NHS England

Healthy London Partnership

London Child Sexual Abuse Services Learning Report

November 2018

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Learning and outcomes from the implementation of Child Sexual Abuse services in London 2015-2018

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Contents

Glossary of acronyms

ABE – Achieving Best Evidence
CAMHS – Child and Adolescent Mental Health Service
CAIT – Child Abuse Investigation Team
CCG – Clinical Commissioning Group
CIN – Child In Need
CPS – Crown Prosecution Service
CSA – Child Sexual Abuse
CSE – Child Sexual Exploitation
CYP – Children and Young People
DNA – Deoxyribonucleic Acid
FME – Forensic Medical Examination/Examiner
GP – General Practitioner
IICSA - Independent Inquiry into Child Sexual Abuse
ISVA – Independent Sexual Violence Advocate
LTFI – Letting The Future In
MASH – Multiagency Safeguarding Hub
MOPAC – Mayor's Office for Policing and Crime
MOSAC – Mothers of Sexually Abused Children
NCL- North Central London
NHS - National Health Service
NICE – National Institute of Clinical Excellence
NSPCC – National Society for the Prevention of Cruelty to Children
PTSD – Post-Traumatic Stress Disorder
RCPCH - Royal College of Physicians and Child Health
SARC – Sexual Assault Referral Centre
SCIE – Social Care Institute for Excellence
SLA – Service Level Agreement
STARS - Sexual Trauma Assessment, Recovery and Support
STI - Sexually Transmitted Infection
SWL – South West London
TSCC – Trauma Symptom Checklist Children
TSCYC - Trauma Symptom Checklist for Young Children
UCLH – University College London Hospital
VRI - Visually Recorded Forensic Interview
WTE – Whole Time Equivalent

1 Executive summary

This report details the learning during the implementation of Child Sexual Abuse (CSA) services in London as part of the CSA Transformation Programme 2015-2018. The CSA Transformation Programme set out to pilot three approaches to supporting children and young people after experiencing CSA. These three models were the Children and Young People's Haven Service (CYP Havens) based within London's Sexual Assault Referral Centre (SARC), the Child House model and Child Sexual Abuse (CSA) hubs.

The report details the service offer, roles and referral pathway of the CYP Havens service, the North Central London (NCL) CSA Hub and the South West London (SWL) CSA service. Outcomes and service user feedback for each service are provided. The report goes on to look at the operational and systemic challenges that were faced in delivering the change across London.

The CSA services all demonstrate the benefit of a multiagency team providing holistic health support and case management. As the CYP Havens expands services and the Child House pilot commences more learning about this will emerge.

The early emotional support element of the services has provided symptom management, case management, advocacy and signposting for children, young people and their families. Access to early emotional support sends the message that the child is believed and there is a direct response to their disclosure: that their mental and emotional wellbeing matters irrespective of the outcome of a criminal case.

Whilst all three CSA services noted the limitation of short-term support, they were able to be flexible to accommodate those children and young people with increased needs. Following the interventions, 18-40% of children and young people required referral on for further long-term support from Child and Adolescent Mental Health Services (CAMHS), third sector or other services. The referral on rates ranged from 18% in the NCL CSA hub, 31% in the SWL CSA service and 40% of children and young people seen at CYP Havens.

Long waiting lists for onward referral into CAMHS and specialist independent sector providers were concerns for all three CSA services and further work is required to move towards trusted referrals to minimise re-assessment and transition issues.

There needs to be continuous communication, training and awareness-raising across partner agencies, especially police and social care. High levels of staff turnover require consistent communications to ensure that all staff understand the impact of the trauma of CSA and the pathway for support.

There remain challenges in delivering a child centred criminal justice process. These challenges need addressing if children and young people are to receive the justice that they deserve without being re-traumatised through the process.

This report has detailed recommendations throughout sections 10 and 11 that relate to each of the operational and systemic challenges faced. The report should be read in conjunction with the 2015 London CSA pathway review and CSA hub Toolkit

2 Background to the CSA Transformation Programme

At present, few children and young people who have been sexually assaulted or abused ever come to the attention of police, social care or health providers; and even fewer in the period soon after the abuse. Children and young people face a variety of obstacles in accessing care and support. The services on offer and their accessibility vary widely.

The NSPCC in 2011 reported that 9.4% of 11 to 17-year olds surveyed experienced sexual abuse (including non-contact sexual abuse) and 4.8% of 11 to 17 years olds experienced contact sexual abuse. This is the same as childhood asthma (9%) and more common than diabetes (2.5%), and yet many of these children are hidden from sight. When they do come forward, National Institute of Clinical Excellence (NICE) guidance[i] recommends that all children and young people who have experienced sexual abuse should be able to expect:

- A safe place to live
- Being listened to and believed
- That they can tell their story
- Early emotional support e.g. strategies for coping with feelings, emotional resilience and symptoms that impact on returning to normal daily life
- A reduction in risk of further abuse

And yet that is not always the experience they report.

In 2015, NHS England (London) and the Mayor's Office for Policing and Crime (MOPAC) commissioned the "Review of the pathway following Children's Sexual Abuse in London" (The CSA Review). The CSA Review recommended the development of improved forensic services for children and young people at The Havens (London's SARC), a pilot of the Child House model (international best practice) and, as a first step, the establishment of Child Sexual Abuse (CSA) hubs in London.

The CYP Havens provides a forensic medical examination service and collection of DNA and medical evidence. In addition to their 24/7 forensic service, they now offer a paediatric-led daytime service, signposting, advocacy and a psychologist-led mental wellbeing service providing early emotional support. The CYP Havens is piloting the use of clinical psychologists in leading 'Achieving Best Evidence' (ABE) interviews for criminal prosecution.

The Child House model is a multiagency service model for children and young people following CSA or child sexual exploitation (CSE). The model was further recommended in 2015 by the Children's Commissioner for England and is supported by the Home Secretary and Mayor of London. The Home Office, NHS England, MOPAC and Department of Education have funded a national proof of concept of the Child House model in London based on the international Barnahus model.

CSA hubs provide a local one-stop-shop for medical treatment, advocacy and early emotional support for children and young people experiencing sexual abuse, where there is no need for collection of DNA evidence. The hubs also support non-abusing family and carers, provide case management and offer advice and guidance to police and children's social care services.

In 2016 the CSA Transformation Programme enabled the establishment of CSA hubs in North Central and South West London, funded by the Department of Health and local Clinical Commissioning Groups (CCG) respectively. During 2018 the CSA Transformation Programme supported South East, North West and North East London to commission CSA hub services, learning from the outcomes of North Central and South West London CSA hubs.

3 National best practice and guidance

Under sections 10 and 11 of the Children Act 1989 (s17), every local authority has a duty to safeguard and promote the welfare of children within their area. The Children Act 2004 extends this duty to the local authority's partners, including health, the police, probation and youth offending and education services, by requiring them to co-operate to improve local children's well-being, protect them from harm and promote their welfare. This applies to children who have experienced sexual abuse and exploitation.

CSA and CSE require a multiagency response to support the child or young person, their siblings and non-abusing family or carers. Working Together to Safeguard Children 2018[ii] provides statutory guidance reminding us that safeguarding children is everyone's business and that:

- A child centred approach is fundamental to safeguarding and promoting the welfare of every child

- The welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary

- Everyone who works with children has a responsibility for keeping them safe

- Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them and their families collaboratively when deciding how to support their needs

- Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children. Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children, which must always be the paramount concern.

There is a wealth of NICE guidelines related to CSA and the impact of trauma including those related to child abuse and neglect, looked after children, depression, anxiety, self-harm, child maltreatment, and sexually transmitted infections.

The joint Social Care Institute for Excellence (SCIE)/NICE guideline for Child Abuse and Neglect (NG76) published in 2017 provides guidance on emotional support for children and young people who have experienced sexual abuse. It recommends evidence-based programmes that emphasise the importance of the therapeutic relationship between the child and therapist and offer support drawing on a range of approaches including counselling, socio-educative and creative approaches (such as drama or art).

It is recommended that individual work with the child (up to 20 to 30 sessions) is conducted in parallel with work with non-abusing parents or carers (up to eight sessions). The guidance also recommends considering individual psychoanalytic therapy or group psychotherapeutic sessions; as well as considering group or individual trauma-focused cognitive behavioural therapy for children and young people who show symptoms of anxiety, sexualised behaviour or Post-Traumatic Stress Disorder (PTSD).

Guidance for undertaking CSA medicals was provided by the Royal College of Physicians and Child Health (RCPCH) in 2015[iii] and provides information on staffing, equipment and premises, as well as training and ongoing peer review. Some key requirements include: suitably trained examiners, quarterly peer review, video colposcopy equipment, digital storage of images, a child friendly environment, chain of evidence processes and sufficient throughput of cases to maintain competency.

NHS England launched the Strategic Direction for Sexual Assault and Abuse Services[iv] in April 2018 which sets out a vision to support victims and survivors to recover, heal and rebuild their lives.

The focus of the strategy is:

- strengthening the approach to prevention
- promoting safeguarding, safety, protection and welfare of victims and survivors
- involving victims and survivors in developing and improving services
- introducing consistent quality standards
- driving collaboration and reducing fragmentation
- ensuring an appropriately trained workforce

NHS England is committed to an increase in investment in sexual assault services. This will drive collaboration nationally and locally and will support the development of sexual assault and abuse services pathways.

The Home Office is preparing a Child House Strategy which will demonstrate the application of international best practice in CSA services and key principles to create an optimal service in England and Wales. There is significant interest amongst agencies across the United Kingdom to improve services for children and young people who experience sexual abuse and an increasing network of learning and best practice.

4 International best practice

The Barnahus model (Scandinavia)[v] and the Child Advocacy Centres (USA and Canada)[vi] are models of best practice which can be emulated in England and Wales to improve services for children who are victims of CSA.

Some key principles to be adopted are:

- Child-centred – jointly planning with the child or young person the services and support they receive
- Flexible and responsive to need
- Trauma-informed
- Easy and early access to emotional and mental health support – meeting the advocate and CAMHS professional on the same day as medical assessment
- A team that listen to the child
- A team that is co-located
- Focus on the recovery of the child, whether or not there is an ongoing criminal justice process
- Working in partnership across agencies
- A holistic service with space for children and young people to share broader concerns
- Offering support to non-abusing parents, carers and siblings
- Outreach and not just clinic-based
- Balancing confidentiality with the need to share information to safeguard the child or young person
- Providing expertise and advice for professionals

These key principles of international best practice have shaped the 'Child House' model which was recommended in 2015 in the London CSA pathway review and informed the CYP Havens and CSA hub models in London.

5 Principles of transforming CSA services in London

The London CSA hubs make best use of existing paediatric and independent sector services, create a network of expertise and deliver additional early emotional support. The CSA hub is a first step towards the Child House model, starting the cultural change and enabling system change to better support children and families. A co-located team of paediatrician, play specialist, advocate and CAMHS practitioners provide a holistic assessment in a weekly clinic with follow up closer to home.

The CYP Havens service provides a one-stop-shop for urgent cases requiring forensic examination. To meet demand, they have invested in paediatricians, a child and family nurse advocacy team and clinical psychologists to create a multi-disciplinary team. They have built on multi-agency working with police and social care and established stronger links with the CPS and social care, with plans to add a social care liaison officer to the team in 2018.

Both the CSA Hubs and the CYP Havens facilitate early access to emotional and mental health support, enabling children and families to meet the advocate and CAMHS professional on the same day as medical assessment. There is evidence that early access to CAMHS or advocacy services reduces progression to PTSD and the need for long-term mental health intervention. Studies by Hahn[vii] and Berkowitz[viii] show that intervention within 4-6 weeks of a trauma or disclosure has been shown to decrease long term post-traumatic disorders.

