

Centre of  
expertise  
on child  
sexual abuse



LONDON  
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# Effectiveness of services for sexually abused children and young people

## Report 1: A knowledge review

Di McNeish,  
Liz Kelly and  
Sara Scott

October 2019



## Acknowledgements

We would like to thank the key informants, focus group participants and the staff, managers and young people from the services we visited all of whom provided invaluable contributions to this review. We would also like to thank DMSS Associates Sue Botcherby, Jennie Williams, Sarah Lloyd and Anna Ludvigsen who undertook fieldwork and provided research support, and the staff of the CSA Centre for their input and advice.

## About the authors

Di McNeish has many years' experience of practice, management, research and policy development specialising in services for children and families. Following an early career in local authority social work, she worked in policy and research in the voluntary sector and has had a long-standing commitment to promoting evidence-informed practice in children's services, as co-director of the 'What Works for Children' collaboration (involving Barnardo's, the University of York and City University), co-editor of *What Works for Children* (Open University Press, 2002) and trustee of the Social Care Institute for Excellence from 2003 to 2007. Di is now co-director of DMSS Research and has continued to specialise in research on children and families, gender and inequalities.

Liz Kelly is a feminist researcher and activist who has worked in the field of violence against women and children for 40 years: she was a founder member of groups that established a refuge in Norwich in 1973, the Women's Centre and Rape Crisis Centre. She is the author of *Surviving Sexual Violence*, and many book chapters, journal articles and research reports. In 2000 Liz was appointed Professor of Sexualised Violence and since 2006 has held the Roddick Chair on Violence Against Women. She is director of the Child and Woman Abuse Studies Unit (CWASU), London Metropolitan University, which has completed over 110 research projects, is known for making connections between all forms of violence against women and abuse of children, and runs the only MA on Woman and Child Abuse in Europe.

Sara Scott began her working life as a youth worker in Salford. She undertook her PhD at the University of Manchester and wrote *Beyond Disbelief: The Politics and Experience of Ritual Abuse* (Open University Press, 2001). From 2001 to 2007 Sara was Principal Research Officer/Head of Research at Barnardo's, directing a three-year research programme on the sexual exploitation of young people. She spent 12 years as a volunteer counsellor and trainer with Manchester Rape Crisis and eight years as part-time foster carer. Since 2007 Sara has been co-director of DMSS Research. She has undertaken research into young people's involvement in the August 2011 riots, and evaluations in the areas of violence, abuse, exploitation, mental health and gender inequality.

## About the Centre of expertise on child sexual abuse

The Centre of expertise on child sexual abuse (CSA Centre) wants children to be able to live free from the threat and harm of sexual abuse.

Our aim is to reduce the impact of child sexual abuse through improved prevention and better response.

We are a multi-disciplinary team, funded by the Home Office and hosted by Barnardo's, working closely with key partners from academic institutions, local authorities, health, education, police and the voluntary sector. However, we are independent and will challenge any barriers, assumptions, taboos and ways of working that prevent us from increasing our understanding and improving our approach to child sexual abuse.

To tackle child sexual abuse we must understand its causes, scope, scale and impact. We know a lot about child sexual abuse and have made progress in dealing with it, but there are still many gaps in our knowledge and understanding which limit how effectively the issue is tackled.

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# Summary

This report sets out the findings from a knowledge review commissioned by the Centre of expertise on child sexual abuse (the CSA Centre), as part of a suite of work to expand the evidence base on how best to assess the effectiveness of services responding to child sexual abuse (CSA).

The review was undertaken by DMSS Research in partnership with the Child and Woman Abuse Studies Unit, London Metropolitan University, between July and December 2018. It involved four phases:

- ▶ a rapid review of the literature, to highlight what published evidence does and does not tell us about service provision, and to establish what evaluations had already been conducted in this field
- ▶ 'key informant' interviews with 13 individuals identified for their practice and research experience and expertise
- ▶ three focus groups bringing together practitioners, policymakers and commissioners
- ▶ site visits to 12 CSA services across England and Wales, which incorporated interviews with managers and staff (either individually or in groups) and with 12 young people who had used the services.

