbers were also identified as a competency maintaining problem for designated doctors examining historic cases of CSA and providing follow up after an acute sexual assault (discussed below)
- Varied level of support for parents during the forensic examination
- A Young Person's worker reported a difficulty for boys in accessing the Haven services due to a perception that the Havens are for girls

- A high level of pre-existing self-harm in those young people attending the Havens

#### **Suggestions from Havens staff and stakeholders**

- Haven staff to become stronger advocates for the service, to increase visits to community services and third sector providers out in the boroughs to enhance their understanding of the services and to build relationships
- Create capacity for paediatricians and young person's/child advocate to follow up referrals with one-to-one clinical conversations with local services to ensure complete handover of physical, emotional and social needs
- Havens to keep a directory of services for use as a resource by the Young Person's workers, NEW child advocate and teams out in Boroughs
- Young People's workers to come out to run a session on the street with the MAC-UK worker (see section 13 Third Sector)
- Investment in emotional support services including a clinical psychologist and counselling, based in the Havens to assess and support the child/young person and their family in the months post assault
- Havens to improve onward referrals to a broader team of community colleagues such as : school nurses, school counsellors, specialist youth teams e.g. MAC-UK, Red Thread

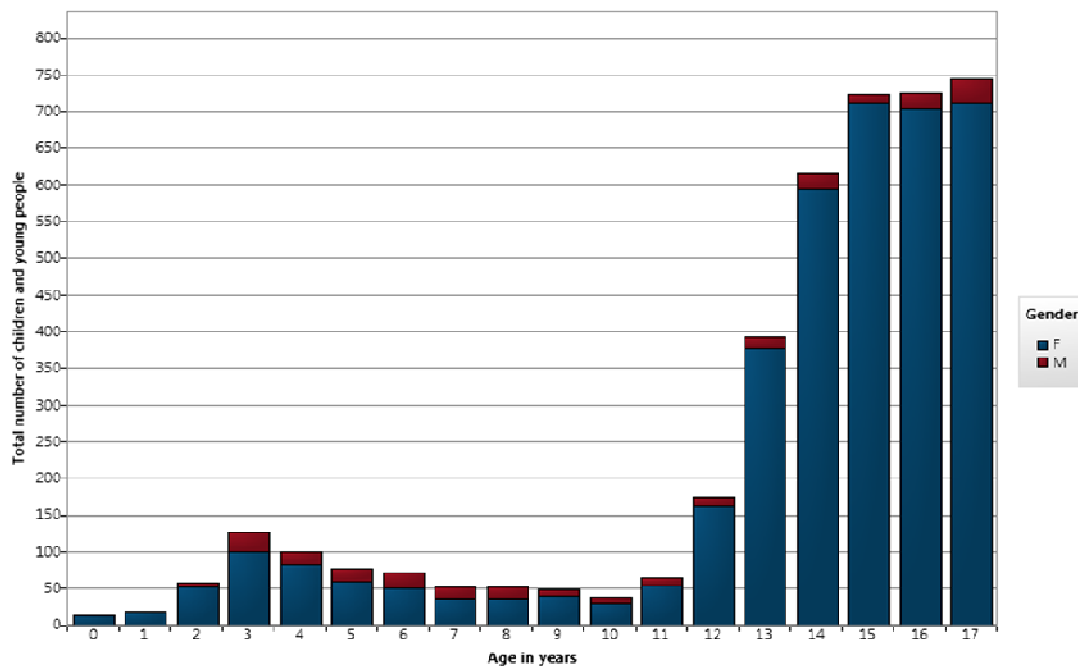
## **6.2 Review of the Havens caseload (2004/2013)**

The majority of children and young people attending the Havens for forensic medical examination are teenagers, with over 90% of Haven attendees being females. There is wide geographic variation across London in Haven attendances for forensic medical examination which cannot be explained by differences in population sizes alone.

Approximately one third of teenagers attending the Havens for forensic medical examination report a history of self-harm that pre-dates their Haven attendance. There appears to be wide geographic variations in self-harm among Haven attendees from across London with nearly half (49%) of teenagers from some areas reporting a history of self-harm.

Overall, there were 4126 children and young people under 18 years of age seen for a forensic medical examination at the Havens between 2004 and March 2014. The vast majority (93.4%) were female, 6.6% were male. The distribution of children and young people varied substantially by age with a peak during adolescence and a smaller peak around age 3 years (Figure 1).

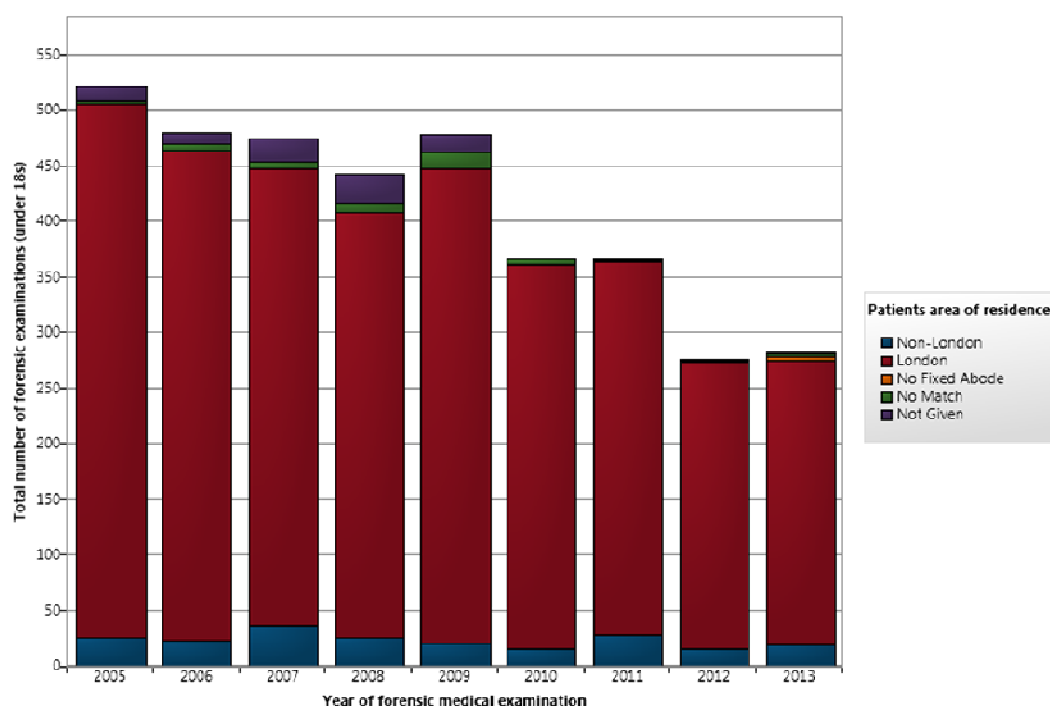
Distribution of <18s attending the Haven for forensic examination by age and gender (2004 - March 2014)



**Figure 1: The distribution of children and young people who attended the Havens for forensic medical examination by age and gender (2004 – March 2014).**

The number of children and young people attending the Haven for forensic medical examination reduced between 2005 and 2013 (see Figure 2). Consistently about 90% of the children and young people who came to the Haven for forensic medical examination lived in London.

Total number < 18s seen for forensic medical examination at the Havens by year and area residence

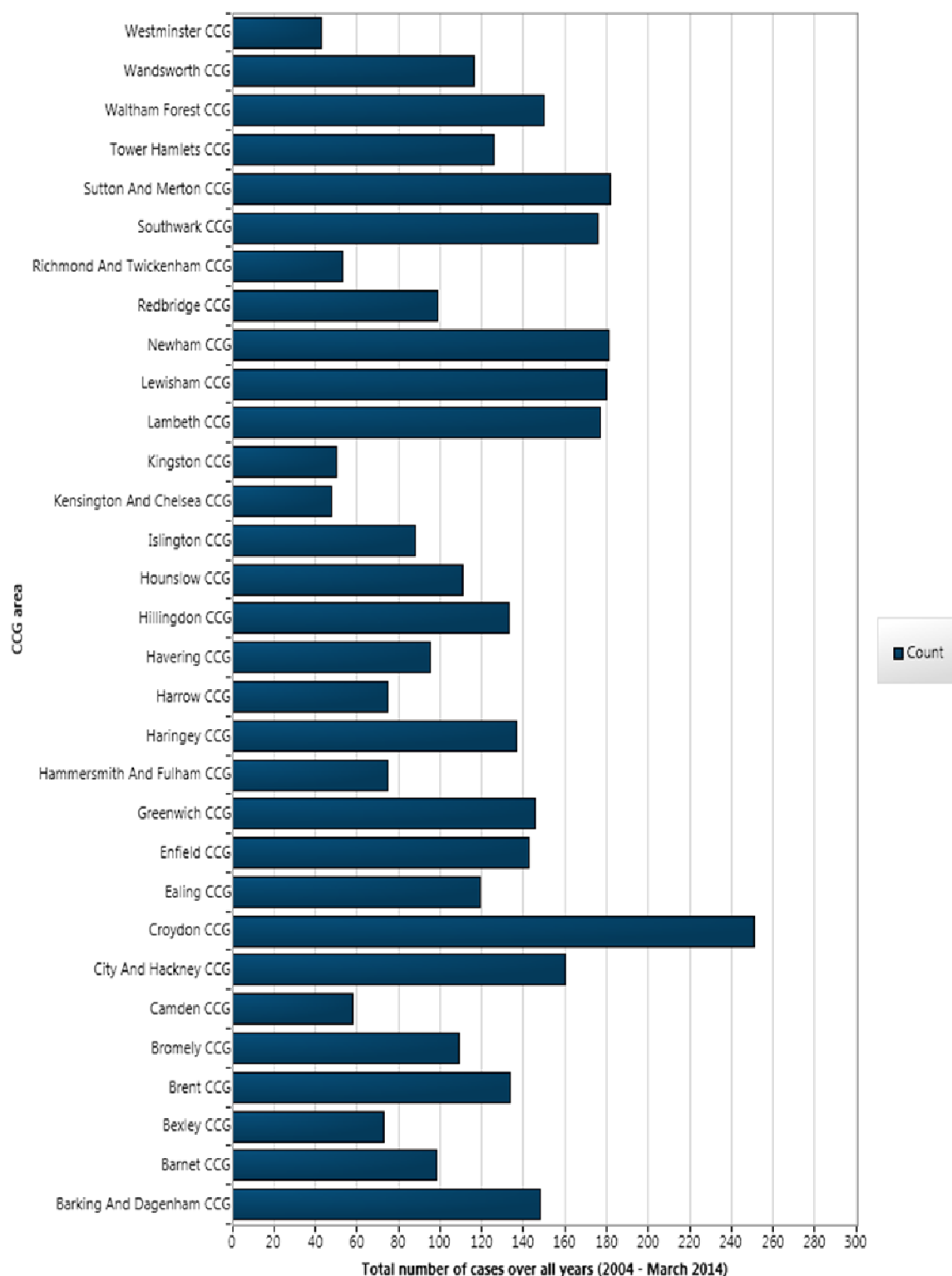


**Figure 2: Total number of children and young people (under 18 years of age) who presented for a forensic medical examination at the Havens by year and general area of residence**

Overall 3734 children and young people (<18 year olds) who attended the Havens for forensic medical examination between 2004 and March 2014 reported living in London. Their distribution by area of residence varied widely across London (Figure 3). The highest total number of children and young people (251) came from Croydon and the lowest number (43) came from Westminster.

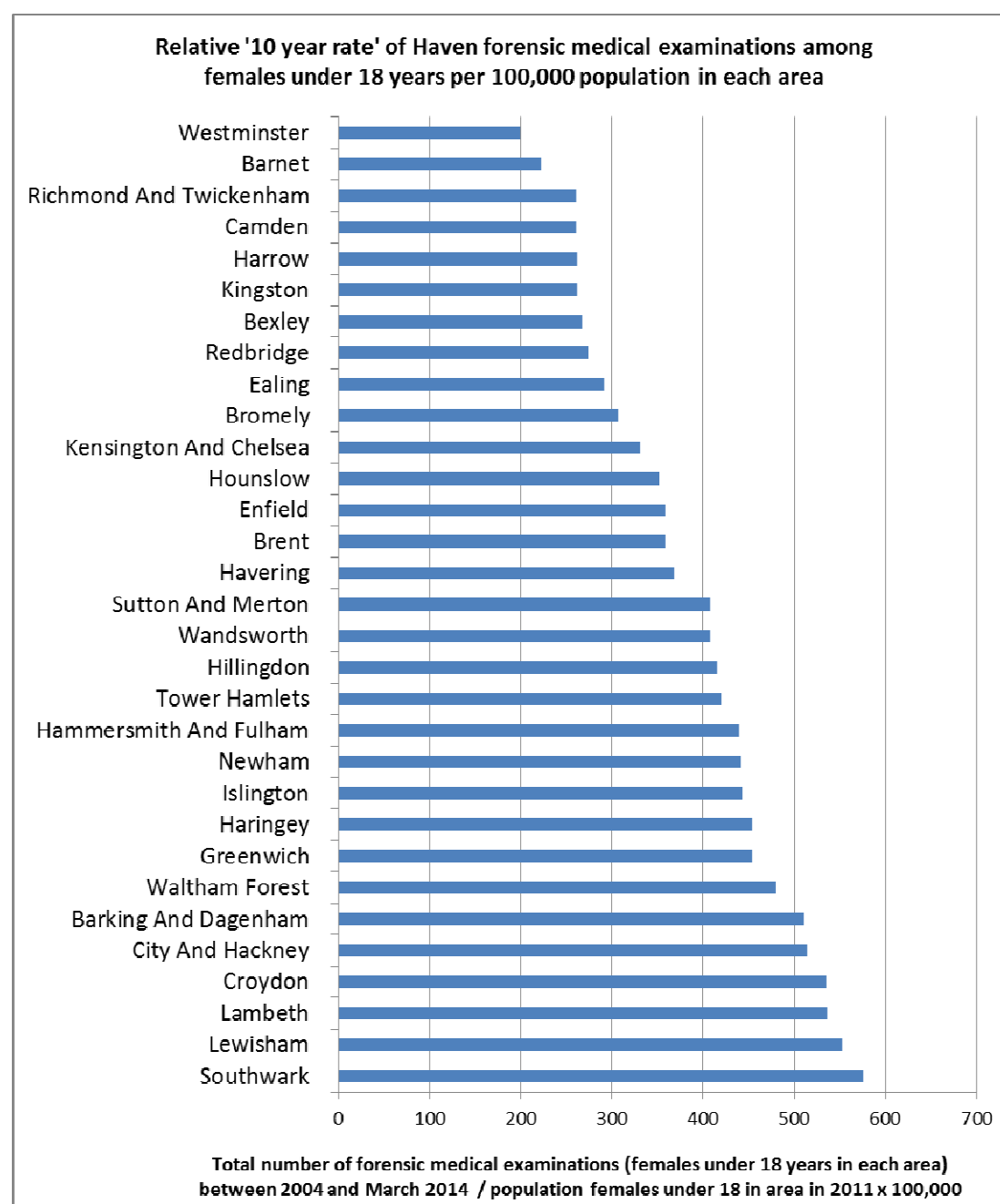
While there is a clear geographic variation in forensic attendances among < 18 year olds across London, their population distribution also varies widely. Again, as females represent over 90% of Haven attendances only their Haven attendances and population size data were used to create a rate comparison by geographic area (below).

Total number of <18s attending the Haven for forensic medical examination by London area



**Figure 3: Total number of children and young people (<18 years) who attended the Havens for forensic medical examination by London CCG area between 2004 – March 2014. Note the Haven database does not match current CCG areas exactly.**

To account for the difference in population sizes across London a rate / 100,000 population of < 18 year olds was calculated as described in the methods section.



**Figure 4: The relative “ten year forensic rates” / 100,000 females under 18 for each area of London**  
The population data from the Office of National Statistics, based on 2011 census data as reference year.

There were 3480 females under 18 years of age living in London who attended the Havens for forensic medical examination between 2004 and March 2014. The London average “ten year rate” was 392.08 / 100,000 females <18 years of age. Thus for every 100,000 females under age 18 years of age living in London between 2004 and March 2014, approximately 392 attended the Havens for a forensic medical examination. The “ten year rate” of Haven forensic examinations varied

substantially by area with the highest rate being over 2.8 times the lowest (574.54/ 100,000 in Southwark compared to 199.34 / 100,000 in Westminster).

Compared to the prevalence of sexual assaults estimated by previous studies, including the 2011 NSPCC study *Child abuse and neglect in the UK today*, the Havens are seeing only a fraction of those sexually assaulted for forensic medical examination. This is not particularly surprising as we also know from previous studies including the one above that the majority of children and young people do not tell anyone about the sexual abuse.

There are many factors that would influence the above “ten year rates”, thus they should only be viewed as a relative comparison of the females under 18 who attended the Haven for forensic examination by London area. It is not possible to extrapolate anything further than that. These rates may or may not reflect a true picture of the *actual rates* of acute CSA across London. Similarly they may or may not represent the *rates of reporting* CSA to social services, police or others. Likewise they may or may not represent the *actions* of social services, police or others in *referring* children and young people for forensic medical examinations or the *actions* of the Havens in *accepting referrals*. They do not tell us anything about historic CSA rates. None the less, there appears to be a clear variation across London which is worth further exploration. If this does provide a reasonable representation of the prevalence of CSA then it may also be useful in guiding preventive programmes, acute services and longer term support.