Both CSA Hub and CYP Havens services focus on the recovery of the child, whether or not there is an ongoing criminal justice process. They offer a holistic service with space for children and young people to share broader concerns. A key element identified by the services, especially in cases of young children, has been to offer support to parents, carers and siblings, or another trusted adult. Where service capacity allows, the advocacy and CAMHS support is not just clinic-based and is provided as outreach.

The London CSA services are becoming centres of expertise and now offer specialist advice to social workers, police officers, sexual health colleagues and others. Signposting and case management is a key part of the support offered to children. The CYP Havens provides a training programme for paediatricians and has developed an extended professional network including CSE leads, independent sector providers, CAMHS, paediatricians, children's social care, multiagency safeguarding hubs (MASH) and police child abuse teams.

Both the CSA services and the CYP Havens offer elements of the Child House model but without significant investment, it is not possible to aspire to all elements. The differences are detailed in the table below.

Table 1: Differences between CSA hub, CYP Havens and Child House models

	CYP Havens	CSA Hub*	Child House
Multi-agency team	• Paediatrician • Paediatric Nurse • Clinical Psychologist • Family Nurse Advocate • Young Person's Advocate • Crisis Worker • Police Liaison Officer • Social Care Liaison Officer (planned)	• Paediatrician • Early emotional support team which may include therapeutic practitioners and advocates • Play Specialist where available	• Paediatrician • Sexual Health Nurse • Therapeutic practitioner • Advocate • Play Specialist • Police Liaison Officer • Social Care Liaison Officers
Service offer	Holistic paediatric assessment with paediatrician and crisis worker or advocate. Sexual health screening/treatment Early emotional support – on average 6-8 sessions Case management and referral onto local long-term services Psychology-led Forensic Interview Pilot Over 16-year olds can access adult counselling services	Holistic paediatric assessment with paediatrician, early emotional support practitioner and/or advocate, and play specialist where available Early emotional support – on average 6-8 sessions Case management and referral onto local long-term services	Holistic paediatric assessment with paediatrician, play specialist, therapeutic practitioner and advocate Sexual health screening/treatment Early emotional support Long-term therapeutic support for child and family up to 2 years Psychology-led Forensic Interview Pilot Police and social care liaison to facilitate the criminal justice process
Availability	24/7 for acute forensic medical examinations Mon-Fri daytime service for all other aspects of service	Regular clinic for non-recent cases of CSA for paediatric assessment and emotional support delivered flexibly	Daily service with extended hours and weekend opening

		and often as outreach	
Commissioning model	Jointly commissioned by MOPAC and NHS England (London) at a pan-London level	Predominantly utilise existing commissioned services • Community paediatricians • Clinic in existing health premises • Local follow up Additional commissioning of early emotional support North West London CSA Hub funded by NHS England and other sectors funded by local STPs	Jointly funded by the Home Office, MOPAC and NHS England (London), Department for Education Commissioned by NHS England (London)

*currently CSA hub services are available in North Central, South West and North West London. Lambeth, Southwark and Lewisham have commissioned a CSA hub service. North East London is currently working towards establishing a CSA hub.

6 Key roles in holistic CSA health services

6.1 Paediatrician

Paediatricians may carry out either forensic medical examinations (FMEs) or general paediatric assessments following disclosure of sexual abuse, depending on the timing of the disclosure.

Both FME and general paediatric assessments are holistic assessments that include a medical examination to identify signs of sexual or other abuse with documentation of injury related to the allegation or other injuries (abuse or non-abuse related), a general top-to-toe health check, screening for sexually transmitted infections (STIs) with samples sent to the laboratory with a chain of evidence form. The paediatrician will also provide or arrange for vaccinations, treatment or other medical care as identified. Further discussion includes answering questions from the child or young person and their family, providing information on sexual abuse and keeping safe, creating a management plan and follow-up. The paediatrician will also liaise with other agencies and contribute to safeguarding processes and procedures.

Paediatric assessments provide reassurance to parents and can provide evidence in civil, family court or criminal proceedings. They also assist with assessment and care planning goals for social care and local medical professionals.
If a child or young person does not wish to be examined, they are never forced. In these cases, the team still provide assessment through consultation and share findings with relevant services and professionals.

6.2 Advocate

Advocacy services offer holistic, child-led support, advice and advocacy in person and over the phone around the criminal justice process, housing and in accessing other relevant support. An advocate supports children and young people to communicate their wishes and feelings and helps them get the services they need, all the while guiding and supporting them through the process. They will liaise with other agencies on behalf of the child or family and contribute to safeguarding processes and procedures. Advocates will also assist in other forums such as child protection conferences and strategy meetings.

6.3 Early Emotional Support Practitioner

Early emotional support provided by the CYP Havens and CSA services in North Central and South West London focuses on assessment and brief intervention. Approaches differ across the three services however all provide early help for children, young people and their families to understand the impact of trauma, regulate their emotions and manage symptoms. Through a series of 6-8 sessions the early emotional support practitioner supports the child or young person and their family, as best meets the needs of the child. Long term emotional support needs are identified, and referrals made to local CAMHS, school counsellors or independent sector specialist providers as required.

7 CYP Havens service

7.1 Team and Service Offer

The CYP Havens Service is part of the Havens SARC, and provides services for children and adolescents presenting after sexual abuse or assault. The service is based in a purpose-built and child-friendly centre at King's College Hospital, Camberwell, however services can be provided across all three Haven sites in London. The other sites are in Paddington and Whitechapel.

The CYP Havens provides:

- Expert advice and consultation on child sexual abuse and assault during normal working hours via a multidisciplinary team
- Forensic medical examination and documentation of injuries for children and adolescents who have experienced sexual assault or abuse: 24 hours a day, seven days a week.
- Holistic child protection medical examinations during normal working hours for children under 13 years for broadly up to 3 weeks following assault and for adolescents 13-17 years up to 1 year following assault.
- Follow up after-care for children and adolescents. This includes medical care, STI screening with medical follow up, advocacy and psychology services.
- The CYP Advocacy Service provides specialist advocates for children (0 to 12 years) and adolescents (13 to 17 years)

- The CYP Clinical Psychology Service provides assessment and a brief intervention to children and adolescents, and their families
- The Psychology Forensic Interview Service is a pilot being run in conjunction with the Metropolitan Police, in which police interviews are led by Clinical Psychologists working with investigating police officers.

The CYP Havens is a service funded by NHS England (London) and MOPAC and is provided by King's College Hospital NHS Foundation Trust.

7.1.1 Timeframe for Support

The CYP Havens sees all children and adolescents who have experienced sexual assault within the last seven days, requiring a forensic medical examination (the 'forensic window'). If the assault occurred just outside of seven days, a forensic medical examination may still be appropriate.

Outside of the 'forensic window', the CYP Havens sees adolescents where the assault occurred within the past twelve months. They receive an examination, medical treatment, advocacy and clinical psychology brief intervention.

The CYP Havens also sees children aged 0-12 years presenting up to 3 weeks after the assault, for medical, advocacy and clinical psychology services. Care coordination and signposting to appropriate local services is provided.

7.1.2 The CYP Forensic Interview Service

The CYP Forensic Interview Service is a pilot in which children and young people under the age of 18 and residing in London who disclose child sexual abuse are being offered a Visually Recorded Forensic Interview (VRI) with a specially trained Clinical Psychologist. These interviews substitute standard ABE interviews which are led by police officers within a police station.

It is based on the Barnahus Model: a model adopted by many different criminal justice systems. It has been proven to be effective and is in line with the United Nations Convention on Rights of the Child and it embodies the principles of child friendly justice.

The VRI is supervised by the police, who remain responsible for the quality of the interview, but Clinical Psychologists lead the interview. Registered intermediaries are used when required. Training and supervision are provided by the police.

The pilot's aim is to make it easier for children and young people to tell what happened and to be calmer and more comfortable during the interview, thereby leading to a fuller account and improved criminal justice outcomes. In some European countries, albeit with different criminal justice systems, this approach is used and is proven to be successful.

7.2 Roles in the CYP Havens

The CYP Havens service is delivered by a multidisciplinary team made up of paediatricians, sexual offences examiners, advocates and clinical psychologists. The team reviews cases at a weekly multi-disciplinary safeguarding meeting to ensure a joint care approach.

The general roles of the health professionals are described in section 5 above. Specific details of the advocacy and emotional support services are as follows:

7.2.1 Paediatrician/ Sexual Offences Examiner

FMEs are provided by the CYP Havens for all under 18-year olds with the primary purpose of collecting forensic evidence and documenting injuries. FMEs are undertaken by a specialist medical sexual offences examiner with support and co-assessment from a consultant paediatrician. Either doctor may be called as a professional witness in a criminal trial.

General medical examinations are provided if there is no requirement for FME. These include STI screening and treatment and holistic assessment and care. Medical examinations provide reassurance to parents and can provide evidence in civil, family court or criminal proceedings. They also assist with assessment and care planning goals for social care and local medical professionals.

7.2.2 The CYP Advocacy Service

The CYP advocacy service has a team of three Family Nurse Advocates/support workers for children under 13-year olds; and three Young Person's Independent Sexual Violence Advocates (ISVAs) for 13 to 19-year olds.

The Family Nurse Advocacy team is generally the first point of access for parents/primary care givers. Through a telephone call they explain the process prior to the child's visit. On arrival they ensure that the carers consent and that the child themselves understands why they are at the Havens. They then provide on-going care to the child and their parent/carers. They explain how the case will progress and co-ordinate continuing care, including liaising with schools, signposting to voluntary services, and working with social care, General Practitioners (GPs) and other local medical services. They also provide an expert advice service and can coordinate care with local services, where the child does not attend the Havens.

For adolescents, the Young Person's ISVAs provide practical and emotional support, assess risk and agree care plan goals, contacting the young person within five working days of their FME. The team also provide first stage recovery, safety, stabilisation and psycho-education support for young people prior to referral into counselling or psychology services; whether internally, or where available, externally. They also provide support for young people through the criminal justice system, including at Court.

7.2.3 The CYP Psychology Service

The CYP Psychology Service offers psychological assessment and brief intervention, comprising clinical interview and psychometric and diagnostic assessment. Brief

intervention is 6 sessions with the child or young person, which the parent/carer may also attend. Parents/carers can also access three individual sessions. Brief intervention is typically informed by Trauma-Focused Cognitive Behavioural Therapy, but this will depend on the child's needs. Therapeutic groups and workshops are also available for adolescents and parents/carers.

The service additionally provides support through liaison and onward referral following discharge from the Havens. The service implements an early screening process of all children and young people attending the Havens to identify those at high risk of mental health difficulties.

The CYP Psychology Team, recently expanded in May 2018, comprises two full time clinical psychologists and one part-time senior clinical psychologist. In addition to the clinical service, the team runs the Psychology Forensic Interview Service and provide consultation and training to professionals.

7.2.4 Police Liaison Officer

The CYP Forensic Interview Service is supported by a dedicated Police Liaison Officer, who acts as:

- the primary point of contact between the service and investigating police officers;
- the referral coordinator for children and young people referred to the service by their investigating police officer;
- VRI quality auditor ensuring that VRIs completed as part of the Psychology Forensic Interview pilot meet police standards
- part of the CYP Havens team, contributing to and collaborating on service audit, development and research

7.3 Referral pathway into and out of CYP Havens

7.3.1 Referrals into the CYP Havens

Under 13-year old referrals are generally from police or social care. Referrals are accepted from other sources, but children's social care are then contacted straight away, in line with pan-London safeguarding procedures. For young people 13 years or over, referrals are accepted from police, social care, education and any other agency as well as through self-referral. While it is standard practice to refer all adolescents to social care, if the young person is considered Gillick competent and does not want referral, the Havens will not make an immediate referral to social care. The Havens work closely with young people, and parents/primary care givers to explain the benefits of social care involvement and have extensive experience of achieving this with the young person's consent.