Drawing on this work, the report outlines the current landscape of service provision, identifies core elements of effective practice in the field, and outlines the implications for the feasibility of multi-service evaluation.

## Key findings

The outcomes for sexually abused children and young people that were considered most important by both the professionals and the young people involved in this review were:

- ▶ being heard, believed and understood
- ▶ not blaming themselves
- ▶ a reduction in trauma symptoms and improved coping strategies
- ▶ positive, trusting relationships with adults and peers

- ▶ increased self-worth and confidence
- ▶ no longer being abused
- ▶ having hope for the future.

There were, however, some differences of emphasis according to the roles of professionals. Therapeutic staff were most likely to perceive 'success' in terms of 'most significant changes' in children and young people's relationships to themselves and others. Some commissioners and policymakers were more inclined to identify more concrete outcomes, such as 'no longer going missing' or 'engagement with education'.

There was considerable consensus on the core elements of effective services for sexually abused children and young people. These included:

- ▶ providing consistent relationships
- ▶ having an empowerment ethos
- ▶ having ways of working that are power-, inequality- and trauma-informed
- ▶ utilising a range of activities
- ▶ supporting non-abusing parents and carers
- ▶ having minimal waiting times and being able to offer long-term support.

Professional qualifications of staff were considered less important than the personal characteristics of workers. At the same time, the importance of staff support and supervision was strongly emphasised.

It was widely felt by professionals that barriers to achieving the most positive outcomes for younger children are often linked to the engagement of parents or carers. Practical barriers here include time and money, especially when families are geographically distant from services, and the competing needs of other children in the household. There can also be emotional barriers to parental engagement, particularly if a parent's own needs for support are not being met. Adequate funding to provide services for parents is therefore crucial.

For older children and young people, the timing of support and overcoming mistrust of professionals were felt to be often the biggest barriers. Services need the flexibility and resources to be able to spend time building trust, allow for chaotic lives or defer therapy.

Professionals felt that boys are under-identified as victims of CSA, as are black, Asian, minority ethnic and refugee children and young people. Reaching under-served groups was considered to take time and resources that many services may not have.

### *The service landscape*

A number of shifts in provision of CSA support over the last few decades were highlighted by professionals. Many of today's services were established in the 1980s, but in the last two decades the focus of child protection has shifted from CSA in general towards child sexual exploitation (CSE) in particular – and while specialist CSE services have developed, the number of general CSA services has declined. Current commissioning priorities reflect concerns over the criminal exploitation of children and young people (particularly 'county lines'), and over some young people's harmful sexual behaviour as well as their experiences of victimisation.

Services we visited fell into six broad 'types':

- ▶ specialist services providing support for children and young people affected by sexual exploitation (e.g. Barnardo's CSE services)
- ▶ post-abuse therapy services for sexually abused children and young people (e.g. the NSPCC's 'Letting the Future In' services)
- ▶ complex safeguarding services for children and young people (e.g. local authority teams)
- ▶ post-abuse therapy services for both adults and children
- ▶ sexual violence services providing post-abuse therapy alongside other support for adults and children (mostly Rape Crisis Centres)
- ▶ a specialist service providing support for young people with learning disabilities.

Most CSA support services were heavily reliant on non-statutory funding (e.g. from Children in Need, the Big Lottery Fund and smaller charitable trusts), with only a small proportion of their activities commissioned by health, criminal justice or social care agencies.

### *Views on evidence and evaluation*

Professionals participating in this review emphasised the importance of knowing:

- ▶ what children and young people (and parents) think of services
- ▶ what the long-term outcomes are for children who have used services after being abused
- ▶ what works for specific groups of children and young people
- ▶ what interventions consist of and how they work
- ▶ what changes are significant for individual children and young people
- ▶ not only what does work but what does not.