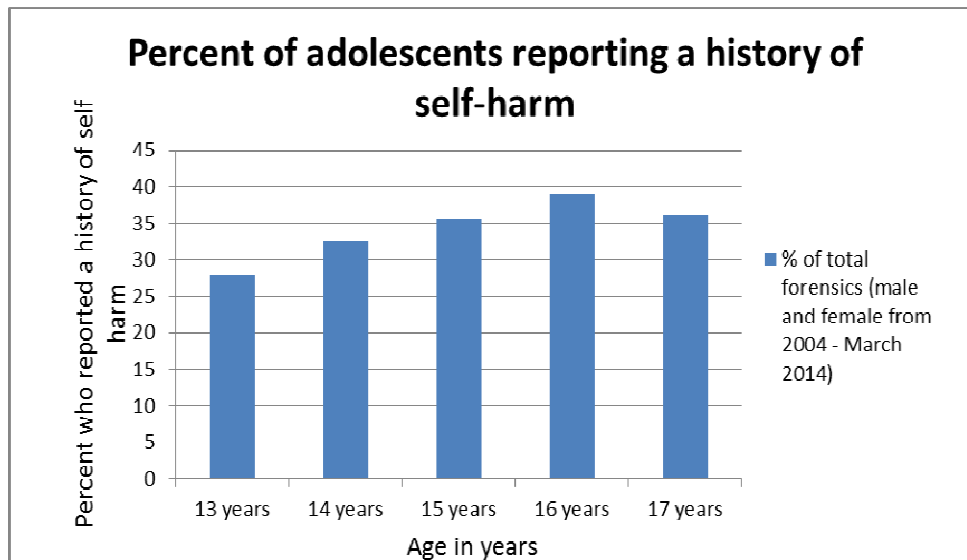
The distribution of cases by wider London area (northwest, north, northeast, southeast and southwest) may also be useful for future planning. The total numbers (percent of total) of Haven forensic examinations, between 2004 and March 2014 for all <18 year olds, by larger geographic area are listed below;

- 738 (19.8%) from **Northwest London** (Hillingdon, Hounslow, Ealing, Harrow, Brent, Hammersmith and Fulham and Kensington & Chelsea, Westminster)
- 524 (14%) from **North London** (Barnet, Enfield, Haringey, Camden, and Islington)
- 959 (25.7%) from **Northeast London** (Tower Hamlets, Hackney, Newham, Waltham Forest, Redbridge, Barking and Havering)
- 935 (25.0%) from **Southeast London** (Southwark, Lewisham, Greenwich, Bexley, Bromley and Croydon)
- 578 (15.5%) from **Southwest London** (Richmond, Kingston, Sutton, Merton, Wandsworth and Lambeth)

## Self-harm

The review also looked at data on pre-existing, self-reported histories of self-harm among children and young people attending the Havens for forensic medical examination. Overall, 28% children and young people reported a history of self-harm when asked during their forensic examination. The vast majority (96%) of these were teenagers, among whom the percentage reporting a history of self-harm ranged from 28% of the 13 year olds to 36% of the 16 year olds (Figure 5).





**Figure 5: Self-reported history of self-harm among adolescents who underwent a forensic medical examination at the Havens between 2004 and March 2014, percent of total males and females aged 13 to 17 years.**

There were wide variations in the percentages of teenagers (13 to 17 years old) reporting a history of self-harm by London CCG area, from a high of 49% of those attending from Tower Hamlets to a low of 21% of those attending from Brent (London average 35%), data not shown and available on request. Several international surveys report the prevalence of self-harm among children and young people at 12 – 20%<sup>31, 32</sup>.

It is not possible to interpret this data in isolation, and it must be noted that this is a self-reported history of self-harm which may or may not have been active at the time of forensic examination. It is not possible to determine if the teenagers who attend the Havens for forensic medical examination are representative of all the teenagers living in the same areas or if they represent a generally more vulnerable group of children and young people. Regardless, the prevalence of self-harm among the Haven attendees is concerning and demonstrates a clear need for mental health support for these children and young people.

This review has identified significant issues regarding the availability and accessibility of psychological support for children and young people following sexual assault. This gap is underscored by the findings of the recent House of Commons Health Committee report on Children's and adolescents' mental health and CAMHS from November 2014 which highlighted the substantial gap between need and availability of CAMHS support for children and young people<sup>33</sup>.

The need for services to provide mental health support to children and young people following sexual assault has also been highlighted in the NHS England document '*Securing excellence in commissioning sexual assault services for people who experience sexual violence*', the report on Child Protection Clinical Networks commissioned by the Department of Health and the Royal College of Paediatrics and Child Health (RCPCH) as well as in the 2009 publication by the RCPCH on Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused<sup>34, 35</sup>.

## Key points from Haven database review

- Majority of children and young people attending the Havens for forensic medical examination are teenagers
- Over 90% of Haven attendees under 18 are female
- There is wide geographic variation across London in Haven attendances for forensic medical examination which cannot be explained by differences in population size alone
- Over 1/3 of teenagers attending the Havens report a history of self-harm that predates their Haven attendance
- There appears to be wide geographic variation in self-harm among Haven attendees from London, with nearly half teenagers from some areas reporting a history of self-harm

## 7. Paediatric services

In England and Wales, the Designated Doctors for Safeguarding Children and Young People<sup>36</sup> are the doctors based either in the acute or community and are responsible for ensuring services are commissioned for the examination, care and safeguarding of children and young people who report child sexual abuse (CSA). This review identified that in each CCG, the doctor(s) examining children for CSA may be the Designated Doctor, the Named doctor or another paediatrician. These doctors usually physically examine cases of historic CSA, document findings, screen for sexually transmitted infections (STIs), provide or arrange for vaccinations, treatment or other medical care as needed, liaise with other agencies and contribute to safeguarding processes and procedures.

If a child or young person reports recent / acute CSA he or she may be brought to the Havens for a forensic medical examination. Following this examination children under 16 years of age are typically referred to the Designated Doctor for Safeguarding in their area of residence. For children under 13 years of age the Designated Doctor provides or arranges all necessary medical follow up and support. For young people 13-17 years of age they can return to the Havens for follow up or be referred to local GUM clinics. For these patients referrals to the Designated Doctor may primarily be for information for strategy meetings, local sexual exploitation intelligence gathering and possibly for arranging support. Local paediatricians may also have further information about the child or young person with regard to future risks.

To date, 25 full surveys have been completed covering 27 (84%) of London's Boroughs (City of London excluded). Almost all respondents were either the Named or Designated Doctors for the area or a Consultant Paediatrician who regularly saw CSA cases. In addition to the 27 CCG areas for which full surveys were completed, brief preliminary survey information was also available for two additional areas, thus there was at least some information on CSA services in 91% of London Boroughs.

## 7.1 Paediatric Survey findings – historic CSA cases:

### Clinical services for children after CSA

- 20% see CSA cases in a CSA clinic and 24% see them in general clinic for vulnerable children, where they see a mixture of CSA, child protection medicals and other concerns.
- 40% do not have a specific clinic, they see patients on an ad hoc basis when they are referred
- 16% do not see patients for CSA; they refer them elsewhere (though they may see patients for safeguarding in their clinics)

The clinic frequency varies from to  $\geq 1$ x per week to  $< 1$  per month with many patients seen on an ad hoc basis. The length of time it takes for a new patient to be seen for CSA varies from  $< 1$  week to 1 month, but most are able to see new patients within a week or two. Approximately two thirds of the doctors (64%) are able to see patients on an urgent basis if needed regardless of whether they have a clinic space available. Of note, in these clinics not all of the children and young people are physically examined for CSA or screened for STIs; some clinics are primarily concerned with safeguarding and other care. Overall 80% of doctors that were surveyed as part of this review currently physically examine for CSA.

Most of the doctors who do not currently examine for CSA reported that their clinic numbers were too small for them to maintain competence in this specialised area. They did not feel their caseload justified investment in appropriate equipment and continuing education to maintain sufficient knowledge to provide this service. They had therefore made arrangements with local commissioners for their CSA cases to be referred to colleagues in other boroughs who were more familiar with CSA.

The average number of new CSA cases seen in each borough per year varies widely from 2 to 80, with a median of 8.5 new cases per year. In the majority of boroughs the paediatricians see  $\leq 20$  new CSA cases per year, with 54% seeing  $\leq 10$  and 29% seeing  $\leq 5$  new cases per year. In general, there are only a couple of doctors able to examine patients for CSA in each of these clinics. In some clinics there are no doctors who can physically examine for CSA while in others there are up to nine. Most clinics (65%) have some plan or protocol in place for when their examining doctor(s) is away or on leave, but 30% did not and 4% did not know if a plan existed. While a few doctors reported having good support from the top down and noted this was very helpful for them in providing a good service, others stated that they feel isolated in seeing CSA cases and would like better support structures to be established. Many would like to continue caring for these children and young people, but only if they see enough patients to maintain their skills and are supported by a larger or more central network of doctors.

Most of the doctors are sometimes asked to examine / assess patients for CSA following an acute assault where the child / young person had not been referred to the Havens. Generally this occurs when the referrer (typically social services or the police) is not familiar with which cases should be seen at the Havens. When these situations arise, the doctor advises the referrer to call the Havens and this is not a problem in most areas. One area felt police sometimes tried to pressure them to see cases and thought this occurred because they did not want to drive to the Havens.

Currently only a few clinics accept referrals from outside their borough; two clinics do so on a formal basis with agreed pathways and four other boroughs do so informally, ad hoc, if needed. Of the clinics that do not routinely accept referrals from outside areas, half would be willing to do so if their clinic was appropriately resourced, funded and staffed.

### **Clinic supports, services and facilities**

The supports available to clinics where children and young people are being seen for CSA vary widely. While only 52% have nursing support, 72% have some support from other medical staff (including GUM doctors, training doctors or others). In a minority, other supports are also available (play specialists to three clinics, clinical psychologists in one clinic).

As children and young people may be exposed to infection via sexual contact there is a need for their aftercare to include STI screening, prophylaxis (for example against Hepatitis B and HIV) and treatment of any infections. Screening is typically recommended at baseline, two weeks after the last exposure (swabs and urines) and additionally several months later (blood tests).

Less than half of doctors surveyed (48%) can provide phlebotomy in their clinics, the rest have it available locally. Over half of the doctors (56%) can screen for sexually transmitted infections (STIs) in their clinics and another 32% have STI screening available locally. However, the completeness of STI screening varies widely and the provision of Chain of Evidence (see below) is also limited and variable. Prophylaxis is also variable with 32% reporting that they can provide Hepatitis B vaccinations in their clinic while 64% can arrange for it to be provided locally, though with varying ease / completion.

### **Chain of Evidence**

Among sexually abused / assaulted patients, particularly children, the presence of a sexually transmitted infection may be of evidential value in court, particularly if it can be linked to the alleged assault. In these cases it is necessary to obtain and send any samples for STI screening with the same rigor and integrity as used when obtaining other forensic specimens. The whole process should form an unbroken Chain of Evidence (COE) with samples handed directly from person to person (e.g. examining doctor to lab technician) with all parties clearly documenting same. All clinics seeing CSA cases should be able to either provide COE or arrange for it to be provided locally.

By their own report, 48% of doctors surveyed said they have a good working system for COE and either do it regularly or occasionally, 4% do it rarely and struggle; 44% cannot provide COE in their clinics and state that they have a place to refer patients for this, 4% cannot offer / arrange it at all.

However, when those who knew their (or their referring location) COE protocols were further questioned (n=20), only 30% have what appears to be a clear, robust COE procedure. Another 30% have a COE procedure which may be Trust policy, but which may require review as it might not hold up in court if challenged. Another 5% have a COE procedure that definitely needs reviewing and 35% do not have a clear or robust COE procedure at present.

## STI screening

Details of screening were further explored in the 14 clinics that provided STI screening. These clinics generally see more new CSA patients per year (median 17 compared to the overall median of 8.5) as well as most having support from nursing or other medical staff. A third of doctors have support from local GUM colleagues in their clinics when screening for STIs. The vast majority of these clinics (86%) either had a clear robust chain of evidence (COE) protocol or a COE protocol in place that might benefit from review. Of these 14 clinics, details of STI screening were sought and are summarised below.

- Only one clinic routinely screens all three sites (mouth, genital area and anus) unless history indicates otherwise. This clinic has the largest patient volume and a relatively large pool of examining doctors
- Two thirds of clinics can theoretically screen all three sites but do not do so routinely. They are guided by the history of alleged assault and / or symptoms
- One fifth of clinics typically swab one site only
- One clinic was not sure what STI screening they do
- All 14 had some rapid transport to a lab available and access to advice or help from microbiology or GUM colleagues
- One clinician commented that they lacked a chaperone for examinations

Among the clinics that refer out for STI screening, most of the doctors leave the decision of what to screen up to the other clinic. Many were not familiar with the COE protocol at the referring location; some simply assume the GUM or other clinic can (and does) provide COE. Several of the doctors noted difficulty in arranging STI screening, particularly for younger children. Others can refer teenagers for STI screening but not younger children as their local GUM clinics do not accept either < 13s or < 11s (depending on the clinic). For these patients it is very difficult or impossible for the doctors to arrange STI screening at present. Based on survey response it appears that STI screening is not being completed routinely for children and young people seen for CSA.

## Misconceptions about STI screening

While there is not a great deal of data on the epidemiology of STIs following CSA, what information does exist indicates that there is at least some risk from the sexual exposure. There were several misconceptions about STI epidemiology and screening in children and young people following CSA with several doctors stating that they had not had any need to refer any of their patients for STI screening in many years<sup>37, 38</sup>. They were unsure if their local GUM clinics would accommodate younger patients and did not think STI screening was necessary. At least one was under the misconception that the Havens screened for STIs at the forensic examination and therefore no further screening was needed. **Hepatitis B vaccination**

Many of the doctors surveyed referred (or theoretically could refer) patients to their GPs for vaccination against Hepatitis B. The ease of access varied and actual service provision is unknown;

some commented that it was a struggle to arrange. It is not clear if hepatitis B vaccination is being provided according to current recommendations from BASSH / CHIVA<sup>39</sup> and this should be further reviewed.

#### **Key issues identified regarding STI screening & prophylaxis against Hepatitis B**

- There is wide variation in the STI screening and COE procedures in use in London. Knowledge of STI epidemiology following CSA appears to be variable. It can be very difficult for clinicians to arrange for STI screening in younger children. The protocols for Chain of Evidence STI screening (where available) vary; while some may be robust others might not stand up if challenged in court.
- Provision of prophylaxis against hepatitis B appears to be highly variable and should be further reviewed. Prophylaxis against HIV and syphilis were not explored in this review.
- While we have limited information on the prevalence of STIs among children who were sexually assaulted, there is definitely some risk (probably less than 5% based on available evidence). A lack of knowledge / good practice in this area may be leaving children with undiagnosed and untreated infections.
- All patients must have access to prophylaxis, screening and treatment as indicated. Overall there is a need for clear, consistent, evidence based guidance on STI screening and provision of prophylaxis following CSA - that is accurately followed by those seeing the patients.
- Consideration should also be given to the development of a user-friendly London-wide Chain of Evidence protocol.
- Redundancy must be built into the system to ensure care is available and provided to all children and young people.

## **Colposcope**

Children who are examined for CSA often require anogenital examination. This examination is often documented using a colposcope which is essentially a magnifying video camera. Typically a video recording is made of the anogenital examination to document findings (be they normal or otherwise). There is guidance from the Faculty of Forensic and Legal Medicine (FFLM) and Royal College of Paediatrics and Child Health (RCPCH)<sup>40, 41, 42</sup> on how these intimate images should be consented for, obtained, stored, peer reviewed, used in court and otherwise used for teaching / training. All doctors who examine children for CSA should have access to a colposcope to document the anogenital examination.

Currently 8 of the clinics do not have access to a colposcope, and 7 out of 8 of have made arrangements to refer these patients to other doctors if a colposcope examination is needed.

Of the 17 doctors who have access to a colposcope, half report using it frequently and being comfortable / confident users and a further third may not use it frequently but have a good aide memoire to prompt them in its use. However, three doctors report that they do not use their colposcope often and struggle when they need to do so.

Of those with a colposcope, 76% report having a consent form that specifies how the images will be stored and used, 59 % have regular peer review of their images and 94% report having adequate secure storage of their images. However when storage details were discussed it appears that there may be some storage issues worth further exploration.

Five of the colposcopes are only able to capture still images rather than video record the examinations. Of these, the images are all printed on paper and most are kept with the patients notes. While some of the notes were reportedly stored securely and / or with very limited access, the fact that the images are kept with the patient's notes is potentially of concern as this could allow patient identification.

Of the 12 doctors whose colposcopes are able to video record their examinations, one has the capacity to make video recordings but does not do so. This team typically do not record or store their images and there is thus no peer review of the images. One clinic stores their images on an encrypted flash drive, another on a "secure electronic folder" and another one records the images on a memory stick which is then brought to medical records. One clinic has a machine whose software is apparently so old the images can only be played on that machine but regardless, these recordings are also not patient identifiable. The remaining seven clinics all store their colposcope images on encrypted DVDs.