7.3.2 Referrals out of the CYP Havens

Onward referrals are made depending on the particular needs of the child or young person and what is available in their locality.

Where children and adolescents present with needs beyond the remit of the CYP Psychology Service, the CYP Havens team aims to support their onward referral to appropriate services via specialist psychological assessment and established referral pathways. The service has sought to establish *'trusted referral routes'* into local CAMHS and independent sector services, aiming to avoid the need for a repeated assessment. They have been successful in terms of referrals being accepted, however they cannot bypass local waiting lists for assessment (which vary widely across London, from 0 to 28 weeks).

Onward referrals are made early enough to enable sessions to be used to support the transition. A challenge to this is the child or young person's readiness to consider onward referral to a new service which can be daunting, especially the prospect of having to talk through their experiences with a person they do not yet know. Whilst children and young people may need and want further therapeutic support, the prospect of transitioning to a new service and clinician (even with a supported transition) presents a barrier to them accepting and accessing such support.

Local services are often preferable for children and young people in terms of travel and the helpfulness of local support networks, but this approach will not be suitable for all children and young people. The CYP Psychology Service is currently exploring ways of increasing its clinical provision, so that long-term support can be provided in-house.

7.4 Case Study A

7.4.1 Presentation

A was a 5-year old boy at the time of referral whose parents are separated. *A* was visiting his father at weekends but then expressed that he did not want to visit his father. His mother noticed significant changes in *A*'s behaviour. He disclosed oral/anal rape by his father and then disclosed that his paternal grandfather had also assaulted him at the father's home. The father also has a 7-year old daughter from a previous marriage. Early STI results indicated *A* may be positive for Hepatitis B. *A* refused to attend school as this was where he was picked up by his father. The police referred *A* to the Havens for an FME.

The mother presented at the Havens with shock and anger. She did not know where to turn to for help or understand any of the processes happening around her and her child. Over the following days, she was in desperate need of support for herself.

7.4.2 Post FME Havens Interventions:

The Child Advocate established regular phone support with *A*'s mother and signposted her to a specialist third sector provider, Mothers of Sexually Abused Children (MOSAC)/Parents Protect. The Child Advocate also made checks as to the safety of the seven-year-old half-sister. The Child Advocate liaised with the Community Paediatrician to arrange follow up medical and sexual health care and *A* was given the appropriate vaccinations.

Support included an extensive search for emotional support services for both *A* and his mum, discussion with the GP, CAMHS, NSPCC, school welfare, independent

sector services and police Child Abuse Investigation Team (CAIT), as well as chasing the STI/blood results. A meeting was facilitated with the social worker as *A*'s mum was frustrated at what she perceived as a lack of social services help. A referral was made into an art/music therapy school, but *A* was discharged as the school could not handle complex issues and the panic attacks *A* was experiencing. Eventually, *A* was referred to Surrey's Sexual Trauma Assessment, Recovery and Support (STARS) by way of exception because there was insufficient local support

Social services could not locate readily available local services. The allocation of a family support worker involved a five month wait. The CAMHS threshold was not met. MOSAC's waiting list closed to new referrals. Barnardo's service was not provided in the child's borough of residence.

7.4.3 Summary outcome:

The involvement of the Havens Child Advocate resulted in strong coordination of local statutory services, emotional support for *A*'s mother (ongoing) and eventual out-of-London therapy support for *A*. The police investigation progressed well.
Prior to the CYP Havens service, *A* would have received an FME with associated medical follow-up and referral back to the local team only.

7.5 Service Data

The CYP Havens is able to present data from the period before and after opening the specialist CYP Havens service from April 2016 to 2018, to enable comparison of referral rates. Prior to April 2016, children and young people were seen by the core Havens team.

7.5.1 Referrals received

Over 565 children and young people attended the CYP Havens in both 2016/7 and 2017/8, which was a significant increase from 344 in 2015/16, following the extension of the referral criteria up to 3 weeks after assault. The most significant increase was in under-13-year olds, due to the lack of local CSA services.

Chart 1: Number of children and young people supported by the CYP Havens

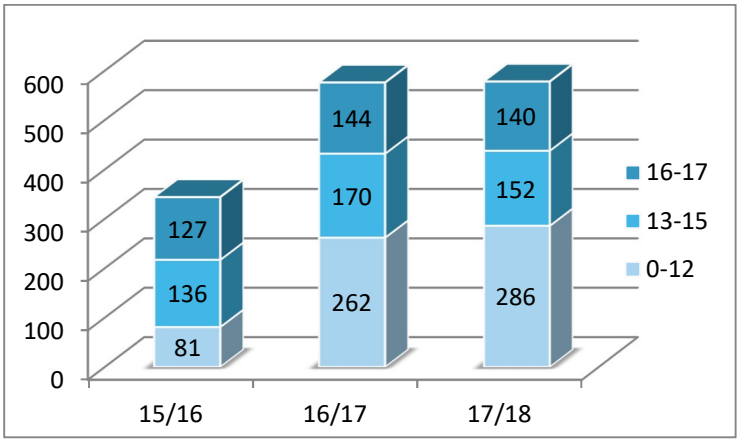
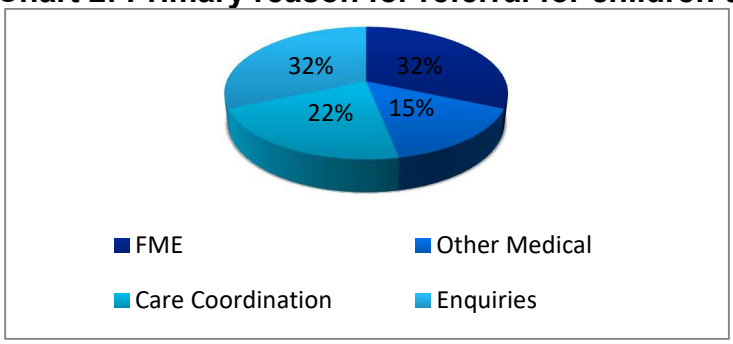


Chart 2: Primary reason for referral for children under 13



7.5.2 The Children and Young People's (CYP) Psychology Service

The CYP Psychology Service was open to new referrals between January and August 2017, followed by a temporary period when the service was closed to new referrals (Sept – Dec 2017).

Between January and August 2017 (8 months) there were 63 referrals, of which 55 were accepted and 8 were not accepted. Of those not accepted, 3 were declined and signposted to local services due to the assault timeframe being outside the Havens remit, 3 were referred on to the young person's ISVA, 1 was declined due to the client presenting with severe mental health needs and onward referral to CAMHS, and 1 was declined due to the client and carer not providing informed consent for the referral.

Of the 55 referrals accepted, 36 accessed the psychology service for assessment and/or intervention, whilst 19 did not access the service. Of those accepted but who did not go on to access the service 10 declined the service as their mental health needs were already being met elsewhere, 6 declined the service as it was no longer wanted or considered needed, 2 did not respond to contact and were discharged with no onward referral following liaison with the professional network, and 1 did not respond to contact but was referred on to children's social care following liaison with the professional network. Liaison was completed where appropriate with the professional network for all referrals prior to closing to ensure their needs were met elsewhere.

Of the 36 who accessed the service and attended an initial assessment, 32 were added to the waitlist for intervention, 3 were referred on (2 to CAMHS and 1 to Children's Social Care), and 1 was discharged with no needs identified.

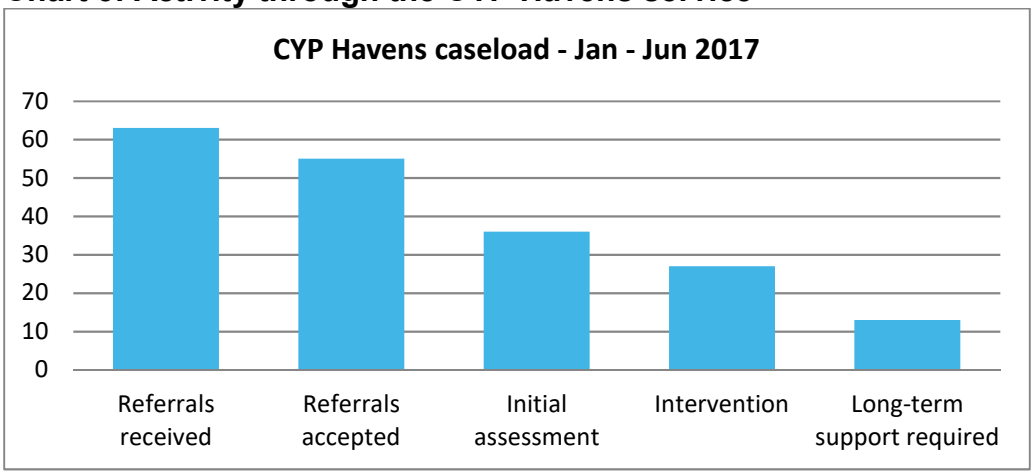
Of those 32 who were added to the waitlist for intervention, 27 went on to access intervention (26 children and young people, and 19 parents/carers accessed intervention) and 5 did not go on to access intervention. Of those 5 offered intervention who did not go on to access intervention, 3 were discharged with no onward referral following liaison with the professional network to ensure their needs were met elsewhere and 2 were referred on to CAMHS.

Of those 27 who went on to access intervention, 1 remains in intervention currently and 26 have completed intervention. Of those 26 who have completed intervention, 13 were discharged with no further needs identified and 13 were

referred on to an alternative long-term service. 8 were referred to CAMHS, 4 to an independent sector organisation, and 1 to children's social care. All onward referrals were accepted.

The journey of the children and young people referred is summarised in Chart 3, with only 21% referred being referred on for long-term support at the end of the brief intervention.

Chart 3: Activity through the CYP Havens service



The Trauma Symptom Checklist for Young Children (TSCYC) and the Trauma Symptom Checklist for Children (TSCC) was completed with children and young people accessing brief intervention with the CYP Psychology Service, before and after intervention, to assess impact of intervention on their mental health.

The TSCYC and TSCC are standardized and normed trauma measures for young children (aged 3-12 years to be completed by the primary caregiver) and children and young people (aged 7-17 years) respectively, who have been exposed to traumatic events such as child sexual abuse, peer assault, and community violence.

The TSCYC or TSCC was used to understand whether the brief intervention helped children "stay well" or "get well" in terms of their mental health. "Staying well" meant that their scores on the TSCYC or TSCC remained in the non-clinical range (e.g. no clinically significant difficulties present) before and after intervention. "Getting well" meant that their scores on the TSCYC or TSCC moved from the clinical range (e.g. clinically significant difficulties present) before intervention to the non-clinical range after intervention.

For the children/young people where there was a pre and post TSCYC/TSCC score, the number who 'stayed well' or 'got well' in regard to the following symptoms were:

- Post-traumatic stress symptoms – 15 of 17 children and young people
- Difficulties with dissociation – 15 of 17 children and young people
- Sexual concerns – 8 of 16 children and young people

- Depressive symptoms – 14 of 16 children and young people
- Anxiety symptoms – 15 of 16 children and young people

This data suggests that the majority of children and young people completing brief intervention with the CYP Psychology Service 'stay well' or 'get well' across a range of indicators.

However, 50% continue to experience clinically significant difficulties in terms of sexual concerns. This identifies an area of future service development in order to see how children and young peoples' needs in this area might be better met.

7.6 Service Feedback

7.6.1 Feedback from Children and Young People

Service user feedback shows 100% of the children and young people were satisfied with their care, and 92% of caregivers would recommend the service to a friend or family member. Children and young people said; "I feel very blessed to be here and I feel very happy and full of hope for the future" and "it really helped me when I was going through a tough time, and I am really thankful for it".
The main themes reported were being made to feel safe and secure by staff and feeling listened to and understood. Parents reported "she was in a safe space and need not worry" and "it is definitely a place to feel safe and not worry about what you are talking about."