However, service staff and managers expressed some serious concerns about what the impact would be on services of participating in a cross-service evaluation – and, in the current funding climate, how the findings would be interpreted and used by funders/commissioners.

All the services we visited were already undertaking some monitoring and evaluation activities. However, staff in many of them regarded evaluation as something they did because current or potential funders required them to do so and felt that evaluation tools had been chosen in order to meet external demands rather than because of their value to the service and its clients.

## **Conclusions**

This review suggests there is considerable consensus among both professionals and service users on the core outcomes and the key features of successful services. This is an essential prerequisite of any cross-service evaluation in the field.

However, there are limited numbers of services, which exist within a rapidly changing landscape. The precarious funding position described by numerous participants would pose a serious risk for any evaluation in this field.

There is also considerable diversity between the broad service groupings we have outlined above; this makes it difficult to see how they could be included in a single evaluation.

# 1. Introduction

This paper forms part of a suite of work undertaken by the Centre of expertise on child sexual abuse (CSA Centre) to expand the evidence base on how best to assess the effectiveness of services responding to child sexual abuse (CSA).

Considerable work has been undertaken by the CSA Centre in this area, beginning with the 'Evaluation Fund' which supported 17 providers to improve their capacity to assess and evidence their services' effectiveness (Sullivan and Sharples, 2018). This was followed by a one-day workshop to share the key elements of monitoring and evaluation good practice, and the publication in June 2019 of a practical guide for services seeking to monitor and evaluate their work (Parkinson and Sullivan, 2019a).

Building on the learning from the Evaluation Fund, in 2018 the CSA Centre carried out consultations with the sector and desk research to identify areas for further exploration in relation to understanding services' effectiveness. The following research questions were identified:

- ▶ What are the key elements of practice of CSA services which facilitate success?
- ▶ Are these elements different for children and young people who are or have been in care and/or have learning difficulties/disabilities?
- ▶ What are the challenges to achieving success?
- ▶ How should effectiveness be measured in an evaluation study?
- ▶ What are the outcomes considered most important by service users and staff of CSA specialist services?
- ▶ Do models of service fall into coherent groups (e.g. based on needs, age bands, type of abuse)?
- ▶ Which service models are believed to be showing particular promise, and why?

This knowledge review was commissioned to establish whether common elements of effective provision and positive practice exist, with the aim of informing considerations around the feasibility of a multi-service evaluation study of support services.

Undertaken by DMSS Research in partnership with the Child and Woman Abuse Studies Unit (CWASU) at London Metropolitan University, it has drawn on existing published evidence and on interviews and focus groups with service users, providers, commissioners, policymakers and researchers.

To support the knowledge review, the CSA Centre undertook a survey of service providers to broaden its knowledge of services responding to CSA (Parkinson and Sullivan, 2019b); and commissioned work to explore the experiences of a 'boost sample' of service users with learning difficulties or experience of being in care (Franklin et al, 2019), as its initial consultation with the sector had identified that these groups were particularly vulnerable to sexual abuse (CSA Centre, 2017).

In addition to the research questions listed above, the knowledge review also sought to establish:

- ▶ the level of interest in/appetite for conducting a national evaluation
- ▶ whether there are enough services doing similar things to enable an evaluation to be designed
- ▶ whether there are service groupings, not already being evaluated, which have sufficient commonality to lend themselves to a shared evaluation.

This knowledge review was commissioned to establish whether common elements of effective service provision and positive practice exist

## 2. Methods

The study was designed across four phases, each building on the previous one, which were undertaken between July and December 2018.

A **rapid review of the literature** was conducted to highlight what was and was not known about service provision, and to identify evaluations already conducted in this field.

Both London Metropolitan University's Child and Woman Abuse Studies Unit (CWASU) and DMSS Research provided material relevant to this work, as did the CSA Centre.