#### **Issues with colposcopes**

- Access to colposcope examination varies by area but most areas are able to arrange for a colposcope examination elsewhere if it cannot be provided locally
- Consent and storage for intimate images varies and should be reviewed, expert views may need to be sought on 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 should be improved (in line with recommendations from the FFLM and RCPCH)
- It might be worth exploring how consistently colposcopes are used to document anogenital examinations (normal or otherwise)

#### **Documentation of findings**

Previous studies have shown that doctors, including paediatricians, lack knowledge of the anogenital area. Some studies have demonstrated that doctors have difficulty correctly identifying aspects of normal anogenital anatomy and it is known that terminology varies<sup>43, 44, 45</sup>. While knowledge was not assessed in this study, the doctors own opinions were sought regarding their own comfort / confidence in anogenital examination for CSA and in writing up their findings for reports / court.

The 25 doctors surveyed were asked about examinations:

- 28% said they are generally very comfortable with CSA examinations and rarely feel out of their depth or in need of a second opinion

- 36% feel mostly comfortable but sometimes out of their depth or they would like a second opinion
- 24% feel somewhat comfortable and are or would be happier co-examining with a colleague
- 12% are not particularly comfortable or confident with CSA examinations

With regard to documentation of findings:

- 46% feel very comfortable documenting their findings and are sure of their terminology
- 42% feel fairly comfortable but occasionally seek advice or look things up
- 13% do not feel comfortable

In female anogenital examinations it is sometimes necessary / helpful to assess the hymen (a part of female genital area) for injuries by using a cotton swab or Foley catheter, or by flooding the area with water. When further questions were asked regarding the use of these examination techniques only 60% of doctors reported using one or more of these techniques (see Appendix for full responses).

### **Knowledge of acute (forensic) timeframes**

Almost all of the doctors surveyed said they knew which cases should be referred to the Havens for forensic examination. On further questioning the accuracy of this knowledge was quite varied and there were several misconceptions.

At least 6 doctors were under the misconception that the Havens see < 13 year olds up to 72 hours after an alleged assault and > 13 year olds up to 7 days. However the forensic window is not age dependent; it depends on pubertal status of the child / young person and the type of alleged assault. Forensic examinations are guided by the FFLM recommendations which are updated every 6 months. Many doctors understandably weren't sure of the time windows and routinely phoned the Havens for guidance.

### **Training and support for CSA examinations outside of the Havens**

When asked, nearly half of doctors said they are happy to see CSA cases and would like to continue with all aspects of their care. Additionally 40% would like to continue seeing the cases but would prefer to hand over some of the acute care, such as STI screening and/or examinations requiring colposcopes, 4% said more support was needed for them to see CSA cases and 8% would prefer not to see CSA cases.

Doctors were asked details of what support needs and training they thought should be provided for those seeing CSA cases in London.

- 64% would like a 24 hour helpline staffed by experts in CSA or a 9-5pm helpline in line with paediatricians working hours. Some noted that the Havens are available for questions already 24/7 or feel that have a good local support in place



- 88% would like access to a second opinion or rapid patient review by an expert in CSA within a few days (in person or over the phone)
- 80% would like regular pan-London peer review sessions organised on a quarterly basis

## 7.2 Paediatric survey findings - the Havens

The doctors were also asked for their views on the Haven services – current and future.

### Referrals to and from the Havens

The majority of doctors who had referred patients to the Havens had no difficulty making the referral, with just four stating they or a colleague had had difficulty.

Those that had identified difficulties mentioned that sometimes it is difficult to get through to a doctor at the Havens and several noted that advice varied depending on who took the call. One had difficulty getting the Havens to see cases in a ‘grey area’ in terms of the forensic window, whilst conversely another said the Havens had very willingly seen a patient beyond the forensic window to document an acute injury. For those who had phoned the Havens for advice, 75% said the advice/assistance given was excellent or good and 25% found the advice mixed or did not know.

All of the doctors had received referrals from the Havens and the vast majority think the referral paperwork needed improving. The main issues identified were:

- Illegible handwriting
- Not enough information included in referral
- Unclear what was expected of them

They generally suggested or would prefer a typed report with a cover letter, including full details of alleged assault, findings on examination, treatment provided and stating very clearly what needed to be done by them (cc’ed to GP with consent). Some expressed concern that a typed summary might delay information being provided to the paediatricians and while they would like this, they also need something quick to allow them to participate effectively in strategy meetings.

A few wanted verbal handovers (paediatrician to paediatrician the next day), whilst others did not want this as they lacked time to take these handovers themselves. A few would like a full copy of the forensic notes

### Forensic examinations and Havens services

The time window for obtaining forensic specimens (swabs, urine, blood, or other) is based on the time since the alleged assault as well as the nature of the alleged assault and the patient’s pubertal status. The window varies from up to 2 to up to 7 days generally speaking. Of note, sometimes the length of time since the alleged assault and the details of the alleged assault are not clearly known (initially or ever). These ‘grey area’ cases are generally discussed and the decision to provide a

forensic medical examination is made on a case by case basis; decisions vary somewhat by Haven and by forensic team.

While it is more common than not for children, young people and adults NOT to have any anogenital injuries following sexual assault, where injuries do occur, many heal very quickly and may or may not leave a trace. Some injuries on the other hand take several weeks to heal<sup>46, 47</sup>. There is some evidence and guidance to suggest that an 'acute' sexual assault should be defined as any that occurred in the past three to four weeks<sup>48</sup>.

Currently the Havens do not routinely accept patients for documentation of injuries beyond the window for swabs and these cases are typically referred to the Designated Paediatricians in the borough of residence. If however it is not be possible for the child or young person to be examined in their local area quickly then an exception might be made on a case by case basis to document any possible acute injuries. The Havens do not examine historic cases of CSA or provide medical aftercare for <13 year olds. The Havens do not provide any psychosocial support or counselling for < 18s.

The doctors were asked which patients they thought the Havens should see and what services the Havens should provide. Nearly all doctors said the Havens should be more flexible and see children and young people beyond the forensic window for swabs in order to document potential injuries.

- 88%, said the Havens should be able to provide semi-acute medical aftercare to all ages
- 88% also said the Havens should provide bridging counselling / psychosocial support for children and young people until local services are available (several said this was vital)
- 52% said the Havens should at least *be able to* provide all medical care and necessary follow up for < 13s
- 40% said the Havens should *be able to* examine historic cases of CSA
- Several noted that care should be provided locally if possible, but if not or if patient prefers, the Havens should be able to provide full comprehensive care for all ages

## 7.3 Paediatrician feedback on other services in the CSA pathway

### Social services

Doctors were asked to rate social services response to CSA cases in their area. Overall results reported were 4% excellent, 24% good, 16% fair and 8% poor, with the most common response being 48% mixed.

There were a variety of comments. Several doctors thought social services lacked resources to handle these cases and lacked experienced /skilled staff or had high staff turnovers. Several expressed frustration that they were not being asked to attend strategy meetings and their input was not being sought early enough in case discussions. There was concern both for cases that were referred to them inappropriately for medical review and for the ones that were not referred to them, again inappropriately; where social services and / or the police independently decided no medical review was needed. Several thought social services did not appreciate the medical needs of children and young people in CSA or suspected CSA cases.

## Police

Doctors were asked to rate how police respond to CSA in their area. Overall results reported were 12% excellent, 24% good and 8% fair, with 36% mixed and 29% who did not know. Many doctors did not have a lot of contact with the police in relation to CSA.

## CAMHS

Doctors were asked to rate how CAMHS responds to cases of CSA in their area. Overall results reported were 4% excellent, 8% good, 8% fair, 44% poor, 32% had mixed experiences and 4% did not know.

There were many comments about CAMHS. A few reported that they had excellent or very good CAMHS support but many felt that CAMHS criteria were too strict and that they did not accept referrals unless a child was actually or nearly suicidal. A few said CAMHS did not know if they were commissioned to see children for CSA. For some, in the rare cases when CAMHS accepted a referral, the wait was too long. Several commented on a lack of funding and resources for CAMHS. In general, many found CAMHS largely inaccessible and several doctors no longer even bother to refer most patients to them.

Several doctors refer patients to local charities for support (NSPCC funded, Barnados or others) where that is available. About 60% thought they had some access to counselling or support for families, most thought this could be provided via social services.

When asked specifically if there was a long wait list for CAMHS or if patients were seen quickly, 32% said there was usually a long delay but in 20% of cases they could get a patient seen urgently if needed and 12% felt that children that met the criteria were seen fairly quickly. Many commented that it wasn't so much an issue of delay – rather that CAMHS simply did not accept their CSA referrals. In some areas doctors thought CAMHS avoided starting therapy/support if a case was going to court (until court was completed), contrary to CPS guidance<sup>49</sup>.

## 7.4 Paediatricians opinions on ideal model for London

Opinions on the ideal model of care for CSA in London were sought from the paediatricians. The options discussed were;

1. **Current model** – Havens provide forensic medical examinations for all ages, medical aftercare for ≥13 year olds only (no counselling for < 18s, no historic CSA)
2. **Haven plus model** – as above but to also include 2 week and other related medical follow up for all ages
3. **Hub and spoke** – development of several hubs where children and young people can be medically examined for historic CSA (STI screening, colposcope examinations) but with the safeguarding kept with local paediatric teams. This idea is largely similar to the Child Protection Clinical Networks advocated Department of Health and RCPCH
4. **Hub and spoke** – as above but safeguarding also handled by the hub

5. **Child and adolescent SARC** – development of a single centre like St Mary’s in Manchester (or possibly more than one) where all cases of CSA in London are seen (acute and historic) and where all follow up is provided. This centre would be developed as a centre of excellence for teaching / academia / outreach. Same court structure as present.
6. **Child House / Child Advocacy Centre model** – similar to SARC model but developed in line with child-friendly justice where all services (court related testimony / interviews, medical examinations / aftercare, psychosocial support and safeguarding) are provided in one place and the child / young person generally completes their part in any court process within a few weeks of the allegation. This model is also consistent with the recommendations set out in the Service Specifications for the Clinical Evaluation of Children and Young People who may have been sexually abused (RCPCH 2009) in its provision of continuity of care and psychosocial support.

None of the 25 doctors surveyed think the current system is the best choice. Three quarters (19/25) think the Child House or Child Advocacy Centre Model would be their first choice for children.

If a Child House model could not be developed these doctors generally favoured a hub and spoke model as their second choice (with opinions varying on the best location for the safeguarding). Many thought the safeguarding should be by whichever team either knew the child or was more experienced in CSA. Some of these doctors chose the paediatric SARC model as their second choice, others the Havens-plus model. Several commented that the Child House model in several local hubs would be the best choice given the population size of London.

Of the six doctors who did not think a Child House Model was the best choice, a hub and spoke model was generally favoured with similar mix of opinion regarding the location of safeguarding provision. A few preferred the Haven-plus model, but of these six, none favoured the Paediatric SARC model.

### **Suggestions from paediatricians**

- Most thought there needed to be flexibility with whatever system/model was developed and that the child should be the focus in any decision making. They generally felt that the child should be examined and cared for by those with the most experience and in line with the child and families choice. This would require additional capacity built into the system not only to provide adequate back up coverage but also to ensure choice could be offered
- Most favoured the Child House model as it seemed the most child-focused; most were also not aware of this model prior to the discussion (one was aware of CAC in USA)
- Many expressed concerns, both here and throughout the survey, that paediatricians are becoming deskilled in CSA as they are not seeing sufficient numbers. They are concerned this will worsen if specialist centres / hubs / SARCs are developed
- Conversely some felt paediatricians turned away from community paediatrics because they did not want to handle CSA cases and removing these cases would encourage others into this field

- Several suggested the model should allow for paediatricians to work sessions in whatever model (centre or hub) is chosen to keep up their skills, build networks, participate in peer review and have more support in general
- Almost all thought the Havens should offer some bridging counselling or psychosocial support
- Almost all thought the Havens should be able to provide short-term medical follow up in all acute cases e.g. 2 week STI screen
- Half thought the Haven should also be able to offer ALL medical follow up for under 13 year olds
- Most doctors would like more support including helpline, access to an expert second opinion and pan-London peer review of cases
- Several doctors noted specific examples of unique services that worked well in their clinics which may be worth further exploration (including access to play specialists, CAMHS / counselling and things like music therapy)

## 8. Metropolitan Police Services – CAIT and Sapphire teams

The Child Abuse Investigation Teams (CAIT) teams investigate allegations of abuse against children under 18 years of age, involving family members, carers or people in a position of trust. Generally they work with children and young people, but the recent high profile cases of child sex abuse are causing a growing number of adults to come forward with cases of child sex abuse to be investigated.

The Sapphire teams are units of specialist officers whose role is to investigate rapes and other serious sexual violence. This includes providing care and support to victims, as well as investigating the offence to the satisfaction of victim and bringing the offender to justice. These cases do not include those perpetrated by family, carers or people in a position of trust. They investigate a mixture of child and adult cases of serious sexual assault, which in the case of children and young people includes gang related assaults, sexual exploitation, strangers and internet/social media related assaults.

Additionally there is a pan-London sexual exploitation team, responsible for identifying and supporting children and young people at risk of sexual exploitation.

### CAIT and Sapphire Police Survey and ad hoc discussions:

Both teams employ Sexual Offence Investigation Trained (SOIT) officers who are specially trained to interview and support victims of sexual assault. A survey was sent out to all CAIT and Sapphire teams (18 and 19 teams respectively) in London to seek responses and feedback from the SOIT officers. The eight responses included six CAIT teams and two Sapphire teams.

When questioned about the **referral process**, several teams cited delays in the schools passing information onto social services, and then the social worker taking many hours to complete an often incomplete referral to the police.

If an allegation is made whilst the child is at school, police reported that the child is generally left in class to complete the day before being brought by social care to meet the police and attend the Havens if appropriate. Not only did they feel this delay is stressful for the child, but at the end of the school day the teachers that have been supporting the child all day may go home. Additionally police and social workers may end their shift, introducing another person to an already sensitive situation. Officers feel that the sooner they get the referral, the sooner they can assess the risk to the child and put provisions in place. This suggests better links are needed between police, social services and schools, with a review on the process and timeliness of reporting.

Not only do delays cause the problems outlined above, but officers feel that children can sometimes retract what they have said after speaking to siblings, family and friends.

Other officers felt the system worked well, but only if they are able to reach the designated social worker for an immediate discussion. Too frequently the social worker is out of reach and the discussion is delayed too long. Additionally it was noted that due to funding cuts social workers thresholds have been raised and in some cases of sexual assault/exploitation they do not take action.

All police officers that responded reported no issues with referrals to Havens. Their referrals are guided by the forensic window timings and discussion with Haven staff. All had phoned the Havens for advice and all had found them to be very helpful.

When questioned about who was present in the **ABE interviews** the most common answer was police officer, child and intermediary if necessary. The intermediary has role in assessing the child's understanding and can stop interviews for breaks. The intermediaries are used generally in cases for under five year olds and sometimes for under eight year olds. Among officers surveyed five out of eight described inviting an ABE trained Social worker to attend the interview but noted that they usually did not. Only one response mentioned the parent/carer. All officers surveyed were confident that they had access to an Independent Sexual Violence Advisor (ISVA) if needed but it was noted that these are not children specific ISVAs.

Interviewing officers in both CAIT and Sapphire teams are trained in interviewing techniques for children and are supposed to be provided with some feedback as part of their regular supervision with senior officers.

Further discussions with the sexual exploitation team identified that ABE interviews take place in 20 ABE suites across London identified for children. The one site visited was not child friendly at present, but this and other suites are planned to be refurbished by the end of March 2015. The suites are generally sited in police buildings (not police stations used by the general public) and include a standard interview room with facilities for video recording the interview, a control room (for a second officer) and a family room for any waiting family members. There is no provision for communication with the interviewing officer during the interview, but they often stop for a break and can speak to other officers involved.



**Police Interview Suite**



**ABE Interview room**

(N.B. photos of the Children's House interview rooms are included in Section 15)

After several months of investigation and results from forensics, all information regarding cases is provided to the Crown Prosecution Service (CPS) who decide whether or not the case will go to court. Currently the ABE does not suffice for court and the child still has to attend court to testify and be cross-examined. Younger children are usually interviewed via video link, whilst older are present in court. Some officers noted that older children prefer to be in the court room.

Two Met Police officers interviewed have reviewed the Child Advocacy Centre (CAC) model in the USA (See Section 15) and a recent model in Northern Ireland. Those officers supported considering this model for London.