Children also reported that "The staff were very friendly, easy to talk to, made us feel comfortable and safe." They "…felt comfortable…she was non-judgemental and supportive…".
Children felt listened to and understood, saying "talking to the staff put me at ease and makes me feel better that someone is actually listening to what I have to say…", "I was listened to and given the support that I wanted."

Some children and young people, and their caregivers, identified areas of potential change to further improve care offered. They reported that the CYP Havens was difficult to locate and/or they wanted greater flexibility with regard to appointment times (such as evenings and weekends).

8 North Central London CSA Hub

8.1 Team and Service Offer

The North Central London (NCL) CSA hub service brings together professionals from a number of organisations into a multiagency team, tailoring health support to the needs of individual children, young people and their families. Children and young people living in the boroughs of Barnet, Camden, Enfield, Haringey and Islington are supported by the NCL CSA Hub.

The NCL CSA Hub operates from paediatric clinics based at St Ann's Hospital (Whittington Health) and University College London Hospital (UCLH). Paediatricians employed by Whittington Health and UCLH work within the clinics with clinical

accountability held by the lead paediatrician. Working within the clinic are also a CAMHS clinician and child and young person's (CYP) advocate. A 0.5 whole-time equivalent (WTE) CAMHS clinician from Barnet, Enfield and Haringey Mental Health Trust sits within the St Ann's clinic and a 0.5 WTE CAMHS clinician from the Tavistock & Portman sits within the UCLH clinic. Both clinics are supported by a CYP advocate employed by Solace Women's Aid.

8.1.1 Timeframe for Support

The NCL CSA Hub sees all children and adolescents who have experienced sexual assault more than seven days ago, outside of the 'forensic window'.

8.2 Roles in the North Central London CSA Hub

The NCLCSA Hub team invested time and effort in creating a sense of team and now benefit from understanding and valuing one another's roles. The team reviews cases at a weekly multi-disciplinary safeguarding meeting to ensure a joint care approach.

8.2.1 Paediatrician

The role of the paediatrician is described in section 5.1 above

8.2.2 Child and Young Person's (CYP) Advocate

The CYP advocate usually meets the child/young person and parent/carer with the paediatrician and therapist at the CSA Hub to explain the service, ensuring that the child/young person's viewpoint is taken into account. Advocates will also assist in other forums such as child protection conferences and strategy meetings. They meet monthly with the CSA Hub team for case review.

The advocate is independent of the police and social care and is there to empower the child or young person to make informed choices to help them recover from the abuse. The advocate has a role in supporting the child or young person through the criminal justice process, including explaining the judicial processes, court preparation visits and emotional support during the trial.

The NCLCSA Hub team found that the advocate being part of the initial appointment enabled better engagement from the child/young person because the advocate is automatically seen as one part of a coherent professional team. There are a number of myths that accompany this difficult work which involve fears that the process re-traumatises victims. An advocate who accompanies the child/young person throughout is more able to explain to other professionals how survivors do cope with the process, even the most difficult parts of it.

8.2.3 CAMHS Clinician

The role of the CAMHS clinician in the hub is to assess and provide up to six sessions of brief intervention for the child or young person, and/or their family, as well as advising the team. The CAMHS clinicians in the NCL CSA Hub have a background in family therapy and clinical social work.

Following an assessment, the child/young person is offered a range of sessions. These can include individual work with a cognitive behavioural and trauma focus, as well as family therapy involving the parent/carer and other family members. The model is strengths-based. Where PTSD is identified, there is a referral to CAMHS for specialist trauma focused work.

8.2.4 Play specialist

UCLH has a dedicated play specialist who supports the NCL CSA Hub clinic. This service is not available at St Ann's. The play specialist reassures and prepares the child/young person for the examination by explaining in easy terms what is going to happen. This is achieved using photographs depicting the process. The play specialist accompanies the child/young person during the assessment and the examination offering reassurance or distraction as required. Should the play specialist hear any allegation from children through play, then this information is passed to police and social care colleagues.

8.3 Referral pathway into and out of CSA Hub

8.3.1 Referrals into the CSA Hub

All referrals into the NCL CSA Hub follow the London safeguarding procedures and the guidance in *Working Together to Safeguard Children 2018*. Referrals are usually made by the borough MASH, children's social care teams or the police. Social workers sometimes phone the NCL CSA Hub team for advice to discuss cases and in some cases are encouraged to accompany the child and family on the day of the appointment.

Referrals can also be received directly from other professionals such as GPs and CAMHS practitioners.

8.3.2 Referrals out of the CSA Hub

If longer term or additional support is needed, the team makes a referral into the relevant available service. In some instances, the support is specialist, in others, universal services are adequate.

Where a child/young person requires longer-term CAMHS support and is eligible for local support, the CAMHS clinician within the NCL CSA Hub can support a smooth transition into the local CAMHS team. This has been possible because the CAMHS clinicians working in the NCL CSA Hub are also employed by the local CAMHS provider. However, this is not usually possible where the referral is made to another CAMHS service provider.

8.4 Case Study B

8.4.1 Presentation

B was 16 years old at the time of referral. *B* alleged non-recent sexual abuse when she was 5-11 years old by an older step-brother. She told what had happened in a letter to her friend which was found by her mother. *B*'s mother noted *B* had been sleeping a lot and had been experiencing more headaches than usual.

8.4.2 NCL CSA Hub intervention

At the first appointment, *B* refused to be examined but stated she wanted to come back to see the paediatrician on her own. Following several appointments with the advocate and the paediatrician, *B* requested to be examined and she expressed worries that her genitals had become abnormal because of the abuse. She was also worried by her headaches.

On examination, the team found:

- Genitalia normal - she had some very mild but normal asymmetry. This was explained, and she was reassured.
- Headaches - migraine was diagnosed. She was offered more effective treatment
- Sleeping a lot – a mental health/depression screen was used to target the work of the CAMHS clinician
- Anxiety – she was supported by CAMHS clinician and the advocate

B was also supported by the advocate throughout the criminal justice process, from reporting to court

8.4.3 Summary Outcome

The paediatric assessment provided reassurance. By giving *B* choice and time to access the service, she felt empowered and listened to. Knowing that she was OK was an important part of the healing process and she was able to explore this at her own pace.

Appointments at the NCL CSA Hub enabled *B* to meet all the team together and reduce barriers to her accepting support from each element of the service.

Prior to the NCL CSA Hub, *B* may have struggled to access the medical support offered and access to emotional support and advocacy may have been dependent on the family's ability to seek out those services.

8.5 Service Data

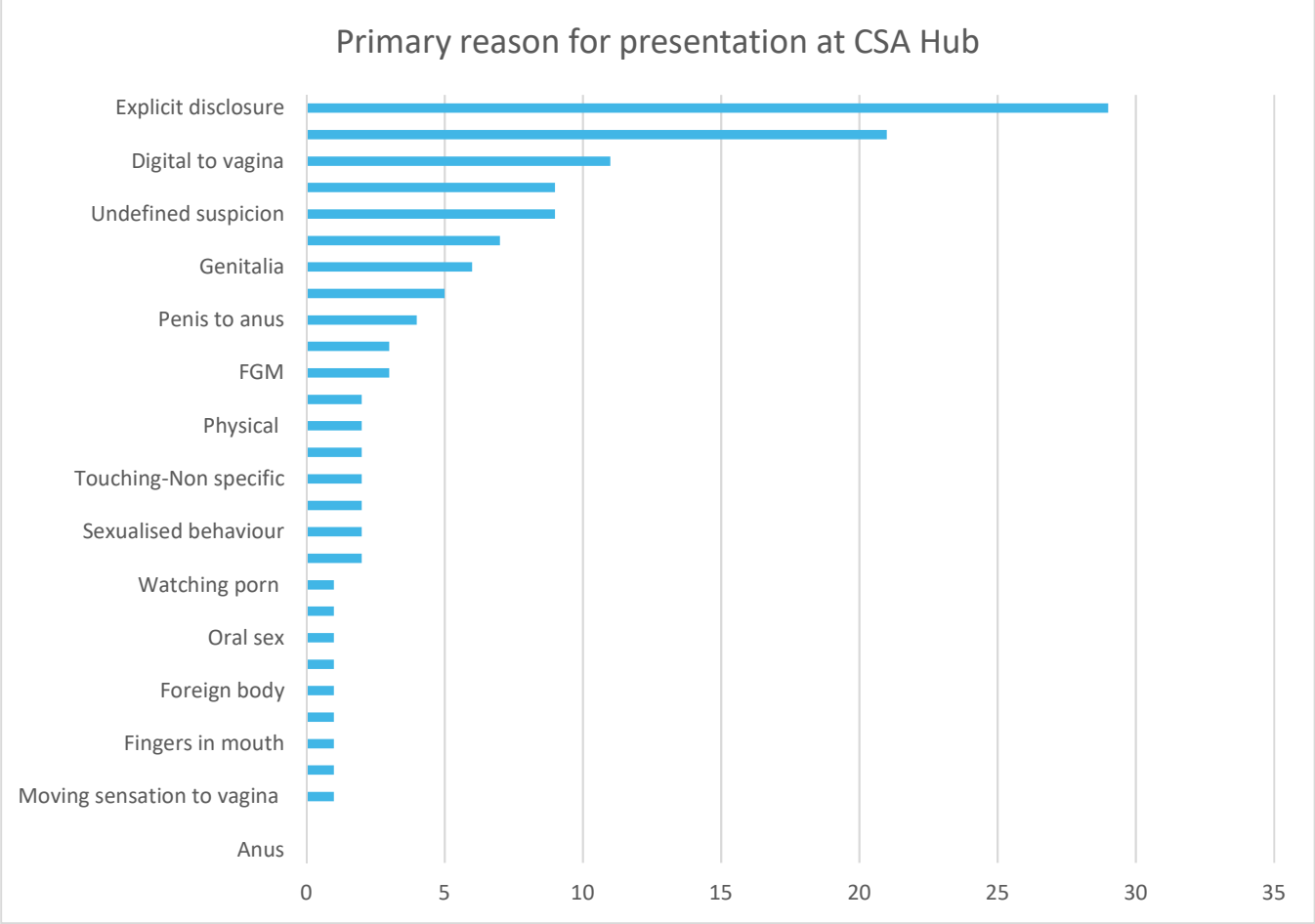
The two NCL CSA Hub sites retrospectively collected equivalent data across the NCL CSA Hub service for the period between 1st January 2017 and 31st December 2017.

8.5.1 Referrals received

There were 118 children and young people referred to the NCL CSA Hub service in 2017 (75 to UCLH clinic and 43 to St Ann's clinic). 81% of the children and young people were female and 19% were male. The average age was 9.42 years (range 0-18 years). In 12 cases the child or young person had a known disability however this is likely to have been underreported. In one case the individual was a suspected

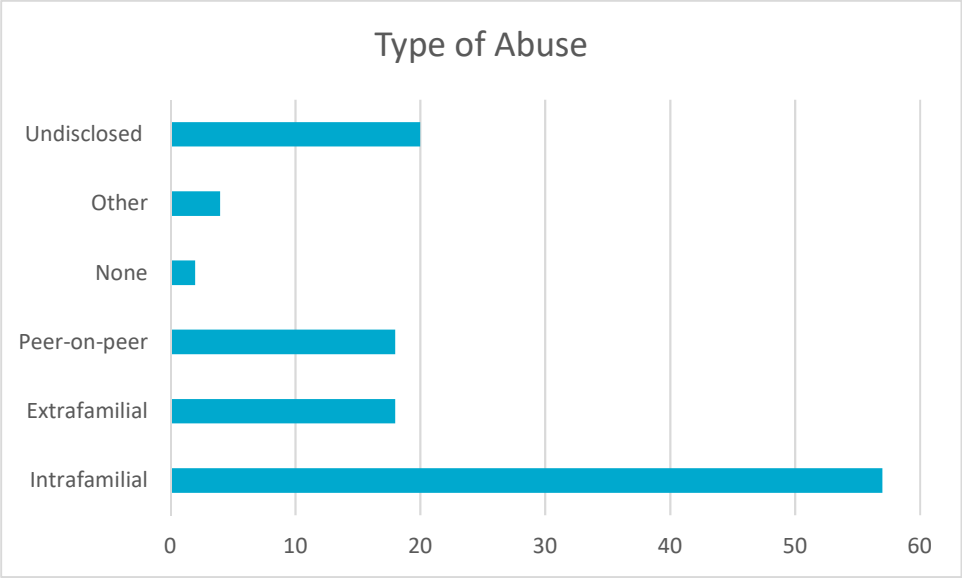
perpetrator as well as victim. In 65% of cases, there was explicit disclosure of sexual abuse by the child or young person.