A search was made on Academic Search Complete using the following search terms:

- ▶ 'responses to child sexual abuse + effectiveness'
- ▶ 'responses to child sexual abuse + evaluation'
- ▶ 'direct work on child sexual abuse + effectiveness'
- ▶ 'direct work on child sexual abuse + evaluation'.

The majority of search results were not relevant, as they were concerned with criminal justice interventions or covered direct work with adult survivors. Thirty papers of direct relevance were located and downloaded, of which 20 were carefully read; the other 10 were excluded as having minimal relevance.

Using Google, additional searches were made for papers on the Barnahus (Children's House) model and the Child Advocacy Centre model from the USA on which it is based; each of these searches produced two further papers. However, the published material on both models focuses almost entirely on the criminal justice processes, with virtually nothing about the integrated counselling and support services. An email follow-up to Nordic academics produced a little more information.

Two more specific searches were undertaken: one on the *Journal of Child Sexual Abuse*, which produced two papers just published online; and one for research linked to Australia's Royal Commission into Institutional Responses to Child Sexual Abuse, which located a paper on models of support.

**Key informant interviews** were conducted with 13 individuals, each of whom had 20–40 years of engagement with CSA – as senior practitioners in social work or therapeutic/support services, as researchers, or as children's and/or adult survivors' advocates. These individuals were selected because they were able to reflect both on previous and current provision, and had knowledge and/or expertise on direct work with children and young people. Several had specific knowledge about work with looked-after children, one with children who had learning difficulties, and one with black, Asian and minority ethnic (BAME) children and young people. The interviews took place by telephone using a semi structured pro-forma linked to the research questions, and were typed up immediately.

The material generated by the literature review and the key informant interviews was used to develop the format of and topic guides for the focus groups and the site visits.

Three **focus groups** in London, Leeds and Cardiff brought together a total of 28 practitioners, policymakers and commissioners. Participants were identified by the CSA Centre's practice improvement team as having national or local policy and funding responsibilities or currently providing CSA support services. Where possible, individuals with expertise in relation to looked-after children, children with learning difficulties or BAME children were recruited.

Focus groups in London, Leeds and Cardiff brought together a total of 28 practitioners, policymakers and commissioners

The focus group included two ‘sorting’ exercises, in which participants were asked to rank and discuss:

- ▶ eleven potentially desirable outcomes of support
- ▶ eight features of an effective service.

The features/outcomes to be ranked in these exercises were determined by the literature review and the key informant interviews. Another structured exercise involved creating a template for an ‘ideal’ service. The rest of the time in the focus groups was spent exploring themes linked to the research questions.

Finally, **site visits to 12 CSA services** across England and Wales, incorporating interviews with managers and staff, took place. The services were selected to provide a geographical spread of services working specifically with child victims/survivors of CSA, and to a variety of providers, types of service provision and approaches to direct work that reflected the diversity of service provision in this field.

The approach taken to site visits was flexible, to fit in with busy workloads and the scale of services; care was taken not to interfere with the services’ support work. In each service we interviewed staff working directly with children and young people, as well as service managers. Some staff teams chose to be interviewed together, others separately. The number of staff interviewed in each organisation ranged from two to 13.

The questions asked of staff reflected those used in the key informant interviews and focus groups, with additional questions about their philosophy and practice, what their services did and why they did it that way, how many children and young people they supported in the last year, sources of funding, and how they currently evaluated their work.

Additionally, each service was asked whether there were young people who had completed (or were about to complete) receiving its support and would be willing to talk to the researchers. Some services were unable to identify any young people to be interviewed, and some young people did not turn up when we visited; in total, interviews were held with 12 young people. Questions focused on what mattered to them about the support they had received, what they thought had changed for them as a result, and their hopes for the future.

## 2.1 Ethical considerations

The project methodology, safeguarding arrangements and research tools were given ethical approval through the CSA Centre’s research ethics committee.