### **Voice of the young person**

Currently 89 young people have been interviewed as part of an ongoing research project at the Havens. The views of these young people from their interviews as part of the research study were reviewed and some themes identified from their experiences of the police:

- One young person said *"It was not easy explaining the incident several times, especially when I was not able to see the same person"*

- Another that the “Police should get all their information as soon as possible as it is hard to remember a year later” Some young people were scared they would get in trouble with the police or be deported
- Five young people noted that communication was very poor with the police, requesting regular updates through the long court process

#### **Ideal model suggestions:**

CAIT or Sapphire teams responses were not specifically asked for suggestions for the ideal model. Sexual exploitation officers provided some recommendations:

- To ensure a standard response to families whether a child sexual assault is managed by CAIT or Sapphire teams
- To consider developing special centres for children and young people to attend to access police for interviews, medical examination and supportive follow up e.g. mental health services
- To maintain a similar number of special centres as there are currently children’s ABE interview suites (x20) – they noted that families do not like to travel outside of their borough and certainly not across the river
- To ensure access for forensic examinations available 24/7 for all ages

## **9. UK Criminal Justice system and response to child sexual assault**

In December 2014 a Joint Inspection Team for the Criminal Justice System published a report outlining the findings of their joint inspection of the handling of CSA cases<sup>50</sup>. Twenty years ago the UK developed a system where children were to be interviewed using a standardised format (Achieving Best Evidence or ABE). This interview is video recorded and can be presented as their ‘evidence-in-chief’ at trial. Children are still cross-examined at trial by the defence team, though special measures can be put in place to minimise the trauma this may cause a child.

The inspection sought to review this process and focused on the quality of the video recorded ABE interviews themselves as well as their use in the criminal justice process. They sought to explore the overall process and its success in achieving justice. They report:

*“In short, the inspection found that the Guidance is not achieving what it sets out to do, which is achieving the best evidence. This is due in part to poor compliance by interviewers and the failure to properly record decisions and actions, with the rational underpinning these. Immediate improvements could be achieved through better planning at the outset, supplemented by improved supervision of interviewers and better quality assurance of the recording. In turn, the CPS need to improve feedback to the police...”* Achieving Best Evidence in Child Sexual Abuse Cases – A Joint Inspection

#### **Key points from this inspection**

- Poor compliance with existing ABE interview guidance
- Need for improvement in interview suites, in particular need to make them more child-friendly



- Lack of use of intermediaries during the interview process, even for very young children
- Poor planning in preparation for the interview with numerous resultant consequences
- Little formal feedback or review on ABE interviews by police supervisors and a lack of training / capacity for supervisors to actually perform this function
- Lack of early investigative advice from the Crown Prosecution Service (CPS) and limited feedback regarding the quality of ABE interviews

In conclusion they noted

*“The evidential importance of the ABE interview cannot be overstated; this is often the key element underpinning a prosecution. In this context it is vital that there is a quality product because it invariably forms the evidence-in-chief of the witness. Currently the failure to apply the Guidance and adhere to the underpinning principles means that the best evidence is not always achieved....”* Achieving Best Evidence in Child Sexual Abuse Cases – A Joint Inspection

They make several recommendations including improved training of fewer dedicated interviewers with greater feedback and also greater input from CPS. They also advise improved pre-interview planning and a need to address the issue of police viewing the interview as a tool for evidence gathering.

The former Lord Chief Justice of England and Wales, Lord Judge, also clearly noted in his 2013 Toumlin Lecture that there is an urgent need to change the system to make it fit the child instead of the reverse. He questions if it is necessary for child witnesses to ever come to court and *“whether for some of them, at any rate, attendance at trial cannot be arranged in a more congenial place, with necessary safeguards to ensure judicial control over the trial process and the safeguarding interests of the defendant.”* He advocates for the introduction of video-recorded pre-trial cross-examinations (Pigot 2)<sup>51, 52</sup> and he states *“What I am prepared to say for certain is that the quicker the court process is completed, the better for the long term interests of the child”*. This is underscored by the Home Affairs Committee recent report which forcefully recommends the implementation of Pigot 2 (Pigot refers to the 1989 report written on the use of video recordings of interviews of child victims in court as evidence and Pigot 2, the second part of the recommendation, that the cross-examination also be recorded pre-trial)

*“We are at a loss to understand why the Ministry of Justice, fourteen years after the Act was passed, has still failed to implement this measure...there can be no justifiable argument for continuing to subject highly vulnerable victims to cross examination in court given the highly publicised risks this clearly carries. Pigot 2 represents the will of Parliament and it is for the Ministry of Justice to implement this measure in a timely manner. We recommend they implement Pigot 2 by January 2014.”* Home Affairs Committee Second Report - Child Sexual Exploitation and the Response to Localised Grooming, 5 June 2013

There are now several pilots underway, based on the Youth Justice and Criminal Evidence Act 1999, whereby the cross-examination of a child will now be pre-recorded prior to trial. This will largely avoid the need for the child to evidence at the time of trial (unless new information comes to light). Within this pilot, the child will go to a special room at the courthouse which is video linked to the courtroom. The judge and all lawyers will be able to hear them as they give evidence. This

procedure is recorded and used in place of the child during the actual trial. There are some thoughts that this will also allow for the interview to be recorded at other locations in the future. This pilot is underway in London Borough of Kingston and other parts of the UK.

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. Furthermore, based on international experience and the above, it is worth considering a broader review of the entire medical, social, investigative and criminal justice response to CSA and bring it in line with the United Nations Convention on the Rights of the Child and the Lanzarote Convention.

## 10. Child and Adolescent Mental Health Services (CAMHS)

### Background

Funding to CAMHS services has been significantly cut in recent years and this coupled with an increase in referrals is leaving services under pressure with long waiting times. Only 6% of Mental Health spend is on Children and Young People<sup>53</sup> and increasingly CAMHS is becoming under resourced with some CCGs planning further cuts for 2015/16. According to NHS England research only 25% of children with a diagnosable mental health problem receive a specialist service.<sup>54</sup>

A national review of CAMHS ordered by the House of Commons<sup>55</sup> described feedback from several London CAMHS providers. For example: Barnet Child and Adolescent Mental Health Service reported an average 26.5% increase in all referrals to CAMHS services, and a 45% increase in self-harm rates.

The introduction of Children and Young Peoples – Improving Access to Psychological Therapies (CYP – IAPTs) nationally has been described as “*strongly positive*” but was only found to be in place in two of the London boroughs interviewed so far. The programme provides investment in infrastructure and workforce training, supporting the development of demand management, and training a number of supervisors and therapists. CYP-IAPTs services include evidence based treatments for self-harm, depression, anxiety, eating disorders and conduct problems. However the introduction of CYP-IAPT has been affected by a backdrop of overall CAMHS budgets cuts.

In the national review Professor Peter Fonagy, National Clinical Lead for the CYP-IAPT programme, stated “*Cuts to CAMHS budgets at CYP IAPT partnerships since 2010 include Hackney (76% reduction), Ealing (19% reduction), Kensington and Chelsea (19% reduction) and Westminster (19% reduction). One CYP IAPT site has reported a reduction in a fifth of staff due to cuts.... another Trust has reported reducing numbers of experienced staff and replacing them with junior staff.... Some services have responded to budget cuts by raising thresholds*”

CAMHS services are divided into four tiers according to severity and provided by a variety of providers. Tier IV inpatient services and Tier I services provided by GPs are not discussed in this review. The following description of CAMHS services is based on discussions with 21 CCGs and 22 CAMHS teams.

### Tier III CAMHS services

CAMHS services are provided by ten providers across London, each serving several neighbouring boroughs but often with different services commissioned by each CCG within the area. Where possible CCGs are choosing to commission CAMHS tier III services collaboratively, for example in SW London. However new Joint Children's Commissioning roles across LA and CCGs are changing the CAMHS strategy to focus more on Early Intervention services as well as driving significant financial savings. During 2015/16 many boroughs are re-tendering CAMHS services, with a drive to create capacity for earlier interventions, but often this is within the same or reduced financial envelopes.

### **Single point of access:**

Most CAMHS providers now offer a Single Point of Access (SPA) for all referrals with a daily triage by a multidisciplinary team who allocate the cases to the correct CAMHS team, and aim for first assessment in under six weeks. Usually CAMHS services include:

- General CAMHS/Complex cases team (for the under 13/14 year olds)
- LAC CAMHS (for looked after children)
- Youth Offending Team (YOT CAMHS)
- Adolescent Team

Each team has varied criteria for referrals and waiting times, but all providers have emergency (on the day) and urgent appointments (within a week) that could be available as required, for example: suicidal ideation following a sexual assault. CCGs reported waiting list targets which varied from 8 weeks to 18 weeks but were not always clear if this was for initial assessment or interventions to commence. CAMHS providers reported wait times for initial assessment ranging from 2-11 weeks, but this was nearly always followed by a further wait to start first-line therapy such as Cognitive Behavioural Therapy CBT (weeks to months) and then a further wait of up to six months for a specialist therapeutic programmes such as psychotherapy or Eye Movement Desensitization and Reprocessing (EMDR).

One of the few exceptions to this is the Tavistock and Portman CAMHS service in Camden which is able to offer assessments and therapy from 4-6 weeks. However they reported that their CAMHS budget is now two to three times the London average, having been successfully invested in over a long period.

### **Referrals:**

Criteria for tier III referrals are increasingly tight as CAMHS budgets are squeezed. This means children and young people who have been sexually assaulted can only being accepted by some CAMHS teams if they have severe mental health conditions such as:

- Severe anxiety, depression or suicidal ideation
- Severe self-harm
- Post-traumatic stress disorder
- Severe phobia
- Other compounding factors: Looked after child, young offender, learning disability

The tightening of criteria as above was reported by 15 of the 22 CAMHS teams interviewed. Many children cannot easily access CAMHS after a sexual assault. This was similarly reported by the

Designated and Named Doctors for Safeguarding Children surveyed. CAMHS providers felt that budget cuts meant children were often left without early support, resulting in worsening emotional health until they presented with a severe mental health condition.

For example, in Kingston CCG in 2012/13, 40% of referrals to CAMHS were rejected as the child/young person did not have a clinical diagnosis or require structured treatment for a mental health condition. This has triggered redesign work in 2014 to make services more efficient. There has been investment in more tier II support, greater clarity of referral criteria and a flow of children between services as treatment need changes.

But for other providers the line drawn at the door of CAMHS tier III remains firm. A member of CAMHS in Oxleas MH Trust stated “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.”

However this was not the case described in seven of the Boroughs interviewed, where services remain able to accept any children referred to CAMHS who have been sexually assaulted. These CAMHS providers able to still offer therapy included: East London Mental Health Trust, North East London Mental Health Trust, South London and Maudsley (in Southwark) and Tavistock and Portman.

The only CSA specific service identified was in Southwark and is provided by South London and Maudsley Trust (SLAM). A service established 14 years ago and providing flexible access to specialist services for any children in the borough following a sexual assault (acute or historic). Unfortunately this service is at risk due to 50% of its funding from the London Borough being cut, leaving the remaining service unsustainable in its present form.

**SLAM Child Sexual Assault Clinic** – established 14 years ago, this service led by Tara Weeramanthri offers holistic emotional and mental health interventions to any child up to the age of 18 years in the borough of Southwark. They accept any child that has suffered sexual assault and has symptoms that are impacting on their daily life. With referrals coming from: consultant paediatricians at The Havens, local paediatricians undertaking medicals post CSA, social services, victim support charity or GP. The service, until recently, comprised experienced Clinical Psychiatrist, CAMHS nurses and children’s social workers experienced in this field. They offer a package of assessment, safety planning, individual therapy for the child, family therapy and parental support with referral to MOSAC if required – which can last up to two years.

Where children and young people do not meet the referral criteria for Tier III services, some boroughs have clear pathways in place for onward referrals, however this is not pan-London. For example in Brent CAMHS team (Central and North West London MH Trust) the triage team recommend a variety of universal services for those with mild to moderate mental health needs. This can include school based counselling from Kids Company (anxiety), GP/Practice nurse for low mood, online therapy and local counselling service (for the over 14’s). Whilst these universal services may be adequate, some providers reported feeling out of their depth as soon as the deeper issues

around the sexual assault surfaced. Currently there is no specialist advice, training or supervision from CAMHS or specialist sexual assault services like The Havens.

The CAMHS providers reported few referrals from the Havens. Most of the children and young people they support who have been abused or assaulted in the preceding months are referred from social care due to anxiety, self-harm or disruptive/aggressive behaviours. These young people then report the sexual assault in therapy but do not wish to report to the police or seek medical intervention at the Havens. CAMHS workers report that young people think that Rape Crisis Centres and the Havens are not relevant to them, as they often feel that they have not been a victim of a rape even when they have.

#### **Haven case tracking:**

This review has undertaken case tracking of 66 children and young people seen at the Havens between April and June 2014 to identify if they were referred to CAMHS and other services and if so did they meet the criteria and how long did they wait to be seen.

Six of the 66 children and young people were referred to CAMHS at the time for forensic examination, with three accepted into Tier III in 3-6 weeks and one admitted to Tier IV inpatient services. Another was referred to CAMHS by the local paediatrician and another to a local counsellor. The remaining 58 children and young people were not referred to CAMHS by either the Havens or their local paediatric teams.

#### **Therapeutic services:**

Once accepted into CAMHS tier III and through the waiting list, children generally received 12-18 months of 1:1 therapy tailored to their individual needs including CBT (Cognitive Behavioural Therapy), EMDR (Eye Movement Desensitization and Reprocessing), psychotherapy and/or family therapy. Generally all providers described the therapy continuing as long as was needed but it was reported that in Barnet and Enfield (BEH Mental Health Trust) this therapy is provided in block of 6 weeks with a review and agreement to continue treatment at each interval, which CAMHS clinicians reported as being disruptive.

Many of the CAMHS providers do not offer support or therapy to parents. Those in south east London refer them to MOSAC, a third sector provider of parental counselling but there are limited services available elsewhere. Five of the CAMHS borough teams interviewed do offer 1:1 support for parents and noted that it was essential to support the parents who may well have complex issues of their own. Other CAMHS providers felt worried by the lack of capacity to support parents and an overreliance on the parent's ability to cope and support their child. A variety of stakeholders thought the trauma of a child's sexual abuse can be as hard for the parent as the victim themselves, with feelings of guilt, shame and blame for having allowed it to happen. Without support parents can struggle to offer consistent and practical support for their children as they deal with their own grief.

One CAMHS provider raised concern about being driven by managers in the Trust to start a therapeutic programme of CBT or psychotherapy, as this is the only activity that is counted by CCGs. They felt clinicians are being discouraged by CAMHS managers from offering early support to the family and wider team as this soft input cannot be easily measured or counted. They feel there is a need for counselling and helping families develop strategies to build emotional resilience and cope

with feelings and symptoms that impact on daily life, for example night terrors, flashbacks, self-harm. They noted that sometimes the child or young person is not ready to move straight into therapy and, as one CAMHS manager said *“Quality is being compromised by targets that are not relevant to the best clinical model”*.

Discussions with CAMHS providers also reviewed the best place to see the child/young person and provide therapy. Some providers were clear that clinic based therapy is confidential, safe and that it *“Feels OK once you get there!”* Other CAMHSs teams reported having tried an outreach model following on from the work of MAC-UK with clinical psychologists offering therapy on the streets. This model has been highly acclaimed and award winning for its work with gangs in Camden and Southwark, with more information in Section 13. Their ideal would be to offer choices to young people including: outreach on street, home visit or clinic based care. The Central and North West London (CNWL) CAMHS team commented *“Don’t forget to ask the young person what they would prefer?”*

### **Views of the young person:**

Currently 89 young people have been interviewed as part of an ongoing research project at the Havens. The views of these young people from their interviews as part of the research study were reviewed and some themes identified from their experiences of the police:

The views were reviewed and some themes identified:

- Those that had accessed CAMHS described being referred to CAMHS and having an initial assessment but never hearing from CAMHS again. One stated that *“CAMHS undertook a phone assessment and then never called back”*
- Some who had been to see CAMHS didn’t see the point in going and found the sessions too reflective and not practical enough. Whilst another said that if you don’t get on with the first person you meet then that’s it
- Others had waited a long time for an appointment and struggled to cope in the meantime
- Two thirds of the young people seen by CAMHS had a diagnosis e.g. PTSD, depression, anxiety, bipolar
- Several young people found the venue *“horrible and depressing”* or *“on the main road so felt embarrassed going in”*
- One complained that *“they stopped the sessions when I still needed more but they couldn’t provide it on the NHS”*
- Another said *“CAMHS understood and listened to me”*
- For those not meeting CAMHS criteria, five were referred to third sector providers e.g. Barnardo’s, Rape Crisis and seven to counsellors
- One young person suggested a more practical and engaging approach to CAMHS could be *“maybe see an occupational therapist so it is less clinical and there are distractions whilst you are talking”*

## Therapy during court proceedings

Several CAMHS and third sector providers said that sometimes therapy is with-held or delayed due to concerns over impact on the trial, noting that they preferred to wait to commence cognitive behavioural therapy until after the trial. Although all stated that therapy decisions are made with the child's best interests at the centre and therefore sometimes it is necessary to provide therapy pre-trial. Others ensure that they offer safety planning, coping strategies and counselling on managing symptoms without discussing the assault itself – reporting that *“the young person has already described the assault to three other people before they come to CAMHS, so they don't want to talk about it anymore”*.