Chart 4: Reason for referral to NCL CSA Hub



Over 50% of the cases seen were considered to be intrafamilial sexual abuse and 28.6% of the alleged perpetrators were reported as the mother's male partner. 15.1% were cases of peer on peer abuse in which the alleged perpetrator was less than 18 years old, and in 17% the alleged perpetrator was unknown.

Chart 5: Type of abuse



Only 72 of the 118 children and young people were examined and in 59 cases the clinical findings were normal.

Chart 6: Findings on Clinical Examination

Findings	Number of children	% of children
Normal	59	50%
Not examined	21	18%
Refused examination	25	21%
Signs of CSA	7	6%
Other medical finding	3	3%
No comment	3	3%

8.5.2 Emotional Support Service – CAMHS Support

Of the 118 children and young people referred to the NCL CSA Hub, 75 received emotional support from the Hub's CAMHS clinicians. There were other cases with a pre-existing CAMHS relationship and therefore they didn't take up the CSA Hub CAMHS offer.

The average number of CAMHS sessions received was 5 sessions (range 1-37). 18% of children and young people supported by the CAMHS clinicians in the hub were referred for long-term support from local CAMHS services. Other referrals were made to counselling services for parents including the Tavistock and Portman and private psychotherapy.

8.5.3 Emotional Support Service – Advocacy Support

Of the 118 children and young people supported by the NCL CSA Hub, 42 received support from the CYP advocate for themselves or their families. On average four sessions of support were provided (range 1-18). In 13 cases there was a need for

onward referral to a variety of other specialist services, such as North London Rape Crisis, local CAMHS and immigration specialists.

8.6 Service Feedback

8.6.1 Feedback from CSA Hub staff and referrers

Consultant Paediatrician at the UCLH CSA hub said, *"Working with the advocate and therapist as the CSA hub team has been a great opportunity for us to develop our joint skills in preparation for the child house model. We have found what works for us and feedback from children and young people, families and professionals is helping us develop further."*

The CYP advocate said: *"It has been brilliant working so closely with the family therapist and paediatrician. Having consultations with young people and family collaboratively has not only expanded and enhanced my practice but service users often comment that they feel 'held' by a team because we are always present in the clinic and flexible in our approach."*

The Family Therapist described how *"the advocate helps to engage the young person and prepare them for therapy by inviting the therapist to join a session to introduce them to the young person"* and that *"information sharing about the stage and progress of the judicial process helps to contextualise how the child and family is coping with therapy."*

The CAMHS practitioner said:
'Many of the young people I see find it really helpful to understand the common ways that the brain responds to trauma, and this helps them to normalise their own trauma symptoms and hold a more compassionate stance towards the ways that their brain has tried to manage and cope with the trauma they have experienced, they have said for example 'Oh that makes so much sense, that's what I experience if I see a reminder of what happened.' We have worked to track their emotional and mental health goals and they have been able to see their PTSD symptoms decrease over time. Another young person commented to me that she was now able to enjoy just sitting down quietly or notice that the sun was shining and feel happy about this, things that she had not been able to do for a significant period. This is often a combination of many factors which has included having practical coping strategies, a space to talk about their feelings and experiences, joined up work to support their communication with safe parent(s)/Carer(s). Young people have used the sessions to also focus on their interests and future focused goals re-building self-esteem and self-efficacy.'

A senior social worker in Haringey worked with a young person who accessed support from the NCL CSA Hub. The young person was seen for paediatric assessment and was supported by both the CAMHS clinician and the young person's advocate through the criminal justice process.

The social worker said "*I started working with the young person after the referral had been made to the CSA Hub. I got the case quite quickly after allegations of sexual abuse were made but already all the necessary professionals were linked in to the young person and their family. This was very necessary at this crisis point for the*

family. 10 months on, the young person says that she received all the support she needed. Whenever I asked her during the process, she always said she had all the support in place, which was great. Working with the advocate reduced anxiety for the young person and their parent around the court process because they had more understanding of what was going to happen, and they felt prepared."

8.6.2 Feedback from Children and Young People

Children and young people said:
"*The doctor explained everything very clearly*." "*She let me see on the screen what was happening."*

The play specialist "*got my mind off what was happening EXCELLENT*."

Parents said: "*Watching my daughter magically heal emotionally in the presence of the doctor was amazing and life transforming*."

"*Everything was clearly explained myself and my children were given the time to talk and more listened to."*

9 South West London CSA Service

9.1 Team and Service Offer

The South West London (SWL) CSA emotional support service is provided by the NSPCC and links in with local paediatric CSA services. The service provides early emotional support delivered by Children's Services Practitioners trained in the NSPCC therapeutic approach 'Letting the Future In' (LTFI). The service is available to children and young people up to the age of 18 years old from the boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

The NSPCC model offers up to 6 sessions involving practical and emotional support, advice, case management and assessment. An in-depth functional assessment of a young person's strengths, difficulties, and risk and resiliency factors following a recent disclosure of sexual abuse is completed and used for onward referral to appropriate services where indicated.

NICE guideline on Child Abuse and Neglect recommends the "Letting the Future In" (LTFI) model. This NSPCC designed service, for children aged 4 to 17 years who have been sexually abused, helps them come to understand and move on from past experiences through activities (such as play, drawing, painting and storytelling). Parents/carers are also offered support in helping their children feel safe.

The NSPCC early emotional support model is based on the assessment phase of the LTFI programme used to determine the young person's therapeutic needs and how their carers can play a role in their recovery. In addition to the commissioned emotional support service, the NSPCC offered to provide the full LTFI or Protect and Respect service for up to 50% of children/ young people who may benefit from these longer interventions.

Paediatric services are locally commissioned through community block contracts in each borough without identified time for CSA. As a result, appointments for paediatric assessment are organised at a time convenient to the child/young person and their family rather than in regular clinics.

CSA paediatric assessments take place in the six boroughs as follows:

- Croydon cases - Croydon University Hospital
- Wandsworth and Kingston cases - St George's Hospital
- Sutton and Merton cases - CYP Havens in Camberwell
- Richmond cases - University College London Hospital

The NSPCC Children's Services Practitioner either attends the paediatric assessment or arranges a speedy follow-up appointment. The NSPCC CSA service is provided at the Croydon NSPCC Service Centre or somewhere convenient for the child/young person and family.

9.2 Roles in the South West London CSA Service

The referral pathways into CSA paediatric services across South West London remain different in each borough therefore it has not been possible to create a single CSA Hub team of NSPCC staff and paediatricians. This lack of a regular CSA hub clinic has made it difficult to create a sense of team and build relationships.

9.2.1 NSPCC Children's Services Practitioner

The NSPCC practitioner provides up to six weekly one-hour sessions to the child/young person and their family to support them following disclosure. The needs of both child and family determine how these sessions are used. During these sessions, the practitioner gets to know the child and, together with the family, assesses the longer-term therapeutic need which will inform the focus of the support sessions.

Practitioners use a range of approaches, including talking, play and creative activities.

NSPCC practitioners may attend CSA medical examinations for the information gathering phase. This provides an opportunity to meet the family to tell them what support the NSPCC offers.

The information gathered informs the design of an individual brief intervention package, based upon an understanding of the impact that the sexual abuse has had on the child/young person. The support provides emotional and behavioural regulation skills training to help alleviate distress and strengthen resilience.

9.2.2 Team Manager

The funding for the NSPCC CSA service includes management and supervision for the team. Staff members also have access to a clinical psychologist to help them with the impact of this work on them. The team manager ensures that families and children and young people can be referred into services that they need by communicating regularly with CAMHS, children's social care, police teams, the CYP Havens and the relevant paediatricians. Awareness raising of the service remains an ongoing activity due to the high turnover of social workers in social care teams.

9.3 Referral pathway into and out of CSA Service

9.3.1 Referrals into the CSA Service

All referrals into the SWL CSA service follow the London safeguarding procedures and the guidance in *Working Together to Safeguard Children 2018*. Referrals are usually made by the local MASH, children's social care teams or the police. Social workers sometimes phone the team for advice to discuss cases. Through significant work to increase awareness of the service with children's social care teams, referrals in Croydon, Merton and Sutton have increased significantly.

9.3.2 Referrals out of the CSA service

If longer term or additional support is needed, the NSPCC CSA service transfers children and young people to 'Letting the Future In' or 'Protect and Respect' services or makes an external referral into the relevant service. Such support services range from CAMHS and specialist support services for survivors of sexual violence, domestic violence or CSE to universal services for children and young people.

9.4 Case Study C

9.4.1 Presentation

C was a 17-year-old young woman at the time of referral. She lived at home with her mother and younger siblings. There was no history of involvement with children's services. *C* disclosed long term rape and sexual assault by her father.

C's presenting issues included:

- Extreme stress about A-Level exams
- Distress caused by the criminal investigation
- Trauma symptoms including nightmares, flashbacks and dissociation

In addition to *C*'s presenting issues, her mother also felt overwhelmed by practical matters, such as divorce and finances.

9.4.2 NSPCC intervention

The NSPCC provided four sessions of support to *C* and two to her mother.

They included:

- emotional support

- opportunities to discuss the long-term impact of abuse and issues connected to the criminal process
- advocacy with *C*'s school, police, children's services
- planning for managing triggers and practical methods for managing symptoms in the short term
- prioritising and planning with Mum
- signposting and referrals to ISVA and therapy at RASASC

9.5 Service Data

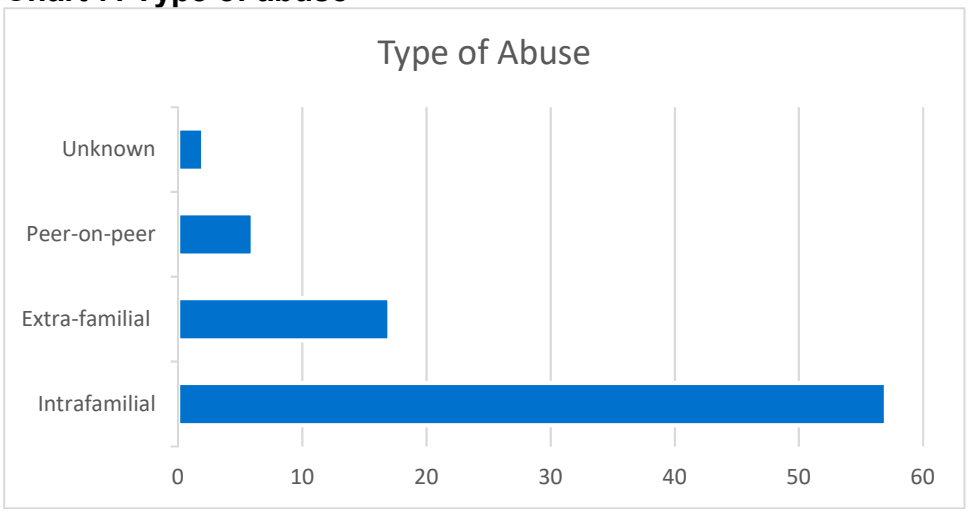
Between January and December 2017, 47 children and young people were referred into the SWL CSA service via local paediatric services across the six boroughs of South West London. 39 of the children and young people were seen for a CSA paediatric assessment. In 6 of the 8 cases in which the child/young person did not receive a CSA paediatric assessment, the decision was taken by professionals that the assessment was not appropriate. In one case the family did not engage, and in the final case the young person did not give consent for the assessment.