Individuals and organisations participating in the knowledge review were assured that they would not be identified by name or other features in any report shared outside the CSA Centre. In practice, this has not been possible in the case of two services:

- ▶ Respond is a specialist abuse and trauma therapy service for adults and children with learning disabilities, and is the only organisation of its kind in the UK; with the agreement of the director, it therefore appears here under its own name.
- ▶ Although the specific project is not named, it is evident that one participating service was a NSPCC project, since it was using the NSPCC’s ‘Letting the Future In’ CSA programme; its inclusion in this report was agreed with the NSPCC prior to publication.

## 2.2. Limitations

This was a small-scale, time-limited piece of work with fieldwork conducted in just three months. It does not therefore provide a comprehensive overview of the field.

The rapid review of relevant literature was based on the research team’s prior knowledge, rather than a systematic search. The identification of interviewees, focus group participants and services was strongly informed by the knowledge and existing contacts of the CSA Centre and the research team. The sample of young people interviewed was small, being constrained by both the short timescale in which services had to recruit them and the need for each interview to take place during a single site visit during August/September 2018.

Although the knowledge review did attempt to explore whether there were elements of effective practice that were specific to work with looked-after children and those with learning difficulties, this research question was answered more comprehensively in the separate study interviewing a ‘boost sample’ of these groups (Franklin et al, 2019) and is therefore not a particular focus of this report.

## 3. Establishing the groundwork

Prior to developing research tools and undertaking fieldwork, a rapid review of existing literature was undertaken. In addition, interviews were conducted with 13 key informants: practitioners and researchers with extensive experience in the field of CSA over several decades. This section sets out the findings of this groundwork stage.

### 3.1 Rapid review of published research

The rapid review provided a broad overview of key evidence on approaches to direct work with children and young people who have been sexually abused. It was not a comprehensive assessment of existing evidence, but rather drew out information pertinent to the following three questions:

- ▶ What do existing models/approaches to direct work with victims and survivors of CSA (including CSE) look like?
- ▶ What are the core elements/principles of such work with children and young people?
- ▶ How has effectiveness been defined and measured?

Relatively few recently published studies of services for sexually abused children and young people in the UK were found, with the exception of some studies on CSE services (Moynihan et al, 2018; Scott and Skidmore, 2006; Scott et al, 2017; Snedden et al, 2016) and the NSPCC-funded evaluation of its 'Letting the Future In' programme for victims and survivors of CSA (Carpenter et al, 2016).

There are clear differences, in approach and content, between support work undertaken with children and young people who have been sexually exploited and those who have experienced other forms of sexual abuse. To a certain extent, the differentiation relates to the age groups most likely to be identified as 'exploited' or 'abused', with most sexual abuse of teenagers being labelled as CSE. However, services also come out of different histories: work with sexually abused children has its origins in social work and child psychotherapy,

while services for sexually exploited young people have their roots in youth work (Bovarnick et al, 2017).

Direct work is generally understood as that which happens face to face and over time, and requires building relationships based on honesty, trust and mutual respect (DMSS, 2015). It may utilise psycho-educational, social pedagogy or psychotherapeutic interventions. That said, many of the texts stress the combination of emotional and practical support, including advocacy, brokering of relationships with other services and work with parents/carers. Support in the aftermath of CSA, therefore, is often much more than just individual therapy.

Both specific studies and overviews note that one of the challenges of direct work with young victims and survivors is that there is no linear pathway of change (see, for example, Hetzel-Riggin et al, 2007): young people begin in different places and their progress has peaks and troughs, perhaps best represented as a spiral where movement is possible in both directions.

While there is no single model of support, the rapid review identified four general approaches: children's advocacy; child centred support; residential (Thompson et al, 2011); and feminist sexual violence services (Mladjenovic, 2004; Vera-Grey and Joanknecht, 2018).

One challenge of direct work with young victims, as noted in the published research, is that there is no linear pathway of change

### 3.2 Interviews with key informants

Interviews explored what the key informants thought sexually abused children and young people need, the outcomes that should be hoped for from specialised support, and the active ingredients of effective services.