The reason given for potentially delaying therapy includes:

- The child is already talking to lots of people through the trial and so does not want to talk to anyone else
- Some therapists noted that they are reluctant to start any therapy as their complete therapy notes could be shared at court, causing further distress for the victim. A service manager from CNWL MH Trust said *“Sharing CAMHS therapy notes in court breaks the confidentiality and wrecks any future therapeutic relationship”*
- There is a risk associated with the therapist being called as a professional CAMHS witness as it changes therapeutic relationship with the child forever

The Crown Prosecution Service (CPS) guidelines state in Sections 31 and 32 <sup>56</sup>:

*31. The CPS guidance “Provision of Therapy for Child Witnesses Prior to a Criminal Trial” is clear that the best interests of the victim or witness are the paramount consideration in decisions about therapy. There is no bar to a victim seeking pre-trial therapy or counselling and neither the police nor the CPS should prevent therapy from taking place prior to a trial. Prosecutors should be familiar with the content of the CPS guidance on pre-trial therapy so that they can advise police and witnesses on the correct approach.*

*32. Providers of counselling or therapy should ensure that records are kept and that the child or young person (and if relevant, parents or guardian) is advised at the start of the process that there may be a requirement to disclose the fact that counselling has taken place, particularly if detail of the alleged offending is raised. Experience over a number of years has shown that properly conducted and recorded counselling or therapy has not caused problems with the criminal trial process.*

There is no definitive answer, but a general consensus from clinicians is that the CPS guidelines must be interpreted with the needs of the child and their family foremost.

**Pre-trial interventions** could include:

- Counselling and supportive strategies to improve for mental health symptoms including self-esteem, confidence, night terrors
- Safety planning to prevent further risk of exploitation or assault
- Supporting the family to support the child
- With other therapy if needed

## **Tier II services**

Tier II services vary widely across CAMHS providers and boroughs, with some CAMHS providers commissioned differently in each London Borough that they cover. Though CYP-IAPTS is the recommended model, from the CAMHS providers interviewed so far, South London and Maudsley Mental Health Trust (Lambeth team only) and South West London and St Georges Mental Health Trust are the only CAMHS service currently commissioned to provide CYP IAPTS.

A popular commissioning model was CAMHS providers commissioned by education and schools directly to provide tier II in schools. These services are available in Oxleas Mental Health Trust, BEH Mental Health Trust, Central North West London Mental Health Trust, North East London FT (NELFT) and Tavistock. However the CAMHS providers reported that often these services are not commissioned in all the boroughs that they serve and are usually under commissioned and over-subscribed with waiting lists of up to 6 months. For example in NELFT, tier II counselling is commissioned in 26% of schools in Redbridge, 14% of schools in Waltham Forest and no schools in Havering.

A new model developing is the investment by local authorities into CAMHS expertise in “*Early Intervention/Help Services*”. Where CCGs and Local Authorities have created joint children’s commissioning roles, 2013/14 has seen a model of CAMHS workers joining the existing Early Help teams of children’s social workers, family support workers, educational psychologists, speech and language therapists. These services have been invested in Southwark and the Tri-Boroughs.

### **Southwark Early Help Service**

In Southwark, the local authority has invested in four CAMHS workers to join the Early Help Service. The aim is to offer short interventions to the hard to reach families and the CAMHS specialists offer help such as 1:1 sessions for anxiety and depression, behavioural therapy, parenting and family intervention. They also offer training and supervision to the wider team , to enable the team member with the best rapport to support the child. This team went live in August 2014, so it is too early to measure outcomes.

### **Tri- Borough – Early Intervention Model**

These three London Boroughs have made significant investment into a two year project of CAMHS support in the early intervention team.

Usually young people over 16 years are able to access Adult IAPTS services and some boroughs commission an online talking therapies service from Big White Wall. Big White Wall provides an online platform for peer support and live therapy for any young person 16+. Services include a support network, guided support modules and live therapy (Further information is in Section 13).

## **CAMHS training and support of other agencies**

Several frontline staff raised concerns that they find it difficult to access support, training and supervision from local CAMHS teams. This used to be more readily available but with recent cuts in



CAMHS budgets this support has diminished. In some boroughs the new CAMHS support in early intervention teams will have this role.

A consortium of Child & Family Training, Lucy Faithfull Foundation, South London & Maudsley NHS Foundation Trust, SWAAY have developed a manual for frontline staff in other agencies. This manual offers training in an integrated programme targeting abusive and neglectful parenting and the associated impairments of children's health and development. It aims to support frontline practitioners to develop intervention skills. This programme is known as the *"Hope for Children and Families programme"* and is currently in pilot phase with Department for Education.

### **Issues raised by CAMHS**

CAMHS providers raised a variety of issues and concerns about capacity for early intervention, raising of thresholds for tier III and lack of ability to provide parental support:

- Some CAMHS providers no longer have the capacity to offer emotional wellbeing in schools and are concerned that they are missing the early warning signs of trauma
- Child sexual assault cases no longer come automatically into CAMHS tier III but now need a mental health diagnosis to be seen
- Most CAMHS providers do not have the capacity to support and supervise colleagues in the wider multidisciplinary team e.g. school teachers, social workers, youth workers
- Some clinicians reported being discouraged by managers from offering support to the family and wider team as this soft input cannot be easily measured or counted for CCGs. The CCG contract monitoring is focused on assessments and therapy
- Following cuts to services, 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

Other stakeholders concerns were:

- One CCG said the investment into CAMHS has been historically too small and it will be cut again this year
- Predicted budgets for 2015/16 range from protected CAMHS budgets for next year to a planned 20% cut
- 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. They said they "didn't like it" and "didn't see the point in going"
- 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 ideal model suggested by CAMHS**

The ideal support from CAMHS requires additional investment in a currently significantly under-funded service that would allow teams:

- To be a key member of early intervention teams and to offer 1:1 support for the child
- 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
- To offer guidance and advice to the child’s existing support network in pre-trial period (including 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 specialist hub
- To provide telephone follow up to ensure all children not meeting the criteria for Tier III are established with a tier II provider, counsellor or third sector specialist service
- To reduce waiting lists for Tier III therapy to six weeks

When the Child House model was discussed with some CAMHS providers as an option for London, the response was positive. Those with whom it was discussed suggested the CAMHS clinicians in the Child House hosted by a CAMHS provider to ensure supervision and that any experienced CAMHS clinician would be suitable regardless of role: child and adolescent psychotherapist, clinical psychologist, family therapist or nurse. The role of the CAMHS clinicians in the Child Hub was recommended to include advice to team, 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.

## 11. Children’s Social care services

Information regarding the Paediatric SARC review was provided to 32 Directors of Children’s Social Services. They were asked to complete a brief survey and participate in a semi-structured interview. The review team received minimal response late in the review process and unfortunately were not able to complete any interviews with social care teams. In the absence of interview data the review was only able to refer to the findings of the NSPCC study on social workers confidence in relation to handling cases of child sexual abuse and a few comments made by young people and Haven staff.

Concerns were raised by Joint Children’s Commissioners who described children’s social care teams budgets being so tight that social workers have been delaying intervening until cases are more serious.

### Social workers knowledge and confidence

The NSPCC Study from 2014<sup>57</sup> described a lack of capacity for social workers to support families, a focus on the judicial process and risks identified with staff competencies.

The report highlighted a lack of clarity for social workers about their role; noting a tension for the social workers between spending time on the judicial processes versus the need to support the child and their family. The social workers interviewed reported insufficient time to develop trusting relationships with children and their families. Instead they were focusing on assessments, statements and accompanying the child to court. Several social workers interviewed had resorted to supporting families in their own time with others referring work onto the third sector where available.

Social workers from London reportedly felt that police directed the process once a disclosure or suspicion of CSA had been made. There seemed to be a sense that the criminal outcome was prioritised over the child's welfare.

Due to difficulties in recruiting experienced social workers, the practice of using agency staff or newly qualified social workers in child sexual assault cases had reportedly increased over the last few years. This was reported to result in staff with no ABE interview training and requiring supervision, being responsible for complex child sexual assault cases. Those that found themselves in this situation reported a lack of meaningful supervision and reliance on peer support.

### **Views of the young person**

A member of the Solace Rape Crisis team reported that young people attending the centre were lacking practical support from local social workers. They said that one young person just wanted some support to change schools, as the alleged assailant attended her school. She said it took ages to arrange the move and in the meantime she couldn't go to school and felt like an outcast. She just wanted someone to talk to and answer her questions.

## **12. Schools – school nursing and school counselling**

In 2014 Wendy Nicholson, Professional Officer for School and Community Nursing at the Department of Health published "Maximising the school nursing team contribution to the public health of school aged children- Guidance to support the commissioning of public health provision for school aged children 5-19. This guidance describes the Healthy Child programme and the scope of contribution of school nurses to the physical health and emotional wellbeing of school aged children.

School nurses have a role in supporting the emotional wellbeing of children through an early help model, focusing on those children that fall outside of the criteria of diagnosed mental health conditions that have become the focus for CAMHS providers. In most boroughs this is still being commissioned through drop in clinics.

The Healthy Child Programme requires school nurses to identify risk factors, recognise early warning signs and provide support where behavioural difficulties are present. They should provide planned structured support that strengthens the family relationship and work with local "early intervention" services, partner and voluntary agencies. Most boroughs confirmed that their school nurses continue to provide drop-in clinics and counselling services for children, with some developing links through joint working in local CASH clinics (contraceptive advice and sexual health).

Several Joint Children's Commissioners confirmed that even though commissioning responsibility has moved to Public health teams, the school nurses are still commissioned to provide drop ins and have a clear role in supporting young people to build resilience around emotional wellbeing. However school nurses reported some isolation in their role, particularly with regard to victims of sexual assault. They said that they were not informed by the named doctor or school of the sexual assault and therefore were not able to "look out for" the young people. Additionally when a young person they were supporting with self-harm or anxiety then disclosed sexual abuse/assault, they did not feel that they could easily access specialist professional advice and supervision for themselves.

**A survey** was sent out Joint Commissioning Leads to be forwarded onto as many head teachers as possible in London via their Schools Partnership networks. It is unknown whether surveys were sent out to all of the 1796 primary schools and 446 secondary schools<sup>58</sup>, but to date just 22 schools have replied. Only 23% confirmed that they offer school counselling. Of those that responded to the survey, one third had supported children following an alleged sexual assault and one third of their counsellors felt confident supporting children following sexual assault with their depression, anxiety, self-harm and other mild mental health conditions. Just under half of responding schools also offered support to parents and siblings.

When asked if they would benefit from additional training, 60% would like specialist training from the Havens, 80% would like access to local hub of expertise in the community and 60% would find a telephone helpline valuable.

**A focus group was held in Greenwich** on behalf of this review with 50 head teachers. They reported that in the vast majority of schools they did have access to some form of counselling, whether they employed someone or were linked to a community project. Most of the Primary Schools did not feel that counselling support following sexual assault was an issue that came up for them very often but they agreed that when it did occur it needed to be dealt with quickly because of the impact on a child's life. The Secondary School heads said that while there would be support for young people affected, their counsellors might not be that confident in this area. Everyone in the focus group said they would welcome further information about available support, the Primary School heads were not aware of the Haven.

A team discussion held on behalf of this review with the **Sutton school nurses** identified that none of the team members were aware of any local support services available for the victims of sexual assault. Contrary to what happens with children with complex needs, no school nurse had received a referral from Community Paediatricians regarding a child who had been sexually assaulted. They said that unless the young person self refers they are not aware of these children and young people.

**Correlating this with data from third sector** providers shows that there is also a network of school counselling commissioned by schools from external providers. **Kids Company** provides school counselling in 40 schools across London (30 primary and 10 secondary/academies). **Entrust** provide counselling in inner London schools. **Place to be** provides counselling in 41 schools in North West London, 41 in South London, 10 in East London and 3 in Central London.

### 13. Third sector providers

Mapping the third sector providers as part of this review demonstrated that it is difficult as a "mystery shopper" to find services in Boroughs for a young person or parent to access for their child. Some Borough Councils have useful information and the Havens provide a resource pack at discharge, but neither is 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.

Interviews with Children's Commissioners from CCG/LAs and CAMHS providers revealed further gaps in awareness of the breadth of services both specialist and generic in supporting children and young

people after trauma and will emotional difficulties. Many could not name local third sector provision and a common request was for The Havens to host a “directory of services” for specialist resources.

Third sector provision offer five types of service including:

- advice and advocacy – helplines, practical advice and ISVA or IDVA advocates
- 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

Interviews and site visits were undertaken with the majority of third sector providers detailed in this section. An accompanying Directory of Services has been developed detailing all third sector providers identified and will be available to the Havens and other providers on request.

### 13.1 Advice and advocacy

#### Rape Crisis Centres

Advice and support is available from the four Rape Crisis centres serving London as well as Kent Rape crisis centre for those living in the SE Boroughs. Each is run by a different charity and provides advice and access to ISVAs. There are also a number of domestic violence charities, such as Advance advocacy and Victim Support, which support young women where the sexual assault was related to domestic violence.

Since 2014/15 MOPAC has commissioned pan-London coverage from four Rape Crisis Centres in the North, West, South and East of London. These centres offer helplines for advice and support, 1:1 counselling, art therapy, specialist facilitated groups for survivors or young people – all in a confidential and safe environment. However they are only open to girls over 14 years of age and not open to boys or men.

They work to a hub and spoke model with one rape crisis centre in each region of London plus spokes of services out in each borough. For example: an outreach ISVA that meets people in their local area, groups run in boroughs led by demand, counselling available once a week in each borough on a local venue such as library, health centre.

Solace Rape Crisis said *“We are only touching the tip of the iceberg, with the people that make it to through to Rape Crisis services, with only 15% reporting the rape to the police. There is a culture of disbelief and rape myths that it must be tier fault or could have prevented it.”*

#### Independent Sexual Violence Advocates (ISVA)

Recently MOPAC, the Home Office and Local authorities have started to commission 25 ISVA’s across London for women from a variety of third sector providers including Solace, Eaves Housing for Women, the HER centre in Greenwich as well as from statutory providers such as The Havens and LB of Camden. These ISVAs offer advice and support for people following sexual assault including practical support for housing, finding sexual health services and the court process. These roles build on the well-established IDVA (independent domestic violence advocate) roles.

However, Brighton and Hove City Council has just taken this one step further and commissioned its new CHISVA role – child independent sexual violence advocate. The rationale for this is that ISVAs mainly support adults and don't have the unique skills and knowledge needed to support children's needs:

- Children's services are different to adults
- Risks of sexting and social media are greater for children and young people
- Legislation to protect children is different, particularly for under 13s
- Grooming and gangs are more of an issue

Joanne Sharpen (moderator of "This is abuse" website and chair of MSUnderstood) identified the absence of this role as a significant gap for London.

**Child line, Barnardo's, NSPCC and Respond** offer national helplines to call for advice and guidance including telephone support to talk through immediate concerns, helping parents assess the level of danger their child is in and signposting them to agencies in their area who may be able to give local support. Children suffering with familial child abuse have found Childline invaluable in having someone to talk to when no one else around believes them. **MOSAC** offer a national helpline for parents of children that have been sexually abused.

There are also useful websites for both children and parents. '**Parents Protect**' provides information and resources which aim to raise awareness about child sexual abuse, answer questions and give adults the information, advice, facts, they need to help protect children. '**This is abuse**' offers advice on warning signs and your rights as well as an anonymous wall to post disclosures and questions. The site is moderated and all posts receive a response with advice and signposting.

## 13.2 Prevention

Education in schools, awareness raising and spotting the signs of abuse were regularly raised by third sector providers as essential to tackling the issue of child sexual assault.

### **Awareness raising and spotting the signs of abuse:**

NSPCC, Barnardo's, Solace, Kids Company, MOSAC and many more raised the issue of a lack of awareness amongst health professionals, teachers and social care staff. They cited a lack of knowledge of the early warning signs and a fear of asking the questions as barriers to early detection or prevention of child sexual assault. Training should be made available to anyone involved in working with children and young people including GPs, school staff, youth workers, school nurses, health visitors, police and social workers.

**The Ava project** provides training and support to other agencies to raise awareness of the early warning signs of child sexual exploitation and sexual abuse, the risk of technology and abuse in young people, as well as how to support a young person to make a safe disclosure. Examples of these programmes include the five day Stella project training - 'Working with gang-affected young people experiencing sexual and domestic violence' and the Violence against women and girls course 'Supporting Survivors to Recover from the Impacts of Violence Against Women and Girls – Post-

traumatic Stress'. **NSPCC** provide training and access to extensive resources on their website including: research, reports and resources about child sexual exploitation, learning from case reviews and factsheets for schools.

**Parents Protect** (<http://www.parentsprotect.co.uk/>) is an information and resources website which aims to raise awareness about child sexual abuse, answer questions and give adults the information they need to help protect children.

#### **Education in schools:**

**Barnardo's, Brook, NSPCC** and many others provide training and education in schools. A counsellor from Brook said *"Educate, educate, educate! When we ran our series of education sessions in Lambeth we saw a doubling of the number of under16s attending our services."* Others reported that young people are just not aware of the Havens and where to access support, perceiving that going to the Havens meant telling the police and social services. Red Thread recommended the Haven has a bus to travel around local estates and raise awareness of the services available and the potential for complete confidentiality if preferred.