66% of the children and young people referred into the CSA service were female and 34% were male. The average age at the time of referral was 9 years (range 1-16 years).

13% of the children and young people supported had a diagnosed disability. All the children and young people referred into the service had explicitly disclosed sexual abuse.

79% had experienced intra-familial abuse, 11% had experienced extra-familial abuse and 6% peer-on-peer abuse. In 71% of the cases, at least one of the alleged perpetrators was a male relation either by birth, adoption or through marriage/long-term relationship.

Chart 7: Type of abuse



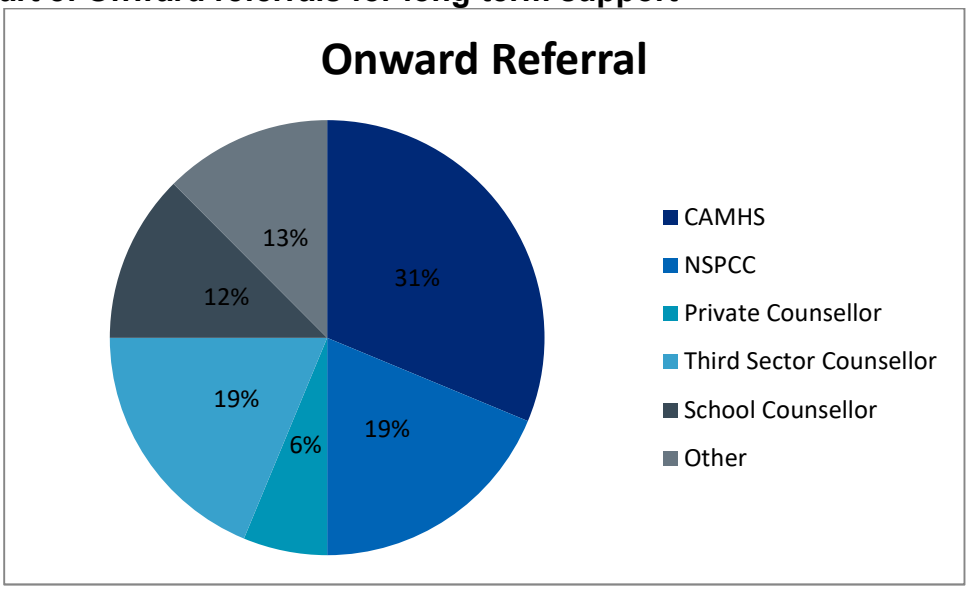
9.5.1 Emotional Support Service

39 of the 47 children and young people referred into the SWL CSA service received emotional support and 8 did not receive emotional support. In 4 of the 8 cases emotional support was provided by another local service. In 3 of the 8 cases, the child or young person and their family either did not consent or did not engage with the service. In only one case, the referral into the CSA service was not appropriate.

Children, young people and families can receive up to six sessions. The NSPCC team divided sessions between the child/young person and their parent or carer according to the needs of the family. Most commonly, the child or young person received four sessions and the wider family two sessions.

Of the children and young people supported by the NSPCC, 41% were referred on for long-term support including local CAMHS, NSPCC services and other counselling services.

Chart 8: Onward referrals for long-term support



9.6 Service Feedback

9.6.1 Feedback from professionals providing CSA services in SWL

A forensic physician said: *"The ability to initiate emotional support by introducing the Children's Services Practitioner at the beginning of the medical assessment has been transformative to the clinical dynamic. The meeting between the professionals and the child is no longer just about evidence gathering and reassurance but is now about starting the path to full recovery. This is a step change for all concerned, and most importantly puts the recognition of the needs of the child and family at the centre of what we do"*

A consultant paediatrician said: *'The ability to work alongside colleagues from NSPCC has meant that the care pathway for the children and young people is*

seamless, with immediate access to the support required in a timely fashion. I believe knowing that children and young people get immediate help has increased the confidence of social workers to refer to the service.'

The clinicians involved do also recognise the limitations to the brief intervention support offered by the NSPCC: *'I would support this kind of work being extended so that it follows the trajectory of the child and family's relationship needs for as long is therapeutically indicated. We have started to build a relationship-based approach to the recovery phase. It now needs to be firmly embedded in the service provision. All the evidence shows that it will pay substantial dividends in the form of mental good health and the reduction in use of adult services in the future.'*

A Children's Services Practitioner at the NSPCC describes the benefits of early emotional support: *'Children and young people are given options of how to express themselves, and this opens up discussions with their parents, either immediately after sessions, or at the review session. They can also start to learn to trust professionals, which will then benefit any future work with them (often parents themselves can be mistrustful of other adults/professionals). Giving children and young people a space to talk about their feelings is often the biggest benefit, as they would not have had such a safe space to begin with, and this leads on to discussions around how we can share this with their parents. And being the person to help facilitate that discussion has a huge positive impact on the children and young people in my view. Feedback from parents and school and other professionals about the child's behaviour and general coping have suggested that sessions help to contain the child/young person's emotions and helped them settle at home and/or at school.'*

The NSPCC Service Manager said: *'We help children to rebuild their confidence and self-esteem and give them a space to talk, play, or write about their worries. We find ways that they can express themselves and communicate more openly with their parents. Involving parents in some play either in the first and/or review session is a great technique to help them share some fun and positive experiences.'*

A CAIT officer worked with the NSPCC in a case in which two siblings made allegations of sexual abuse. The officer said*: "Mum called the NPSCC helpline after her two young children made allegations of sexual abuse. The NSPCC helpline workers supported the family to report the abuse to the police. I became involved in the case as their CAIT officer. The NSPCC provided the phone recordings which are being used as the main evidence in the prosecution. The case is currently awaiting trial.*
The NSPCC continued to support the family through the early emotional support service. The support was primarily for the two children but also gave support through family sessions. The family told me that they couldn't have got through it without their support and that going to the office was like a fun day out. One of the children was very angry and was struggling to deal with what had happened, but by the end of the NSPCC support they noticed a real improvement in his happiness. Having the help of the NSPCC, I knew that the family were getting the support that they needed."

9.6.2 Feedback from children and young people

The NSPCC collects feedback from children, young people and their families at the end of the support. Of the feedback forms collected, 100% gave positive feedback regarding the service.

Children and young people said:
The most helpful thing about coming to the NSPCC was *"when I drew how I felt and how people feel about me."*
"I feel very happy – thank you for your help NSPCC. I am so so happy you turn my life around"
"Thank you for helping me"
"All our conversations were really helpful"
"Thank you for helping me with all my problems, it was really helpful"
"I found it helpful because it made me understand why I shouldn't be looking at inappropriate things on the internet"

What was the best thing about coming?
"Everything was good, I enjoyed all the talks with Children's Services Practitioner"
"Talking about how I felt and doing the different exercises that helped me to relax"

Parents/carers said:
"You put my mind at ease. You helped with my questions. Thank you."
The service *"allowed our child to talk to someone without worrying about anyone being upset. My child seems not to blame himself so much anymore."*
"She opens up more now to me, her mother"
"It was very re-assuring to hear that NSPCC are here to help me after the medical assessment"

What was most helpful?
"Talking it through and exploring all the possibilities of the impact of the incident in future"
"It helped me open up to allowing people give me help and it was awesome that Children's Services Practitioner is such a kind person, I didn't feel judged at all"
"Child had an opportunity to speak about her concerns and be listened to"
"Having Children's Services Practitioner at the hospital allowed us to talk to the doctors without interruption for the children. They got to know our children which made it easier for them to talk during their sessions"
"My child seems happier and seems not to blame himself so much anymore"

10 Operational challenges to delivering CSA services

10.1 Operating across partner organisations

The three CSA services have been set up with different partnership arrangements and a wide range of participating agencies, trusts and independent sector bodies providing services. This separate leadership and priorities can lead to a number of risks:

- No shared vision for the service
- Practitioners working in isolation – with no obligation to have team meetings, no process for escalation, no drivers for service development
- No support for the team to run meetings or events
- Different data collection and reporting requirements which results in duplication of work
- No planning of prospective data collection to inform service development and wider transformational change
- Unclear governance and accountability

Because each CSA service has no lead provider, the CSA Transformation Programme team has provided significant support to the NCL CSA Hub and the CSA service providers in SWL in terms of administration, coordination, publicity and data collection. This in the long term is unsustainable.

Recommendations:

- **Appoint a lead provider of the entire CSA service to provide management oversight, administrative support and strategic vision**
- **Agree a set of activity data and KPIs with an established reporting framework**

10.2 Paediatric Capacity and Training

In London CSA paediatric assessments are usually provided as part of a community paediatric block contract, commissioned separately by each CCG. CSA work is not specified in the block contract and usually there is no protected time in job plans to carry out the examination or the safeguarding work associated with complex cases of CSA.

In many boroughs, there are few and in some cases no community paediatricians with the required training or access to the necessary equipment to safely perform assessments.

Where either of these conditions apply, children and young people are transferred for their assessment out of borough.

As such, London has a capacity and succession planning problem in relation to CSA paediatric provision and it may require a London solution

Recommendations:

- **Pan-London review of paediatric capacity and training, contributing to effective succession planning.[1]**

- **Commissioners specify CSA work within community contracts and providers protect time in job plans**

10.3 Clinical Leadership and Supervision

Effective clinical leadership is critical to ensuring a high-quality healthcare, and clinical supervision is vital for emotional support practitioners to help them with their professional and personal development.

The delivery of clinical leadership and supervision varies across the three CSA services and the variations are the result of a lack of dedicated budget for this activity. In the NCL CSA Hub the early emotional support service was funded as a Department of Health pilot and there was no budget for clinical leadership or clinical supervision. This unfunded shortfall was eventually covered by the providers.

In South West London the NSPCC budgeted for external supervision for the early emotional support service. However, there is no protected time in job-plans for community paediatricians and this has prevented a regular paediatric clinic being established. This prevents the establishment of a holistic CSA Hub service. The CYP Havens budgets for supervision and leadership of its services.

Recommendation:

- **Early emotional support services are funded on a full-cost recovery model that includes clinical leadership and supervision**

- **Funding is made available to provide clinical leadership for paediatricians delivering CSA services**

10.4 Short-term emotional support offer

The 2015 London CSA Pathway Review recommends that children, young people and their families need early help which focuses on symptom management, advocacy and signposting. This is intended to act as a bridge before they can or are ready to access longer term support, and in some cases, providing early help will reduce the need for longer term support altogether. The impact of providing early relational support focused on building resilience within the family network is evidenced by the Child and Family Trauma Stress Intervention study[ix] and the NSPCC's Letting the Future In evaluation[x].

UK Department for Education statutory guidance *Working Together to Safeguard Children* (2018) includes the 'resilience triangle', which shows that a child's ability to recover from traumatic events depends not just on their needs but also on parenting

[1] Learning from the Child Advocacy Centre model in North America and Canada, London could consider establishing four-week placements for paediatric registrars who are training to be a consultant paediatrician with a special interest in safeguarding at either a CSA Hub, the Child House or the CYP Havens.

capacity and family and environmental factors. The CSA services aim to provide holistic support which addresses all sides of the triangle.