A recurring theme was the current dearth of therapeutic support and the skills, knowledge and services (which a number of interviewees had been part of establishing) that had been lost since the 1980s. As awareness of CSA had grown in the 1980s, more attention had been devoted to the issue in social work training and practice, including courses on direct work with children. Alongside this, voluntary-sector support services had emerged in many locations – some located within children’s charities, others in women’s organisations and still others as therapeutic services. Section 5.1 sets out changes that have happened since that time.

Regarding the effective aspects of services, there was consensus among key informants that the most crucial aspects were having an empowerment ethos and enabling children and young people to build trusting relationships with the same worker over time – an insight later echoed in the focus groups and site visits (see sections 4.1, 5.5 and 5.6).

“Consistent, well-supervised and supported workers with a broad skill set are the thing that counts most.” (Key informant)

There was also agreement that workers need a thorough understanding of both power relations and the impacts of trauma. Interviewees stressed how issues of gender, race/racism and learning difficulties could be entangled with experiences of abuse for some children.

“Practitioners need to have a thorough understanding of the operation of power and of social inequalities – and be very thoughtful about the interlocking and intersectional nature of children’s lived experience of inequalities.” (Key informant)

“Boys struggle more with admitting having been abused and the contradictions between ideas of masculinity and being victimised – including expressing feelings.” (Key informant)

Interviewees emphasised the need for CSA to be addressed explicitly in order to break the silence and achieve safety and justice for children and young people. They suggested that this needed to happen not just in direct work with children and young people, but in practice more generally.

“Naming it – clear messages that it is speakable and it was wrong/should not have happened. Knowing others know what has happened – no more secrets – achieving some sense of justice. Community ownership – reframing abuse as not just a private, individual issue. Contact with other survivors.” (Key informant)

“Safety – being safe from further abuse – not possible to begin recovery without it. As spontaneous disclosure is rare, that means proactively looking for signs of CSA. In general, this no longer happens – social workers think they’ll have to ‘prove’ it and won’t be able to, so CSA is often ignored unless CSE crops up. It is a hidden issue, lot of denial, disguised under labels like ‘complex needs’. If CSA is not directly addressed, then contact with abusers often continues so there can be no safety.” (Key informant)

Interviewees agreed that workers need a thorough understanding of both power relations and the impacts of trauma

In terms of direct work, the needs of older and younger children were regarded as being similar, albeit requiring different practitioner skills. Key informants considered play therapy to be essential for younger children.

“Play therapy is crucial – play is what children do. Different skills are required for communication with younger children (some of these are great for older young people too) and you can’t just cut down an adult/adolescent intervention for children.” (Key informant)

“The needs of younger children and teenagers are not really that different – it’s more a matter of developmental stage and the amount of autonomy they have. All the needs of children apply to young people too but are less commonly recognised, e.g. they need to know their parents’ needs are also being met.” (Key informant)

However, some interviewees emphasised an additional need for older young people to explore what the abuse meant for their relationship with their own bodies, gender and sexuality, and for their agency as well as their victimisation to be acknowledged.

“Young people do not want to see themselves as ‘victims’ or as children who have been duped/tricked/bullied – you have to acknowledge their reality as well as help them see the imbalance of power.” (Key informant)

Several interviewees noted that the transition to adult services was often problematic, as support services stopped or changed once the young person reached 18. This was also a concern raised by the young people interviewed later (see section 5.6).

There was widespread agreement on what key informants believed constituted the ingredients of effective services:

- ▶ A consistent relationship.
- ▶ Flexibility.
- ▶ Capacity to work over longer time frames.
- ▶ Addressing abuse directly, including issues of power.
- ▶ A safe space in which children and young people feel welcome.

- ▶ Knowledgeable and skilled staff who are supported and supervised.
- ▶ Giving children and young people choice and control.