Specialist providers like **MAC-UK, Red Thread** and the **Havens** offer awareness sessions in sexual assault and gang violence but these are time consuming and ad hoc – easily pushed aside as caseloads rise. And yet it is this education that is the key to prevention of future childhood sexual assault and exploitation. Many providers of specialist support for children sexually assaulted said that young people are not aware of consent or the law around sex. They have distorted perceptions of normal boyfriend/girlfriend relationships and are not aware when they are being exploited by 'friends' or gang members. They said that these young people are not disclosing rape as they do not see what has been done to them as rape, and yet violent sexual activity without consent is sexual assault. One young person said "Being forced to perform oral sex was not rape as you cannot get pregnant". Education of young people needs to be a priority for Havens and other specialist providers in London.

#### **Managing sexual harmful behaviours:**

Another area of prevention of sexual assault in children and young people is the management of young people with harmful sexual behaviour, to reduce the risks of re-offending and perpetuating the cycle of sexual assault and violence. In London this is provided by the NSPCC service **National Clinical Assessment and Treatment Service (NCATS)**. Children and young people who develop harmful sexual behaviour often have experienced abuse and neglect themselves. A study by Yates (2012) of 34 children with harmful sexual behaviour found that all had experienced physical, emotional or sexual abuse. This is backed up by feedback from the **AIMS service in Lambeth**, which also reported all children seen in the last 3 years for sexual harmful behaviour had experienced abuse and were victims themselves before they became perpetrators of sexual harmful behaviour. And again by Hackett (2014)<sup>59</sup> who reported the vast majority of children with harmful sexual behaviour have themselves experienced physical, emotional or sexual abuse.

NCATS is available to children and young people up to the age of 21 years. If a child discloses previous child sexual abuse, the assessment of harmful sexual behaviour stops whilst an investigation takes place by police and social services. Children that have been previously abused will

be offered therapeutic interventions weekly under spot purchase as required. AIMS is available to any child up to 17 years and offers all children/young people assessment and treatment of their own trauma as well as the sexually harmful behaviour.

#### **Equipping children and parents for prevention:**

The NSPCC offer some services focused particularly of safety and risk reduction for further sexual exploitation and assault. Their service '**Protect and Respect**' works with young people for six months to provide education and reduce risk of further assaults. Their new model '**Women as Protectors**' due to launch in March 2015 will empower mothers to keep their children safe.

### **13.3 Counselling/therapy for children and young people**

Therapy for children and young people following a sexual assault is available from either specialist sexual assault services, holistic interventions or general counselling services. The specialist services available are dependent on which London Borough you live in with the bulk of services focused around Southwark/Lambeth/Croydon, Camden and East London – and also the age of the child.

#### **Specialist services for child sexual assault:**

**Rape Crisis** offer 1:1 counselling for young people over the age of 14 years following a sexual assault. These services are available out of the four hubs in the North, East, South, and West on London as well as local outreach services in many boroughs. However if you are looking for child friendly services then the choices are limited in many boroughs. The NSPCC service '**Letting the Future in**' provides counselling for up to 1 year for children 4-17 years old and available to children living in or near Croydon and East London boroughs. **Barnardo's** provide 1:1 sessions for children under 18 following sexual exploitation for up to 6 months. The Barnardo's service is purchased by the boroughs of Wandsworth, Merton, Richmond, Kingston, Bromley and Hammersmith & Fulham, as well as spot purchased as needed in seven other London boroughs. **Family Matters** provided counselling for 4-18 year olds in Greenwich, Lewisham, Bexley and Bromley. **MOSAC** provide 1:1 therapy for children living in or close to Greenwich. This excellent service is offered up to one year and includes counselling, family therapy and sessions for parents and siblings if required. This is one of the few services that also supports the parents and siblings with 1:1 therapy for up to one year (see Section 13.4).

There is a gap in third sector provision in central, West and North London boroughs.

All of these services are child focused and use messy play, writing, storytelling and art to help express feelings. The environments offer clean, fun, age appropriate settings for children and adolescents (both inside and outside space) with a variety of resources for storytelling. There is currently no waiting list for these services and the NSPCC model is part of a research study, due to report in autumn 2015.



### Letting the Future in – NSPCC

“We see boys and girls aged 4 to 17 in our special play therapy rooms. They do things like messy play, writing, storytelling and art to help express feelings that they can’t put into words. Play is a natural way for children to express themselves. They can safely work through past experiences and come to understand and move on from what has happened.”

“We start by meeting for three or four weekly sessions to get an understanding of the child’s needs. Over time they will get to know us and begin to open up about their feelings. It can take up to a year before they are ready to move on. “

“We also talk to their parents or carers to help the whole family. Parents and carers of children who have been sexually abused can play a really important role in helping their child recover. They are offered some individual support and some joint sessions with the child.”

### Holistic support:

Because child sexual assault rarely occurs in isolation of other social and emotional difficulties, more holistic services are helpful in the long-term support of children. Many third sector providers support children post sexual assault even though that is not their primary aim, and as such have a great deal of experience to share. For example **Kids Company** provide street-level crisis centres and therapy in three sites in South London, which focus on stabilising and supporting the whole life of the nearly 5000 vulnerable children and young person that attend. They offer education, housing support, nutritious food and after school activities - as well as mental health, art and emotional wellbeing support. The ethos is to provide a substitute family environment where each individual is given a comprehensive package of care. Some research completed by Kids Company identified that children attending one of the Kids Company centres are from complex psychosocial backgrounds and are 13 times more likely to have been sexually abused.<sup>60</sup>

Services are provided at Arches II based in Camberwell, and Morgan Stanley Heart Yard and Kids Venture, both at Loughborough Junction in Southwark. All referrals are self-referrals, peer-to peer and word of mouth, as this ensures engagement at the right time for the child and their family.

Both **Red Thread** and **MAC-UK** who work with young people involved in gang violence and stabbing, often identify young people who have been sexually assaulted. They report young people attend the emergency department or GU clinics following a sexual assault instead of the Havens, but noted that often the assault can be missed and only sexual health advice offered. There is a gap for these hard-to-reach young people and potentially the peer referral model used by MAC-UK may provide a better engagement of young people into a support service. **The Well Centre in Streatham** offers follow up in a young people’s hub, including GP, CAMHS and youth workers. This model could be expanded to include sexual assault follow up in a more accessible and less stigmatised venue, and be replicated across London.

## BUILDING TRUST TAKES TIME

The key message to come these third sector providers was the time it takes to build relationships and trust, to undo years of grooming and to empower children and young people again. One said “It takes time to retrain them to believe in normal, loving relationships without violence”. This time is never available to school counsellors (6 sessions), is sometimes available to CAMHS teams (20 weeks to 1 year) but is always built into specialist third sector provision (1 to 3 years).

After 3 years of working with Barnardo’s one young person finally said “*None of this was my fault was it?*”

### Counselling:

Counselling for children is provided by many organisations cross London, some commissioned by the local Boroughs, some schools directly and other third sector funded. These counsellors are not specialists in child sexual assault but are often the people picking up the child when they do not meet the CAMHS tier III criteria. These services are only ever for the child and rarely offer any support to parents.

**Brook** offer counselling to anyone up to age of 25 years, but tend to see children over 12 years as most of their referrals are self-referrals. They said that whilst they start with the sexual assault, they often pick up domestic violence, bullying and neglect. Schools counselling is provide across London by **Kids Company, Place to be** and many other independent counsellors employed directly by schools. These counselling services are available in some primary and secondary schools and are provided by a team of qualified and unqualified counsellors. Several stakeholders raised concerns that even though the unqualified team members are closely supervised and cases allocated on an experience basis, there is a risk that more harm could be done in a complex case of child sexual assault. It has not been possible to map the exact coverage of counselling availability in each borough as it is such a patchwork of provision, but an estimate would be 50% of schools.

Youth counselling is also available in many boroughs from local providers such as Brent Centre for Young People, The Brandon Centre, The Cassell Centre, the Gaia centre. A regular request from stakeholders during this review has been for the Havens to host an up to date Directory of Service for all pan-London and borough specific services, which these are included in.

## 13.4 Counselling for parents/carers

Counselling for parents, carers and siblings is limited, with some organisations providing a series of group sessions for awareness raising and risk reduction but few individual offering counselling and therapy.

The NSPCC services **Letting the Future in** and **Protect and Respect** offer six sessions of group work to parents, covering topics such as: child sexual exploitation and how to protect their child or young person.

**PACE** equips parents with information for notifying police and social care, and provides practical tips for logging information and gathering evidence. Parents can be matched with a local volunteer befriender for further emotional support. Their website offers a resource centre full of advice and guidance as well an online parent’s forum.

**MOSAC** provide a national helpline and resources on their website for any non-perpetrator parent. In addition, their unique 1:1 service is available to those living in or near Greenwich. This includes up to one year's weekly therapy or counselling for each parent and any sibling, ensuring that they offer a whole family approach. This gives the parents a chance to be really open about how it feels for them, the guilt, self-blame and shame, and ensure that are supported to support their child. Several stakeholders identified the risk of over-reliance on parents as a protective factor in a child's life, when no one was taking the time to protect the parent(s).

### 13.5 Services for boys

This review has identified limited services specifically for boys and heard concerns raised by the Havens team and third sector providers (for example, Red Thread, MAC-UK) that boys struggle to engage with services. Survivors UK is pan-London service for male survivors of rape and sexual assault, but this service is only available for men 18 years and over and cannot see young men or boys.

The **BLAST project** is a Yorkshire based organisation that supports only boys and young men after sexual exploitation and assault. The website is packed with helpful resources for young men and professionals and they offer a national telephone helpline. Professionals can purchase posters aimed at boys and young men with details on how to access information, get support and report concerns as well as DVDs entitled 'My New Friend' highlighting the grooming and sexual exploitation of boys and young men and 'Same Risk, Different Gender' aimed at professionals encouraging them to make judgements based on risk indicators, not gender. Unfortunately counselling is not available to boys and young men living in London.

#### Issues raised by third sector:

The main issues raised by the third sector were around social services and the lack of funding for children's social services:

- There has been a "normalisation" of much higher levels of sexual exploitation, violence and assault both amongst professionals and young people
- Lack of awareness of the signs and poor responsiveness – *"social care is taking so long to intervene that the child is taken into care, when the family could have been supported to maintain a place of safety"*
- One provider reported that their local borough stated it is likely to cut services further 2015/16
- Other concerns focused on a lack of counselling for all children and young people affected and lack of support / training for those providing counselling
- Lack of knowledge of available services and a need for a comprehensive directory of services pan-London
- Lack of support for families and carers
- Lack of support specifically for boys
- Need for greater emphasis on education, prevention and outreach
-

### **Ideal model suggested by thirds sector:**

#### Awareness and prevention

- Training for all sectors in signs to look out, how to talk to children and responding to disclosure
- Education from children in schools in healthy relationships and sexual behaviours
- Advertising services available for children and young people

#### Services for children and parents

- All children should be assessed by a CAMHS professional at the Havens or CSA hub after a sexual assault
- CAMHS should 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 CHISVA's in London
- Increasing services available to the under 13s
- 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 worker or child advocate to support child or young person to identify a local key worker before they discharge them
- CSA hub specialist to support local key worker with training, advice and regular supervision
- Havens to strengthen links with existing youth services such Red Thread and MAC-UK. Haven could link up young people at risk of gang related sexual assault and exploitation with local teams or Haven team come out to run joint Street therapy session as handover

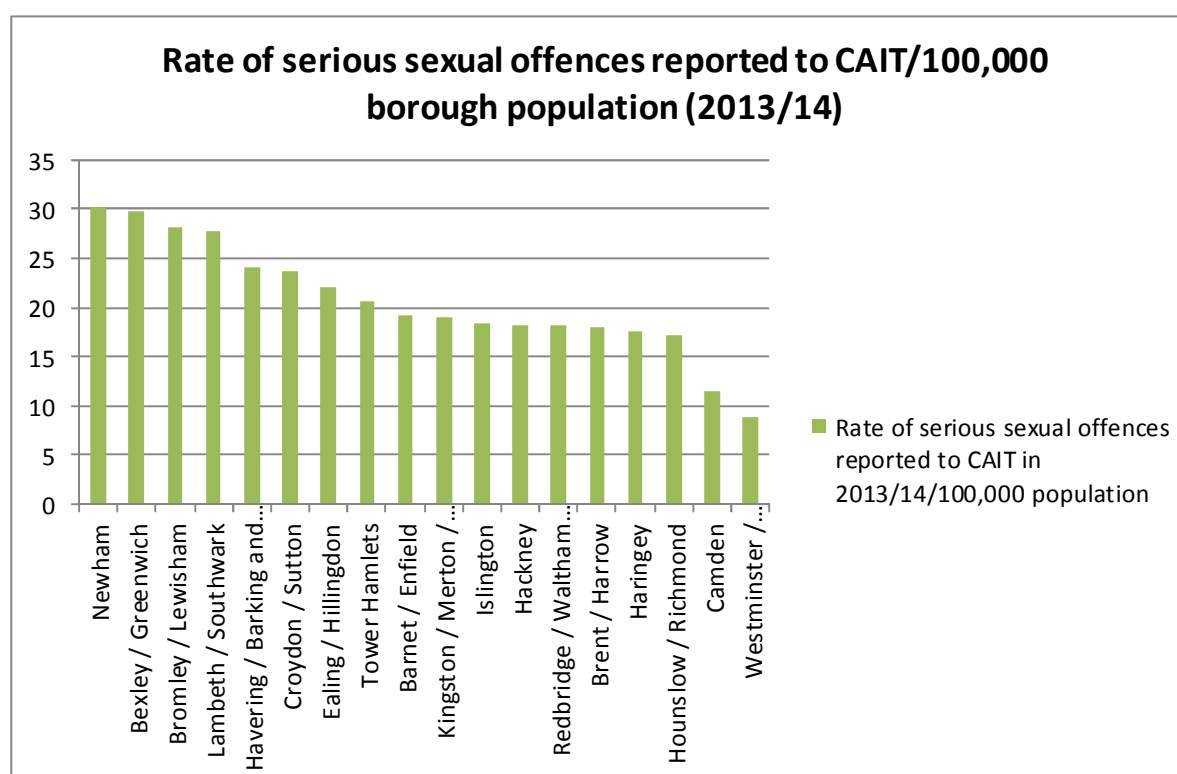
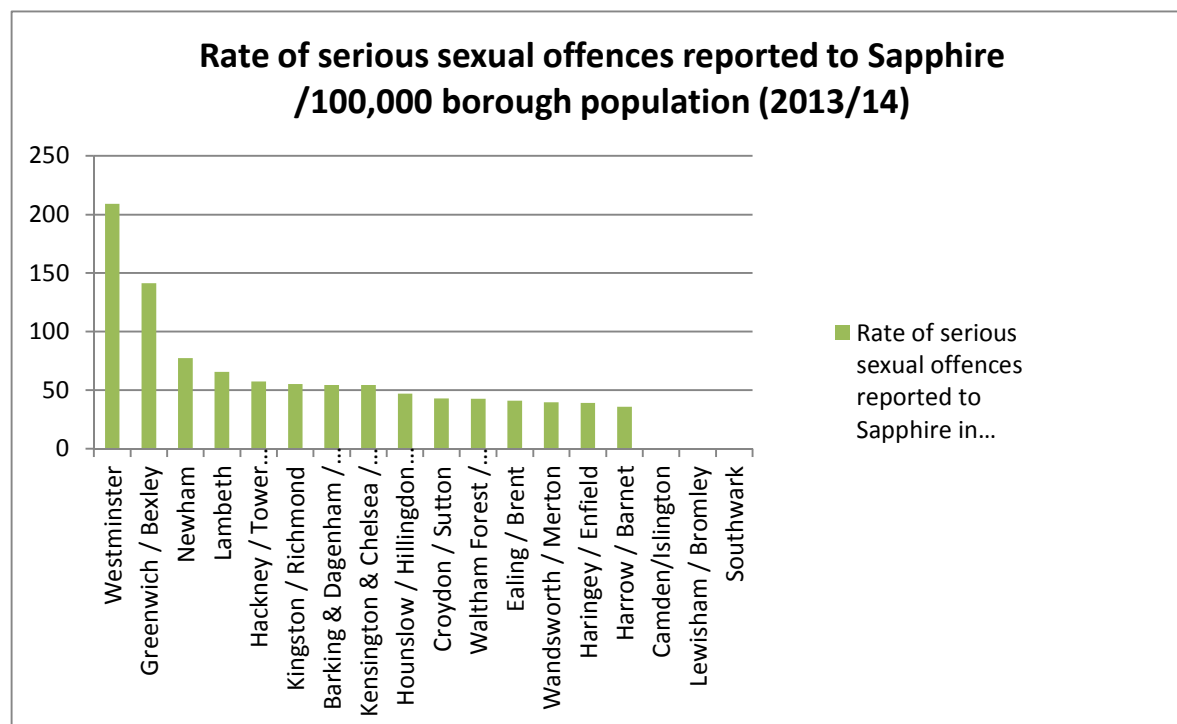
## **14. System capacity and flow**

### **Where are the most serious sexual assaults being reported in London?**

The Met police serious sexual offences data for 2013/14 provides insight into the boroughs with the highest prevalence of reported offences of serious sexual assault. Sapphire teams reported a total of 4110 offences in 2013/14, with Westminster, Greenwich and Bexley, Newham and Lambeth as the boroughs with the highest prevalence of cases of serious sexual offences reported per 100,000 population. CAIT teams reported a total of 1723 offences in 2013/14 with Newham, Bexley and Greenwich, Bromley and Lewisham, Lambeth and Southwark as the boroughs with the highest prevalence of reported offences. It is important to note that this data refers to adults as well as children and young people supported by the CAIT and Sapphire teams.