The early emotional support element of the CSA services has been commissioned on the basis of 6-8 sessions with a focus on practical help, brief therapeutic support, advocacy and signposting. However, for 18-40% of children and young people, this brief support does not meet their needs as they may develop mental health problems that require longer-term support, and/or have to deal long term with a complex variety of issues such as criminal justice proceedings, social care assessments and care order proceedings.

Risks:

- Where a child, young person or their family member has built a trusting relationship with a practitioner, ending the emotional support too early could reinforce a broken sense of trust. In the long term this may increase the number of professionals involved in a child's life without fully meeting their needs

- The early emotional support can identify the need for long-term therapeutic support, but the CSA services cannot provide this support. Onward referrals can result in delay, reassessment and threshold restrictions (see section 11.1)

- The brief support gives an insufficient amount of time to measure outcomes or mitigate against longer term external factors that can impact emotional well-being or mental health (e.g. criminal justice process)

Recommendations:

- **Emotional support practitioners make clear to the children and young people and their family how long the intervention will last and what to expect thereafter**

- **The number of sessions offered should be delivered flexibly within the overall capacity of the commissioned service**

- **Seek to support the transition between services by enabling continuity of practitioners who work part-time in the CSA service and part-time in long-term support services. [2]**

- **Establish trusted assessments between CSA services and CAMHS providers**

- **Ensure quality monitoring to inform future commissioning conversations**

10.5 Providing service over large geographical area

Providing services across a large geographical area presents challenges for accessibility and capacity for the team. The CYP Havens provides support at three locations in London and where possible support is provided at the location which best meets the needs of the child, young person and their family. A purpose-built and child-friendly centre is based at the Haven Camberwell.

The NCL CSA Hub provides paediatric assessments at local hospitals with follow up emotional support service offered a variety of locations across the five boroughs. The SWL CSA service team is based at the NSPCC Croydon Service Centre however similarly the support is offered as outreach across the six boroughs. Locations include schools, children's centres, local community venues and within the home. The extent of travel impacts significantly on the capacity of the team however increases accessibility and choice for children, young people and their families. Providing a variety of locations ensures the site is suited to the particular child or young person.

Risks:

- Travel has a negative impact on staffing capacity

- Capacity is taken up organising access to multiple locations

- A lack of appropriate and available locations can delay offer of support to child/young person

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- [2] For example, the NSPCC team employs part-time practitioners who also work within the *Letting the Future In* team and in the North Central London CSA Hub the CAMHS practitioners also sit within local CAMHS teams

Recommendations:

- **Commissioners support emotional support teams to access local authority and health facilities to use as locations for delivering support**

- **Travel to locations across large geographical area is factored into expectation of throughput of service**

10.6 Record-keeping and information governance

In all three CSA services, each profession keeps separate notes regarding their intervention. Often this is because the different elements of the service are provided by separate organisations, such as paediatric provider, CAMHS and third sector providers.

In the CYP Havens, information-sharing within the team is simple as there is one lead provider, and the clinical psychology is provided under a Service Level Agreement (SLA) with honorary contracts in place. For the NCL CSA Hub team, honorary contracts are in place between the emotional support practitioners and the hospital trusts providing the paediatric assessment to support information sharing between practitioners within the clinic. In South West London there is no contract between NSPCC practitioners and paediatric providers, so consent is sought from the child/young person and/or family for the NSPCC practitioners to be part of the assessment and subsequent information sharing.

Children and young people must give multiple consents within the CSA services to access the different elements of service. All services therefore use a staged approach to gain the child or young person's agreement and consent.

- At referral, the service leaflet describes what is on offer and there is assumed consent that by attending the child or young person and their family has agreed to meet the professionals in the team

- Written consent is required for video recorded medical examination

- Written consent is required for ongoing emotional support

Risks:

- Reduces the capacity of team due to duplicate record-keeping

- Makes the service inefficient and less patient friendly because children, young people and their families are asked for consent multiple times

- Causes missed opportunities for information-sharing through isolated record-keeping

Recommendations:

- **Information-sharing agreements between providers**
- **Honorary contracts or other governance arrangement for emotional support practitioners to sit within paediatric clinics**
- **Joint consent forms with specific sections where necessary**
- **Joint electronic records**

10.7 Dispelling myths and stereotypes

The 2015 London CSA Pathway Review reported low referral rates from police and social care. Anecdotal evidence indicates that police and social care professionals often believe the CSA paediatric assessment to be invasive and re-traumatising for the child or young person. Consequently, if there is not any obvious medical concern such as a physical injury or indication of an STI, children and young people are not referred for health support.

In contrast to this belief, feedback from children, young people and their families describes the reassurance provided by the assessment and how this contributes to the recovery process, knowing that there is no permanent physical impact of the abuse. Additionally, the paediatric assessment allows other unmet medical needs to be treated.

Following awareness-raising and training with police and social care teams led by practitioners from the CYP Havens, NCL CSA Hub and SWL CSA service, referrals in some boroughs for CSA paediatric assessment have increased. However, this is still far below the numbers reporting CSA to the police. For example, 118 children and young people were supported by the NCL CSA Hub in 2017 (reported by paediatricians) in comparison to 556 cases recorded by police across the five boroughs.[xi]

The CYP Havens has opened its weekly multidisciplinary safeguarding meeting to police and social care colleagues in order to encourage and support referrals for health support.

Risks:

- Lost opportunities to reassure and provide for the emotional well-being of victims
- Professionals failing to provide treatment for health-related issues that accompany abuse, for example STIs
- Missed opportunity to dispel worries about body image and lasting damage from abuse, and to give reassurance

- Missed opportunity to contribute a health perspective to the full safeguarding assessment with appropriate onward referral when indicated

Recommendation:

- **CSA service teams should prioritise the education of frontline practitioners whose misunderstanding of the CSA service may be a barrier to referral including approaches such as:**
    - **CSA services clinicians attending police/social care team meetings**
    - **Inviting police and social workers to CSA services case meetings**
    - **Provision of professionals' leaflets and where possible a video of the service offer**

11 Systemic challenges to delivering improved outcomes for children and young people

11.1 CAMHS waiting lists and thresholds

Nationally only 6% of spending on mental health services is for children and young people[xii] and CAMHS services have faced reductions in funding due to financial pressures on CCGs. The CAMHS service in response may raise acceptance thresholds or develop longer waiting lists.

Some local CAMHS providers require the child or young person to have a diagnosed mental health condition to meet threshold and others require a GP referral. Waiting times vary between CAMHS providers, ranging from urgent appointments within weeks to 9 months for a non-urgent appointment. Alternatively, young people aged 13 years or over can be referred to the CYP Havens or one of the Rape Crisis services for long-term support and counselling, but the wait time can be up to one year.

Further delays occur when CAMHS providers undertake a full assessment of each child or young person before they can be accepted onto the waiting list, even though they have been assessed by CAMHS practitioners working in the CSA service. To resolve this, NCL CSA hub and CYP Havens tried to create the process of 'trusted assessments'. This was possible where the CAMHS practitioners worked part-time in the CSA service and part-time in a local CAMHS service.

However, it was not possible if the child lived in an area served by another CAMHS provider or in the SWL CSA service where the assessment was undertaken by an NSPCC practitioner.

To support transition, NCL CSA Hub CAMHS practitioners were able to attend the initial appointment with the new CAMHS service and it was generally a shorter assessment (1 session only).

Risks:

- Children and young people transferring to long-term local CAMHS support wait a long time and usually change practitioners, leading to a lack of continuity and a degree of disaffection on behalf of the child/young person

- While waiting for CAMHS, children and young people may suffer a deterioration in their mental health and the CSA services cannot continue to support them at the same level

- Some CAMHS teams cannot support family members/carers which may result in reduced resilience in the family

Recommendations:

- **Ensure children and young people are assessed by the CSA service and long-term therapeutic options identified before referring to CAMHS, to optimise the use of the specialist CAMHS support**

- **Source alternative services that can offer additional support for the family/carer. For example: MOSAC (third sector organisation providing support to parents and carers), specialist CSE services, Rape Crisis services**

- **Where possible, the CSA service should 'hold' the child while they wait for CAMHS or other long-term support so there is not a gap. This can mean being flexible with the 6-8 sessions where required. Some of the CSA teams were able to flex their levels of support from 2-14 weeks, offering extended support where needed whilst maintaining an average of 6-8 sessions**

- **Fast track children and young people into CAMHS through 'trusted assessments'**

11.2 Social care capacity

Children's social care has been under increasing pressure over the last five years, with high profile cases leading to an increasing number of children identified at risk. The 2017 NSPCC report 'Turning the Tide'[xiii] identified that children with a Child in Need (CIN) plan in England increased from 132 to 171/10,000 between 2009/10 and 2015/16. The number of children subject to a Child Protection Plan (CPP) in England has also been increasing, at a rate of 128 per cent each year between 2002 and 2016. Coupled with a 25% real term reduction in central government funding for children's services (2010/11 to 2015/16), there will be an estimated £2 billion funding gap in children's services by 2020.

The CSA service practitioners across the three services have found inconsistent practice across boroughs and described children's social care closing cases once a child is deemed safe, for example living in a safe home environment and with no access by the alleged perpetrator. The CSA services noted that cases are closed even when holistic social and mental health issues remain e.g. poor school

attendance, self-harm. The NCL CSA Hub team has worked closely with social care colleagues to agree transition of cases to the advocate if the child/young person does not meet the social care threshold.

The practitioners working in the three CSA services reported a continued lack of referrals from police and children's social care, with approximately 150 children and young people supported by the NCL CSA Hub in the same year as 550 cases were reported to the police. Myths and stereotypes persist, with belief amongst referrers that a medical will be invasive and re-traumatising and lack of knowledge of the role of advocates[xiv].

The CYP Havens report that there remains a perception that no findings at forensic medical examination can equate to no abuse having taken place. CYP Havens examiners report that in 95% of cases there are no medical findings even when a child provides a compelling account of alleged sexual abuse.

The NCL CSA Hub operates a case-holder model, with the advocate taking a lead on care co-ordination and navigation following discharge from social care. This frees up social care capacity and ensures continuity for the child from disclosure through to court. However, this arrangement depends on the flexibility of the advocacy service. The Department of Health Review of the NCL CSA Hub described the case holder model as seeking *'to address the complexities and difficulties experienced by children, young people and their families in accessing early consistent support. The case holder does this through co-ordination of the multiple professionals' responses and better access to services including NHS, children's social care, criminal justice services including police, education and third sector specialist providers.'*[xv]

Risks:

- Social workers have limited availability due to large caseloads of children
- Children and young people are discharged from children's social care when they could still benefit from early help e.g. to stabilise school environment
- Children and young people are not referred onto CSA services for health and wellbeing support
- High turnover of social care staff leads to lack of awareness of pathways and/or experience of supporting children and young people after disclosure of CSA
- Myths and stereotypes impact on belief of the child or young person and the type of support that they are offered

Recommendations:

- **Good communication and awareness-raising should be a key aim of all CSA services, with a focus on dispelling myths and stereotypes**
- **CSA services should welcome local social workers to be part of the initial assessment, as well as at weekly caseload meetings and on the day of the Achieving Best Evidence police interview if available at the service**

- **CSA services should offer advice to social workers with queries about potential cases**

11.3 Time delays in criminal investigations

The Children's Commissioner report into the Length of Investigations in 2017[xvi], found the investigative process for CSA cases is considerably longer than adult sexual offences. In 2015/16, the median length of time for investigations of CSA cases was 248 days. In comparison, the median length for the investigations of adult sexual offences was 147 days, which is 101 days less.

Children and families enter the prosecution process with a lack of awareness of how long it will take and the potential impacts on them, ending in cross examination at trial that can create extreme distress or dissociation, and even serve to retraumatise.[xvii]

The delays can be due to a variety of factors including complexity of cases or limited police capacity. Additionally, there is increased pressure on digital forensic teams which has been exacerbated by heightened awareness of their relevance in sexual assault cases and a general increase in digital use.