Less commonly cited ingredients were:

- ▶ Peer support.
- ▶ Work with parents/carers (although this was discussed in more detail across the focus groups, site visits and interviews with young people).
- ▶ Bodywork.<sup>1</sup>

“Peer support is a big part of young people’s lives – there’s a weak evidence base but it’s vital. We can do much more to equip them to support each other and recognise their strengths and their desire to give and not just receive.” (Key informant)

In terms of what counts as success and the outcomes that good support should lead to, the therapeutic goals emphasised were knowing that abuse was not their fault; being able to have good relationships and friendships; having fewer trauma symptoms; and having more positive coping strategies. Other outcomes included good health, life skills and delayed first pregnancy.

“[An outcome should be that] Children have a better support network than previously, and they have a good understanding in relation to the impact of things that have happened to them and how to manage/cope/learn/find help when they need it and move forward.” (Key informant)

“[An outcome should be] Feeling normal/being able to align selves with non-abused peers. Especially when young belonging, identifying and being accepted amongst peers is so important – and being sexually abused is the antithesis of what they mean by normal.” (Key informant)

<sup>1</sup> Bodywork may include massage, breath work etc, with the aim of improving body/mind connections, helping children to get back in touch with their bodies in a positive way.

Asked what would make the most valuable contribution to knowledge in the field, interviewees emphasised the need for longitudinal studies which followed children and young people into early adulthood (also a desire of focus group participants and services), and the development of outcomes frameworks which focused on what mattered to young victims and survivors themselves. There was also a desire for detailed descriptions of what services' work comprised, the absence of which many found perplexing.

“I'd want to know about young people's experience of the service and about what counted for them. I'd like really good descriptions of the practicalities of what was done and how it was done. I want to know which bits of the systems had impacts in what contexts. I'd want to be able to understand the whole of the service or intervention and the role of different parts within it.” (Key informant)

“We have no longitudinal follow up research on things like Cognitive Behaviour Therapy. Does it sustain over time? And what exactly does it change? I don't find it authentic that someone could feel safe in such a short space of time – you might be able to function but that does not mean you are at peace, that you are not still determined by this. It takes the emotion out, but the emotions are what troubles.” (Key informant)

Several interviewees referred to the importance of learning from the history of service provision and referred back to the foundations of this work in the 1980s.

“We need to dare to be radical – we forget that early work on CSA was radical. There is not a great history in children's organisations about this, it was feminist work that disrupted ways children were failed, not listened to. I admire indigenous people who have taken this away from the state, saying explicitly that the state was part of the harm done to children and families. Proximity to the state has damaged the work; to move on demands a boldness.” (Key informant)

The insights on active ingredients of effective services and desired outcomes gained from the rapid review and key informant interviews were compiled to create two sets of statements which were then 'tested' in the focus groups.

The need was emphasised for longitudinal studies and for outcomes frameworks that focus on what matters to victims and survivors

## 4. What did focus groups see as key features of an effective CSA service?

Building on the literature review and key informant interviews, we further explored the question of what constitutes an effective CSA service in three focus groups. These brought together practitioners, commissioners and policymakers and were held in London, Leeds and Cardiff. The groups explored similar themes to the key informant interviews, with the addition of two sorting exercises: prioritising outcomes and ranking the key ingredients of effective services.

### 4.1 Prioritising outcomes

The outcomes statements, derived from our analysis of the groundwork phase, were that the child or young person:

- ▶ has a positive, trusting relationship with an adult
- ▶ has a suitable, stable living situation
- ▶ is no longer being abused
- ▶ is engaged with education
- ▶ has reduced trauma symptoms
- ▶ no longer blames themselves
- ▶ feels safe (in their body, family, neighbourhood)
- ▶ has increased self-esteem/self-worth
- ▶ is able to speak about their abuse
- ▶ can imagine a positive future
- ▶ is not going missing.

Participants were asked to rank these statements in order of importance, and to discuss their reasoning – which prompted most of the groups to reorder their initial lists.