A Met Police representative said that with the high profile sex abuse cases in the media, there has been an increase in the number of adults coming forward to report child sexual abuse. These cases

are investigated by the CAIT or Sapphire teams and have contributed to a 22-27% rise in cases reported over the last 12 months.



**Figures 6 and 7: Calculated rate of serious sexual offences per 100,000 population by London Borough – date from Sapphire and CAIT teams**

## Reporting and flow of cases

Met police data, for children and young people reporting serious sexual offences, can only be analysed by the offence coding including: rape of under 16 years (13-16 years olds), rape of under 13 years and sexual assault under 13 years. Therefore the following data does not include the cohort of young people 16 and 17 years old. (See notes in reference <sup>61</sup>)

In 2013/4, a total of 2485 children and young people under 16 reported serious sexual offences to the Met Police and of those 1903 were under 13 years old. In the same period the Haven saw 192 children under 16 years, of which 57 were under 13 year olds. Local paediatricians reported approximately 450 cases a year of historic CSA. The number of serious sexual offences and rapes reported to the police, the Havens and local paediatric services are significantly lower than the estimated number of children affected by sexual assault based on prevalence studies.

It has been estimated by the NSPCC study <sup>62</sup> 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. 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.

**Table 5: Estimated reporting and interventions for serious sexual assault and rape in children and young people**

Estimated number of 11-17 year olds experiencing contact sexual abuse each year in London (based on NSPCC study)	12,540
Number of cases of serious sexual assault and rape in under 16 years olds reported to the CAIT and Sapphire teams of the Metropolitan police (2013/14)	2485
Number of under 16 year olds attending the Havens (2013/14)	192
Number of under 18 year olds attending the Havens (2013/14)	347

There are likely numerous reasons why children and young people do not report abuse/assault. Third sector stakeholders suggested that in their experience children's fear of not being believed may be great, along with the child's desire to keep even an abusive family situation stable. Met police officers noted that in their experience children retract statements once they see the impact their disclosure is starting to have on their family.

For others involved in sexual exploitation or gangs there can be a lack of awareness that a sexual assault has taken place. The grooming or the cultural "norm" in gangs means that young people can grow up accepting violent sexual relationships and they have no idea about the concept of consent. Gang members are often threatening to the young person's friends and family network, leading to fear of retribution and lack of disclosure.

These could be some of the causes of under reporting of CSA by children and young people, who then may not be accessing the full range of services available. Stakeholders suggested that many attend Rape Crisis Centres, sexual health clinics or emergency department instead. This differs from the public awareness and open reporting culture in Iceland, where they investigate and support a greater proportion of children and young people at the Child House.

## 15. Research and best practice

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, and support through, the criminal justice systems. This review explored international literature and models of care for victims of CSA in an attempt to identify practices consistent with the United Nations Convention on the Rights of the Child (UNCRC), the Council of Europe guidance regarding Child Friendly Justice and that embody the measures set out by the Lanzarote Convention.

The **Children's House and CAC** are very similar models which are based on the same key principles. Both are widely regarded internationally as examples of best practice. These models have been adopted / adapted into many different criminal justice systems and their effectiveness has been validated by numerous studies. As the models are very similar a full description will only be provided for the Children's House as the research team were able to visit that site.

### Key principles<sup>63</sup>

- 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

### 15.1 Children's House (Barnahus - Iceland)

The Children's House was founded by Bragi Gudbrandsson, General Director of the Government Agency for Child Protection as well as the current Chairman of the Lanzarote Committee. The Children's House opened in 1998 and it serves all of Iceland, which has a total population of approximately 320,000, the majority of whom live in and around Reykjavik. There is also now a second House in the north of the country which can provide some services as well.

The Children's House is located in a residential area of Reykjavik. There is no sign or indication on the house to suggest it is anything other than a regular residential house however inside the house has been adapted into several counselling rooms, two specially appointed interview rooms, two observation rooms (one of which doubles as an examination suite), two age appropriate play areas as well as other staff / storage and facility related areas.

### **The pathway for the child:**

#### **An allegation of CSA is made**

In Iceland, when a child tells someone that he or she has been sexually abused or assaulted, that person reports to children's social services and / or police. In 1999 the legislation in Iceland changed allowing Judges to assume responsibility for the interview process in CSA. Generally the case is referred to a Judge and a prosecutor and defence lawyer are immediately appointed (the defence lawyer is appointed to a theoretical suspect if none has been identified at the time). The Judge phones the Children's House to arrange an appointment for an initial forensic interview. The Children's House typically provides interviews and therapy for children from the age of 3 ½ years (age when children typically become verbal) to 18 years of age, however those over age 15 may be interviewed by the police as is done for adults (at the discretion of the Judge). This process, from initial allegation to initial, interview typically occurs within one to two weeks of the allegation in most cases.

If the allegation is not very clear or it's more uncertain, the case is referred directly to the Children's House for an exploratory interview (and these cases can then be referred to a Judge and a full forensic interview arranged based on the exploratory interview).

The majority of the Icelandic cases involve historic (non-acute) allegations of CSA. If however a case is within the forensic window then the child is referred to either the children's hospital (for younger children) or the rape-crisis centre (older children / teens) for a forensic medical examination. The appointment for forensic interview at the Children's House follows the forensic medical examination in these cases (typically within a few days and as below).

### **The Appointment at the Children's House for forensic interview**

The Judge, prosecutor and defence lawyers all attend the Children's House for the appointment with the child, their family (guardians), social worker, police and the child's legal advocate. The Children's House is effectively an outpost of the court at this time with the Judge presiding.

The child is interviewed in a child-friendly interview room which is fitted with a discrete microphones and a video camera to simultaneously broadcast the interview live to an observation room and record the interview for future use. The Judge, lawyers and all other observers sit in the observation room and watch as the child is interviewed by a specially trained forensic interviewer. The interviewers generally have a background in child psychology and all are trained to use a validated standardised interview protocol (NICHD protocol<sup>64</sup>). The interviewer wears an earpiece so the people in the observation room can communicate with her. The Judge may ask, or permit the attending lawyers to ask, questions of the child via the interviewer to further confirm or clarify information. The interviews typically take less than one hour and occasionally more than one



interview is needed for a younger child with short attention span. The recorded forensic interview qualifies as the child's testimony and the child usually does not need to be interviewed again or ever appear in court.



**Reception area**



**Interview room**



**Therapy room**

### **Medical examination**

Non-forensic medical examinations are done at the Children's House by the paediatrician / gynaecologist / nurse team in a child-friendly room. The examinations are recorded using a colposcope and screening for sexually transmitted infections / treatment provided as indicated. If a

forensic medical examination is required it is arranged prior to the interview at the Children's House in the local children's hospital or rape crisis centre.

## **Therapy**

The recorded interview may also be watched by the psychologist who will go on to provide therapy for the child (always a different psychologist to the one who interviewed for court). The child and their family (guardians) can immediately begin treatment at the Children's House (or locally if they live more than an hour away). Treatment for the child typically involves Trauma-Focused Cognitive Behavioural Therapy. The psychologists from the team regularly travel to other parts of Iceland to provide therapy locally.

## **Best practice**

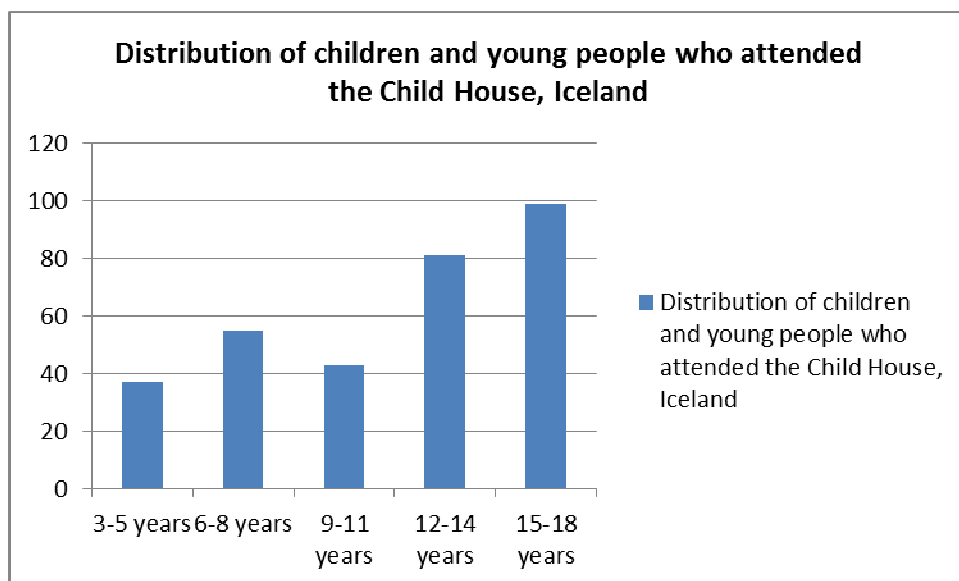
The Children's House has been identified as an example of best practice by Save the Children Europe in their comparative study of European countries<sup>65</sup>. It has received several international awards including by the Multidisciplinary Team Award in 2006 from the International Society for Child Abuse and Neglect (ISPCAN)<sup>66</sup>, it has been highlighted by the Council of Europe as an example of Child Friendly Justice<sup>67</sup>, been a role model for other countries and supported them in developing their own Child House models.

## **Selected statistics obtained during site visit to the Children's House (unpublished data)**

Total number of children interviewed at the Children's House in 2013 was 253 (96 were court interviews, 157 exploratory interviews) with the majority of children seen within two weeks of alleging the abuse. Note: during this year a further 62 older teenagers (15 to 18 years of age) were interviewed by the police in the same format used for adults rather than at the Children's House.

The interview at the Children's House is the evidence that is used in court, effectively completing the court process for the child. They can then begin therapy immediately and that therapy often involves their family. This completion of the court process is substantially shorter than in the UK where it can take 6 months to a year or even longer (from discussions with police). The substantial delay in the UK can impact not only the decision to commence child's psychological support from some providers

The gender distribution of children attending the Children's House was 29% males and 71% females, which is a substantially higher percentage of males as compared to Haven data (< 10%). The age range of children interviewed in Iceland either at the Child's House or by the police includes more young children and less of a peak in the teenage years than seen at the Havens (see Figure 1). However the model in Iceland includes acute and historic cases, unlike the Havens which see only acute cases. The data from London paediatricians interviewed suggests approximately 450 historic cases are seen each year in London in addition to the 400 acute cases seen at Havens on average each year.



**Figure 8: Distribution of children and young people who attended the Child House, Iceland for interviews**

Children and young people attending the Children's House for interview can come for an exploratory interview if there is no clear evidence or disclosure. During court interviews 75% of children disclose assault compared with 38% during exploratory interviews. The team feel that this opportunity for exploratory interviews is a positive and open response to child sexual assault. The percentage of children who report CSA during a police interview in the UK was not obtained but would be very useful to compare. This should be done and compared to results from CAC other international centres with analysis to identify and explore causes of differences in an effort to improve practices.

The Children's House also found that in 85% of children that disclosed child sexual assault, the perpetrator was reported as someone from within their 'circle of trust' (immediate or extended family member, caretaker, friend or teacher).

Since the development of the Children's House, Iceland has seen a two-fold increase in the number of cases being investigated, a three-fold increase in the number of cases brought through to court and a two-fold increase in the number of convictions for CSA post-establishment of Children's House.

The percentage of indicted cases that went onto conviction decreased from nearly 100% (49/50) pre-Children's House to roughly 70% (101/145) now. This is thought to be because pre-Children's House only selected cases were taken through to court (e.g. cases where a conviction was sure). These conviction percentages should also be compared with UK data. Trial processes differ between these two countries though which may make equivalent comparison difficult.

**Table 6: Indictments and Court outcomes pre and post-Children's House**

	Investigations (total number)	Total number of indictments (cases brought to court)	Total number of convictions
<b>Pre-Children's House 1995 – 1997</b>	146	51	49
<b>Post-Children's House 2006-2008</b>	315	155	108
<b>2011 – 2013</b>	267	145	101

## **Epidemiology**

The Children's House was able to provide an estimate of the percentage of the population < 18 years of age in Iceland seen at the Children's House. Overall, based on their attendance statistics, approximately 6 – 7% of children in Iceland will attend the Children's House for CSA by the time they are 18 years of age. The Children's House is seeing a relatively higher proportion of children than the Havens. While estimates regarding the population prevalence of CSA vary, the Children's House figures are probably much closer to the actual prevalence of CSA. In the NSPCC study of UK children, of 11 - 18 year olds surveyed, 4.8 % reported contact sexual abuse at some point in their childhood and 16.5% reported non-contacted sexual abuse. These numbers are similar to estimates of contact and non-contact abuse from other Scandinavian countries<sup>68, 69</sup>.

## **15.2 Child Advocacy Center (CAC) model**

The Child Advocacy Center (CAC) established in the United States in 1985. The aim is to minimise the emotional distress and re-victimisation experienced by children that is caused by the actions of those responding to their allegation of CSA. The CAC model was developed by a District Attorney in Huntsville, Alabama who felt that a lack of coordination in the entire system was harming children, exposing them to repeated interviews and re-traumatising them through this process. He developed a multi-disciplinary team approach to CSA.

The CAC team includes law enforcement, child protection services, members of the criminal justice system, medical (including forensic) and mental health professionals, advocates for the victim and family and other resources. They advocate early therapy for the child and family using trauma focused –cognitive behavioural therapy (see NCAC website for selected bibliography of research)<sup>70</sup>.

The first centre in Alabama became the National CAC (NCAC) and it has served as a model for centres across the United States. There are now over 800 CACs currently operating in a similar manner though each adapted to local area variations. Unlike in the Scandinavian countries, where the organisations are largely government funded, in the United States about 75% of the child advocacy centres are funded by non-profit organisations (they have NGOs working with the public authorities). Their own research has found this multi-disciplinary approach to be more positive for the child, it improves outcomes and also saves costs by eliminating duplication of services. Examinations are free for all children.

In the US there is mandatory reporting laws regarding child abuse for all under 18s. All referrals come to them via child protection services and law enforcement. They do not have self-referral option.

### **Forensic examinations**

Their protocol is similar to the Children's House. If a child is within the forensic window for evidence collection then a medical examination is immediately arranged, pre-interview. They find the medical examination is often therapeutic in itself and commonly there is no evidence recovered. If a child makes a non-acute allegation then the interview is arranged first and a medical examination offered after.

Their forensic interviews are conducted by specially trained interviewers at the CAC rather than by police. Similar to the Children's House the interview is typically observed and questions may be asked via the interviewer. Officers were initially resistant to this change as previously they were the interviewers but feedback since has been very positive and overall they feel the interviews are of better quality with more useful information obtained when performed by the forensic interviewers. Forensic interviewers are provided with regular feedback and peer review as well as supervision. This is a vital part of their process and helps them refine their interview skills.

### **15.3 International uptake of Children's House and CAC model**

The NCAC has been a role model and supported the development of similar centres internationally. It has also become an international training centre and developed an online library of Child Abuse literature / information on best practices. The Office of Juvenile Justice and Delinquency Prevention funded a study to compared communities with and without CACs<sup>71</sup>. They found that CACs were able to help coordinate agencies and facilitate medical examinations. They did not observe differences in criminal justice outcomes between the different areas and found that most children were interviewed only once or twice regardless of the area.

Variations of these models (Children's House and CAC) have now been developed and are in operation in numerous countries including Australia, Belarus, Canada, Croatia, Cuba, Denmark, Greenland, Guyana, Israel, Latvia, Mexico, New Zealand, Norway, Philippines, Poland, South Africa, Sweden and Turkey<sup>72</sup> and are in development in others such as Finland. Some have reported back on their experiences and while there are individual issues for each transitioning to this model, overall the model appears to be effective and adaptable. The full adaptation of the model developed in each country varies with some centres taking up the whole model and others partially implementing the model.

**In Sweden (population roughly 9.6 million)** for example, there are 31 Children's Houses currently (compared to none ten years ago). There are regional variations but approximately 80% of the child population is now covered by one of these houses. In 4/31 they offer all four components of their model (criminal investigation, social welfare protection, physical and mental health). In 16 they offer 3 of those components and in 3 only two components are provided. They plan to set standards for their Children's Houses, develop a manual for assessment and regularly assess them. They would like to see all houses provide all four components and to provide access to these houses for their entire population<sup>73, 74</sup>.

**In Norway (population roughly 5 million)** the Children's Houses were established in 2007 and a review was completed in 2012. There are now several houses across Norway operating in at least 10 cities where judicial interviews, medical examinations and all follow up services can be provided. The centres also facilitate cooperation between and among other agencies involved in violence and abuse work. Their 2012 review identified capacity issues with demand outstripping capacity and plans were put in place to increase staffing levels<sup>75</sup>.