The CSA advocates support children and young people through the investigation phase and on through charging decisions and court. This can include chasing for updates and progress reports and explaining the steps in the process and what to expect. Advocates in the NCL CSA Hub also support the child or young person with pre-court visits, during the trial and post court decision. This can be a critical time regardless of the verdict and the majority of services do not offer post-trial support.

CYP Havens have introduced a streamlined medical report which improves response times when statements are requested by police.

The CYP Havens and the Child House service includes a Police Liaison Officer role to provide:

- advice to health and care staff
- advice, training and awareness raising of CSA to police colleagues
- work to unblock any delays in the justice pathway where possible

Advocacy support will also be available during and post-trial at the new Child House service.

CSA health and care services are well placed to gather evidence and provide feedback on the impact of delays in the criminal justice process on children and young people, and their ability to give compelling evidence.

The following risks arise from lengthy delays in the criminal investigation and trial process:

- Long investigations may mean a child/young person does not want to start therapy whilst the trial is still pending. This can be due to wanting to wait for the

outcome before starting therapy or can be due to fears of affecting their credibility as a witness. See section below on Pre-Trial Therapy

- Young children who wait up to two years for the trial may struggle to remember the detail when examined by defence barristers

- Over a lengthy wait for trial, children and young people may retract due to
  - Intimidation
  - Distressing nature of the process
  - Desire to keep their family together

National opportunities for improvement:

- **In 2018 the updated Young Witness Protocol[xviii] was agreed between the National Police Chief's Council, CPS and Her Majesty's Courts and Tribunal Service to speed up CSA cases. It aims for a CPS charging decision within eight weeks from the initial police report and a trial date within six months. This includes any crime whether the child is the victim or a witness.**

- **The Section 28 pilot led by the Ministry of Justice was found to be an effective special measure and national roll-out is expected in the future. The Section 28 special measure seeks to:**
  - **Pre-agree cross examination questions in a ground rules hearing to ensure they are in child friendly language and not leading**
  - **Pre- record the cross-examination so the child or young person does not have to attend court on the day of the trial**
  - **Undertake the cross-examination outside of the court room, usually in a video linked family room within the court building- with any special measures required**
  - **Enable the child or young person to have some closure on the criminal justice process in advance of the trial – particularly important if the trial is up to 2 years after reporting or a complex multi-perpetrator trial**
- **The trial of clinical psychologist-led ABE interviews at the CYP Havens and Child House aims to achieve better criminal justice outcomes and prevent re-traumatisation**

11.4 Lack of pre-trial therapy

Some defence barristers challenge the credibility of a witness who has received a therapeutic intervention citing memory and recall changes resulting from the intervention.

Guidance[xix] from the CPS states that 'pre-trial discussions may lead to allegations of coaching and, ultimately, the failure of the criminal case'. As a result, some therapists and independent sector providers interpret this as meaning that it is best not to offer therapeutic support.

Some practitioners have concerns that they may themselves be called to court as a witness in relation to any therapy undertaken prior to the criminal trial and that their notes will be required by the court.

An updated version of the CPS Pre-trial Therapy Guidance, due in late 2018, is expected to clarify that the child's needs are paramount in any decision about whether or to offer therapy.

Risks:

- Children and young people may struggle to access professional therapeutic support due to practitioners' fears of cross-examination themselves and experience of observing the impact on other children and young people
- Children and young people may be guarded in therapy sessions knowing that the full record can be subpoenaed by the court
- Professionals may avoid talking about the abuse in therapy, due to fears of undermining evidence but this can add to feelings of shame and guilt by making it a taboo subject

Recommendations:

- **Updated CPS guidance on pre-trial therapy is awaited to clarify this and ensure that therapy is provided if it is in the best interest of the child**

11.5 Lack of awareness of child development and impact of trauma amongst the criminal justice system

There is a less than full understanding among the criminal justice and social care workforce of the impact of trauma on a child or young person's presentation. For example, children may present with a calm, assertive or even angry appearance, instead of appearing upset or vulnerable. This dissociative behaviour is not identified as such but instead seen as evidence that the child is unaffected by the abuse or that it may not even have happened. This lack of understanding of the impact of trauma may affect professionals and juries.

In the Dame Elish Angiolini 2015 [xx] review of rape she writes *"Many of the normal human responses to trauma run counter to the ingrained societal views as to how a victim of sexual assault should respond… not all prosecutors are alive to these issues"* and *"If these common features and behaviours of so many complainants in rape cases are to be explained and understood by juries they must first be understood by police, prosecutors and judges and steps must be taken to address those same issues through the use of expert evidence from psychologists and psychiatrists as well as experts in cultural or religious norms and the effects of prolonged domestic abuse."*

Risks:

- Dissociative behaviour can be seen as evidence that the child or young person is unaffected and therefore the abuse did not take place or was consensual
- Children and young people can be re-traumatised by giving evidence in court in an attempt by the prosecution to demonstrate how upset they are

- Juries may be influenced in their decision making by lack of understanding of the impact of trauma on children

Recommendations:

- **There should be consideration given to pre-trial preparation for jury on the impact of trauma due to CSA on memory recall, behaviours and presentation of the child/young person to minimise bias**

- **Expert witnesses could provide psychological assessment of the child or young person to aid the jury**

- **The Elish Review recommendation 37 states "new legislative provision should allow … expert evidence of the physiological and psychological responses to trauma …. these include the autonomic freeze, flop and disassociation responses or behaviour of the complainant designed to avoid further harm."**

11.6 Public Understanding of CSA and impact on jury decisions

There is increased public awareness of sexual abuse following high profile cases such as Rotherham, Oxford, Jimmy Saville, as well as the Independent Inquiry into Child Sexual Abuse (IICSA) and the #metoo campaign. Whilst this is increasing reporting by adults of child sexual abuse, the area of CSA remains a highly complex subject with varying attitudes and beliefs amongst the public, and low levels of reporting by children and young people.

Media and public understanding of CSA is focused more on child sexual exploitation . Yet CSA in the family is the most common type of sexual abuse in children, comprising two thirds of all CSA.

Public awareness and perceptions of CSA are anticipated to impact on how a jury reaches its verdict. Research evidence from Dr Dominic Willmott [xxi] considers that '*within rape trials, juror decisions are directly related with the attitudes and psychological constructs jurors bring to trial. Evidence that a juror's psycho-social make-up affects their interpretation of the evidence and ultimately predisposes them towards particular verdict decisions, gives rise to the possibility of needing to screen biased individuals out the jury trial process in the future*'.

The NCL CSA hub team reported the following outcomes for children and young people they supported through the criminal justice process.

- Over the first two years of service (2016-2018) a total of 10 cases completed with:
    - 4 guilty pleas
    - 1 discontinued for lack of evidence
    - 4 not guilty verdicts
    - 1 retrial awaited
- 4 cases were still pending trial

- 14 cases were awaiting CPS decisions

Those children and young people receiving not guilty verdicts felt that they had not been believed and found the cross-examination re-traumatising.

Risks:

- The focus on CSE and institutional CSA, as seen in high profile cases, to the exclusion of familial CSA can risk leaving the abuse hidden for many years, with young adults waiting on average 8 years to report abuse and male survivors over 20 years

- Risk of jury bias in sexual assault and rape trials based on the attitudes and psychological constructs of the members of the jury[xiii]

- Psychological damage to children and young people caused by not feeling believed by the judge and jury

Recommendations:

- **Raise public awareness of CSA, especially focusing on familial CSA**

- **Raise public awareness of the impact of trauma on survivors and how this may lead to dissociation and anger which the jury do not identify with a child being assaulted.**

- **Promote effective services such as CSA hubs and CYP Havens through accessible social media platforms, Apps and public awareness schemes to encourage more self-reporting**

12 Conclusions

The CSA services all demonstrate the benefit of a multiagency team providing holistic health support and case management. As the CYP Havens expands services and the Child House pilot commences more learning about this will emerge.

The early emotional support element of the services has provided symptom management, case management, advocacy and signposting for children, young people and their families. Access to early emotional support sends the message that the child is believed and there is a direct response to their disclosure; that their mental and emotional wellbeing matters irrespective of the outcome of a criminal case.

Whilst all three CSA services noted the limitation of short-term support, they were able to be flexible to accommodate those children and young people with increased needs. Following the interventions, 18-40% of children and young people required referral on for further long-term support from Child and Adolescent Mental Health Services (CAMHS), third sector or other services. The referral on rates ranged from

18% in the NCL CSA hub, 31% in the SWL CSA service and 40% of children and young people seen at CYP Havens.

Long waiting lists for onward referral into CAMHS and specialist independent sector providers were concerns for all three CSA services and further work is required to move towards trusted referrals to minimise re-assessment and transition issues.

There needs to be continuous communication, training and awareness-raising across partner agencies, especially police and social care. High levels of staff turnover require consistent communications to ensure that all staff understand the impact of the trauma of CSA and the pathway for support.

There remain challenges in delivering a child centred criminal justice process. These challenges need addressing if children and young people are to receive the justice that they deserve without being re-traumatised through the process.

This report has detailed recommendations throughout sections 10 and 11 that relate of each of the operational and systemic challenges faced. The report should be read in conjunction with the 2015 London CSA pathway review and CSA hub Toolkit.

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[ii] Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children, July 2018

[iii] Service specification for the clinical evaluation of children and young people who may have been sexually abused. Revised September 2015. RCPCH

[iv] Strategic Direction for Sexual Assault and Abuse Services, NHS England, April 2018

[v] http://www.childrenatrisk.eu/promise/wp-content/uploads/2017/06/PROMISE-European-Barnahus-Quality-Standards.pdf

[vi] NATIONAL CHILDREN'S ALLIANCE Standards for Accredited Members 2017. http://www.nationalchildrensalliance.org

[vii] Hahn et al, 2016
http://www.nctsn.org/sites/default/files/assets/pdfs/CFTSI_General_Information_Fact_Sheet.pdf

[viii] Berkowitz et al, The Child and Family Traumatic Stress Intervention: Secondary prevention for youth at risk of developing PTSD, 2016

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[x] *Letting the Future In a therapeutic intervention for children affected by sexual abuse and their carers - An evaluation of impact and implementation*, NSPCC, Feb 2016

[xi] Data from the Mayor's Office for Policing and Crime

[xii] NHS England (Kennedy, 2010).

[xiii] Turning the tide: Reversing the move to late intervention spending in children and young people's services - Action for Children, National Children's Bureau and The Children's Society 2017

[xiv] Data from the Mayor's Office for Policing and Crime

[xv] Transforming services for children and young people who have experienced sexual abuse - A Department of Health and Social Care (England) commissioned pilot. March 2018 https://tavistockandportman.nhs.uk/about-us/news/stories/transforming-services-children-and-young-people-who-have-experienced-sexual-abuse-final/

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[xviii] A PROTOCOL BETWEEN THE NATIONAL POLICE CHIEFS' COUNCIL, THE CROWN PROSECUTION SERVICE AND HER MAJESTY'S COURTS & TRIBUNALS SERVICE TO EXPEDITE CASES INVOLVING WITNESSES UNDER 10 YEARS

[xix] Crown Prosecution Service, *Therapy: Provision of Therapy for Child Witnesses Prior to a Criminal Trial*, Legal Guidance, Sexual Offences

[xx] Report of the Independent Review into The Investigation and Prosecution of Rape in London - Rt Hon Dame Elish Angiolini DBE QC - 30 April 2015

[xxi] Willmott, Dominic. (2018). An Examination of the Relationship between Juror Attitudes, Psychological Constructs, and Verdict Decisions within Rape Trials.