**In Belarus (population roughly 9.5 million)** they have worked with the World Childhood Foundation and Ponimanie to develop child-friendly investigations based in the UNCRC principles. In Belarus Ponimanie has trained psychologists, police officers and prosecutors in interview techniques and child psychology. They now have several facilities with child friendly interview rooms, with video-recording potential. These can be video linked to court, and two treatment facilities in Children's Hospitals are in development. Historically the interviewers have been police but they have now specially trained psychologist interviewers. There has been a mixed response from law enforcement. They also provide trauma focused cognitive behavioural therapy among other types of treatments.

**New Zealand** has another type of multi-agency model for children neglected, physically, sexually or emotionally abused called Starship Paediatric Te Puaruruhau. This service is provided in facility where police and the Department of Child, Youth and Family are co-located. The centre provides 24 hour urgent medical care for acute abuse as well as social work assessments.

### **Summary of UK guidance and international experience**

- The criminal justice system should be made to fit the child, not vice versa
- The child should be interviewed by someone specifically trained, in a child-friendly space
- Interviewers should have regular peer-review and feedback on their interview techniques
- Ideally interviews should be live witnessed as well as recorded and ideally they should be presided over by a Judge with the defence and prosecution in attendance and able to question the child via the interviewer
- This recorded interview should suffice as the child's testimony for court and should be completed as soon as possible / practical after the allegation is made
- Forensic medical examinations / examinations in cases of historic abuse should occur as indicated either before or after the forensic interview
- Therapy should be offered to all children (and their family) as should support and advocacy
- There should be a multi-disciplinary team developed around the child and the child should be at the centre of all decision making
- In addition, peer review and feedback should be provided to all other parties (including social services, advocates, medical, psychological, police and criminal justice)
- Cases should be reviewed with outcomes recorded and fed back to all parties in each case and forensic results should be fed back to examining doctors to inform their practice<sup>76</sup>
- Ideally a multi-disciplinary team should be developed around the child including criminal justice colleagues, social services, counselling, medical care and advocacy

## **Recommendations from research and best practice**

In order to estimate the number of centres that this model would need in London, the review looked at the number of centres serving a similar sized city (New York City population 8.4 million, London 8.3 million). New York City currently has five CACs and therefore a minimum of 5 centres would be recommended if the Child House model is adopted in London. In comparison, Sweden (population 9.4 million) has 31 centres providing variations on the model.

The review also advises the development of an academic centre of research and knowledge regarding CSA in London. This academic centre could include research on epidemiology of CSA and STIs, medical examination findings and forensic results, best practice in evaluations and follow up care, prevention, mental health outcomes, therapy and effectiveness, longer term consequences of CSA, criminal justice process and outcomes and children and families' views and suggestions.

## **16. 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.

### **16.1 Commissioning**

NHS England and MOPAC commission the current sexual assault referral centres (SARCs) in London provided by the Havens, Kings 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 under 13 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.

## **16.2 The Havens – sexual assault referral centres**

The Havens services were well received by the children and young people attending who have been sexually assaulted. Seeking the views of young people from the Department of Health/Haven research study, 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.

### **16.3 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 GUM clinic or gynaecology background), 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 services 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.

#### **16.4 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; their 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.

#### **16.5 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 followed 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.

## **16.6 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.

### **16.7 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 still 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. Training for signs of exploitation, how to respond to disclosure from a child, educating children in healthy relationships and sexual behaviours and advertising services available. 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 Children’s ISVA’s (CHISVA) 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

### **16.8 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

## 17. 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 inequality 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 under 18 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 under 13s 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 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 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

## 18. 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.

- **1<sup>st</sup> choice and medium-term goal:** Children’s House (Barnahus) model x3-5 locations in London
- **2<sup>nd</sup> 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 4<sup>th</sup> 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.

### 18.1 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.

## 18.2 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 inequality 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.

### **18.3 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.

#### 18.4 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.

#### 18.5 Options appraisal and recommended models:

	Pro's	Con's
<b>Children's House</b>	<ul style="list-style-type: none"> <li>• International best practice</li> <li>• Child focused, holistic service</li> <li>• Faster court process with potential for improved prosecution outcomes (benefit for child and society)</li> <li>• Medical examination and follow-up standardised</li> <li>• Long-term emotional support with no waiting</li> </ul>	<ul style="list-style-type: none"> <li>• Dependent on collaborative commissioning</li> <li>• Significant investment by all stakeholders in buildings and staffing</li> <li>• Travel time to one of 3-5 Child Houses</li> <li>•</li> </ul>

<b>Child Sexual Abuse Hub and spoke</b>	<ul style="list-style-type: none"> <li>• Child focused, holistic service</li> <li>• Local hub of expertise to support frontline staff</li> <li>• Medical examination and follow-up standardised</li> <li>• Streamlined services with potential for reduced access times into CAMHS</li> </ul>	<ul style="list-style-type: none"> <li>• Dependent on collaborative commissioning</li> <li>• May require reinvestment into CAMHS in some boroughs</li> <li>• Travel times reduced to one of five to seven centres</li> </ul>
<b>Paediatric Haven Plus</b>	<ul style="list-style-type: none"> <li>• Equitable services for children of all ages</li> <li>• Provision of bridging psychological support</li> <li>• Continuity of medical care</li> <li>• Good use of new Havens paediatric space(already funded)</li> <li>• New staffing investment only</li> </ul>	<ul style="list-style-type: none"> <li>• Cost for additional medical and psychological support in Havens</li> <li>• Travel time for initial and first follow-up appointment only</li> </ul>
<b>One Paediatric SARC for London</b>	<ul style="list-style-type: none"> <li>• One centre of expertise in London acute / historic</li> <li>• Option for local paediatricians to in-reach and maintain experience</li> <li>• Potential for academic centre of research</li> </ul>	<ul style="list-style-type: none"> <li>• Potential loss of paediatric experience in Boroughs</li> <li>• Significant investment in new building and staffing</li> <li>• Travel time to one centre for all appointments for up 1-2 yrs</li> <li>• Support not integrated with local borough services</li> </ul>
<b>No change</b>	<ul style="list-style-type: none"> <li>• No action required</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of medical and emotional support for children and young people</li> <li>• Continued inequity of service for children and young people</li> <li>• Unable to break the cycle of child sexual abuse</li> </ul>

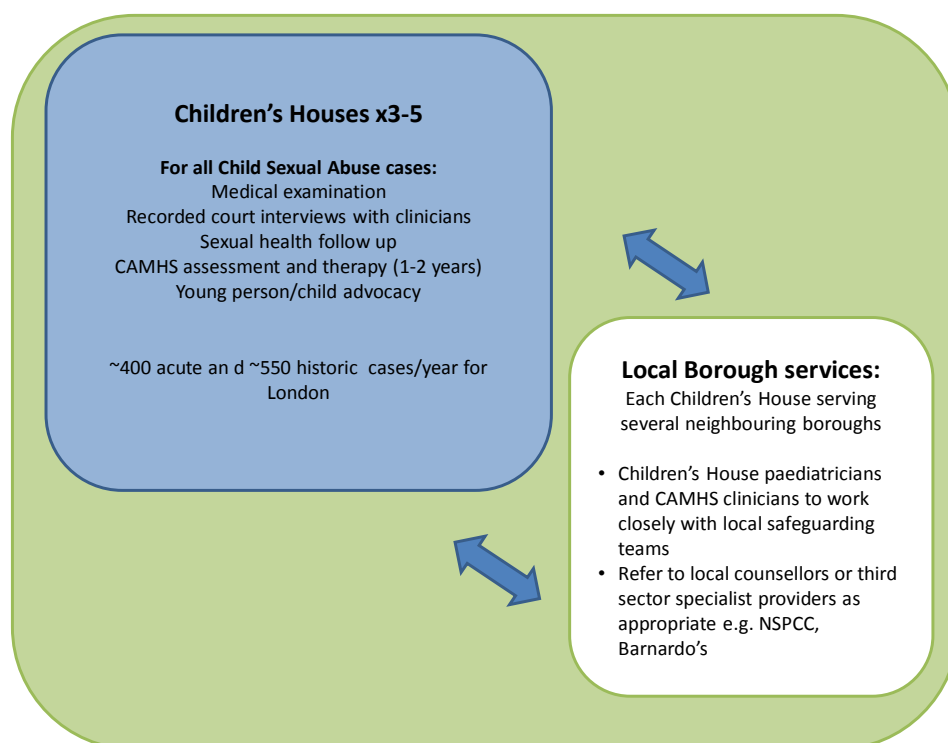
**This review recommends the Children's House model** should be the vision for the care of children and young people following acute and historic sexual assault in London and the UK, in line with the Lanzarote Convention, the UN Convention on the Rights of the Child and in line with the principles of 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 inequalities of service.

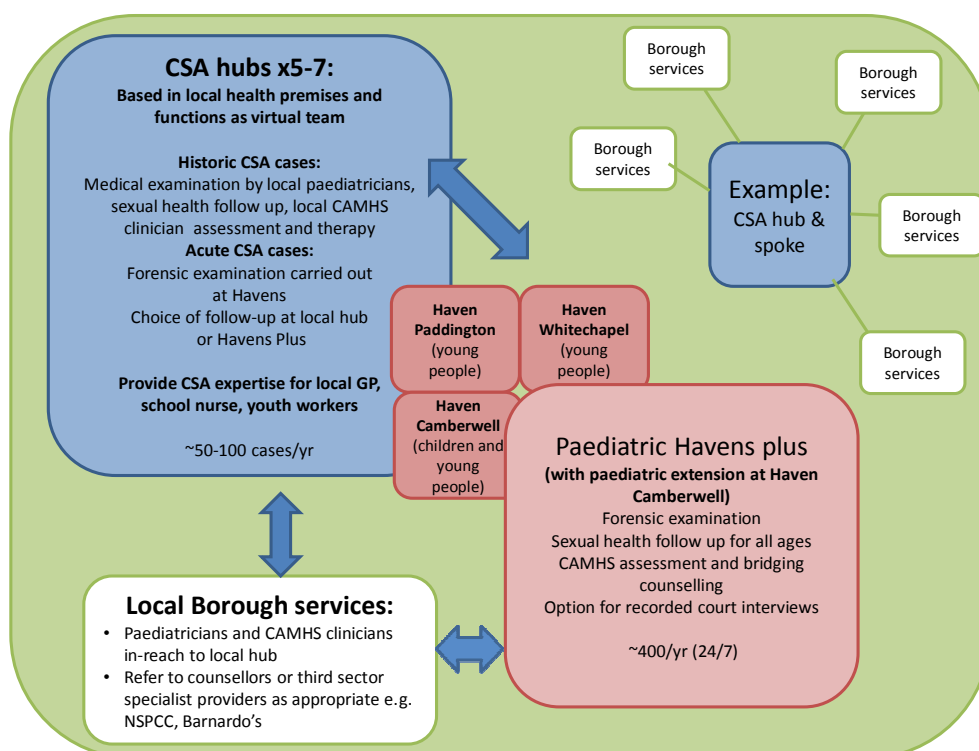
## 1<sup>st</sup> Choice – Children’s Houses for London

Children’s House model – 3-5 sites



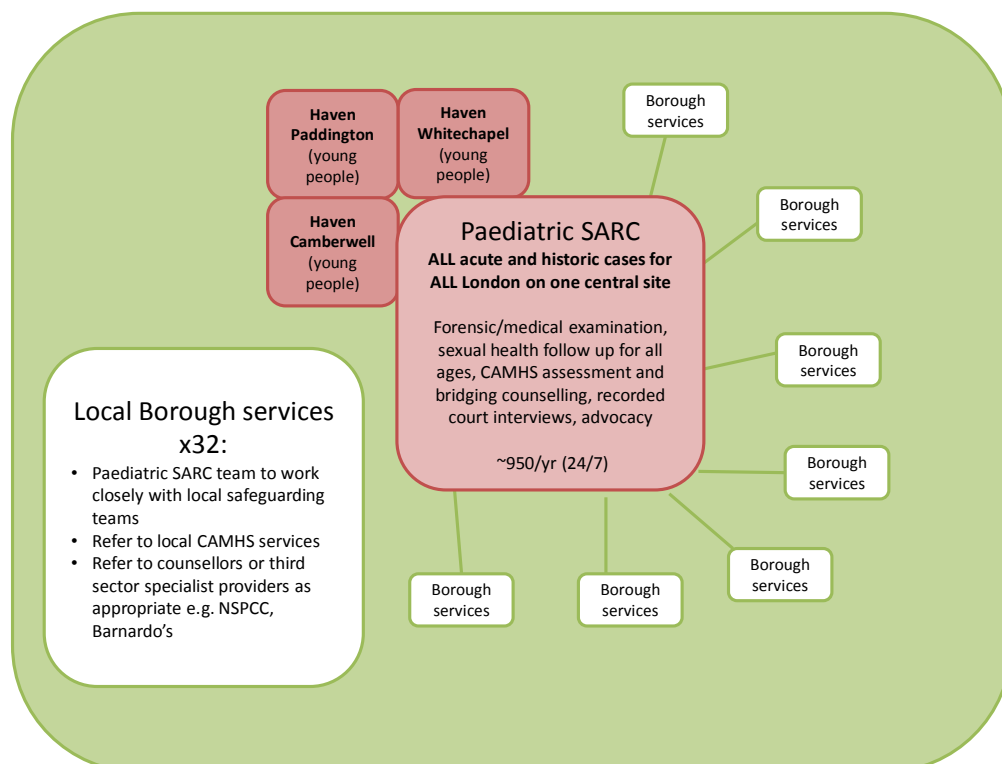
## 2<sup>nd</sup> Choice – Child Sexual Abuse Hubs and Paediatric Havens Plus

Child Sexual Abuse Hubs – 5-7 sites



### 3<sup>rd</sup> Choice – One paediatric SARC for London

#### One Havens paediatric SARC



#### 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	<ul style="list-style-type: none"> <li>Child sexual abuse hubs developed from collaboration of existing services and co-commissioning</li> <li>Paediatric Haven Plus established including building of child friendly suite and recruitment of additional staffing</li> <li>Local redesign workshops for future Children's House model</li> <li>Pilot of Children's House model in one locality</li> </ul>
2016/17	<ul style="list-style-type: none"> <li>Child sexual abuse hubs established covering all London Boroughs and additional staffing commissioned as required</li> <li>Children's Houses co-designed, consulted on and tendered across London</li> </ul>
2017/18	<ul style="list-style-type: none"> <li>Children's Houses established in London covering all boroughs</li> </ul>

### 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 **Appendix 1** 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

## 18.6 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.

## 18.7 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 1: Key articles of the UNCRC relating to child sexual abuse/assault from United Nations Human Rights

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>

*Article 3.1: In all actions concerning children, whether undertaken by public or private social welfare institutions, courts, administrative authorities or legislative bodies, the child shall be a primary consideration.*

*Article 3.3: States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.*

*Article 19.1: States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.*

*Article 19.2: Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as other forms of prevention and identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and,*

*Article 34: States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent: a) the inducement or coercion of a child to engage in any unlawful sexual activity; b) the exploitative use of children in prostitution or other unlawful sexual practices; c) the exploitative use of children in pornographic performances and materials.*

*Article 39: States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.*

## Appendix 2: Suggested Child House or Child Sexual Assault hub locations

The following are some suggestions of locations for Hubs and Child Houses 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 Kings 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

## Useful websites

UNICEF

<http://www.unicef.org/rightsite/>

[http://www.unicef.org/crc/files/Rights\\_overview.pdf](http://www.unicef.org/crc/files/Rights_overview.pdf)

UK Government

<https://www.gov.uk/government/policies/creating-a-fairer-and-more-equal-society/supporting-pages/the-united-nations-convention-on-the-rights-of-the-child-uncrc>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/296368/uncrc\\_how\\_legislation\\_underpins\\_implementation\\_in\\_england\\_march\\_2010.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/296368/uncrc_how_legislation_underpins_implementation_in_england_march_2010.pdf)

## Regarding the Lanzarote Convention

Council of Europe

The Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, Briefing updated on 5 May 2014

[http://www.coe.int/t/dghl/standardsetting/children/BriefingLanzaroteMay2014\\_en.pdf](http://www.coe.int/t/dghl/standardsetting/children/BriefingLanzaroteMay2014_en.pdf)

[http://www.coe.int/t/dghl/standardsetting/children/ECPATInternational\\_en.pdf](http://www.coe.int/t/dghl/standardsetting/children/ECPATInternational_en.pdf)

UK

<http://www.publications.parliament.uk/pa/cm201415/cmselect/cmcumeds/517/51704.htm>

ECPAT UK

<http://www.ecpat.org.uk/content/council-europe-lanzarote-convention>

## Additional studies regarding countries not discussed

Northern Ireland <http://www.dhsspsni.gov.uk/csereport181114.pdf>

Ireland <http://www.hse.ie/eng/services/Publications/corporate/sexualabuseservices.pdf> and [http://health.gov.ie/wp-content/uploads/2014/05/sexual\\_assault.pdf](http://health.gov.ie/wp-content/uploads/2014/05/sexual_assault.pdf)

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