Two main discourses emerged from the discussions. One emphasised the need for abuse to have stopped as an essential precursor to therapeutic work. In the other, ending the abuse was seen as an aim, with positive work regarded as possible even if abuse was still occurring.

Participants' adoption of these discourses tended to depend on the child or young person they had in mind. Some were typically thinking about a younger child abused in a family/institutional context; the others focused on a teenager being sexually exploited. The differences between these two broad groups of abused children and young people emerged as a theme throughout our review: both groups were clearly identified as in need of support but the approaches to the work were different.

There were also differences in how important participants considered it to be that a child/young person was able to speak about their abuse. Some thought this needed to be an early outcome which would then facilitate other outcomes. Others argued that children and young people may never speak explicitly or specifically about the abuse, but nonetheless can be helped to move forward.

Beyond these differences, there was a good deal of agreement about the most important outcomes. The most frequently top-ranked outcomes were:

- ▶ has a positive, trusting relationship with an adult
- ▶ has a suitable, stable living situation.

A trusting relationship with an adult and a suitable, stable living situation were widely considered to be the most important outcomes

## 4.2 Features of effective services

The groups went on to rank eight ingredients for effective services, again derived from analysis of the groundwork phase, in the following order of importance:

- ▶ Staff understanding of power and inequality.
- ▶ Staff supervision.
- ▶ Length of time service can work with a child/young person.
- ▶ Flexibility in frequency/level of contact.
- ▶ Flexibility in where service is delivered.
- ▶ Multi-agency working.
- ▶ Range of professionals on the team.
- ▶ Professional qualifications of staff.

A striking common view was that professional qualifications were much less important than the characteristics of workers: that they needed to be empathic, trauma-informed and child-focused. However, supervision was ranked highly by all groups.

Flexibility (particularly about the length of time/frequency of contact) was consistently ranked higher than multi-agency working or the range of professionals in the team.

Staff understanding of power and inequality was ranked as a high priority by some but not all participants in focus groups.

This key question was returned to in the site visits, with staff and with young people themselves (see Chapter 5).

## 4.3 Are different ways of working required for different groups of children and young people?

Focus group discussions explored whether there were different needs and ways of working for different groups of children and young people, depending on the forms and contexts of their abuse or on their characteristics (age, gender, ethnicity, class and disability).

Different forms and contexts of abuse were thought to raise different issues. The complexity of relationships where abuse is intra-familial was highlighted – and a key factor was whether there is a non-abusing parent who can be engaged. Different approaches were thought to be needed for peer abuse and for where the abuse is ongoing or no disclosure has been made – as is often the case with CSE or where abused children are also displaying harmful sexual behaviour.

In terms of age, participants emphasised the need to take into account developmental stage, levels of understanding and communication, and the different levels of autonomy, choice and control over their lives that children and young people had at different stages. The value of play therapy for younger children was emphasised.

The key issues raised about gender, ethnicity and class were under-identification of boys, and of BAME and refugee children and young people, as victims of CSA. Reaching under-served groups was believed to take time, resources and a diversity of staff that most services were acknowledged not to have. Disabled children were understood to be more vulnerable but less visible, and work with them takes more time and requires different communication methods.



A common view was that professional qualifications were less important than being trauma-informed, child-focused and empathic



Not being able to ensure a safe, stable base for looked-after children was seen as a key issue, alongside the likelihood of other issues in their lives. There was recognition that numerous agencies are often involved, and a sense that looked-after children's lives are very exposed. Working with parents/carers was seen as important but more complex here. These themes were further explored in the boost sample interviews: having a trusted adult was highlighted, as was the need for safety and support alongside the importance of communication across agencies and ensuring the right provision at the right time (Franklin et al, 2019).

#### 4.4 An 'ideal' CSA service

There was considerable consensus across the three focus groups about what an 'ideal' CSA service should look like. The following attributes were noted:

- ▶ Is individualised and adaptable to the child's needs.
- ▶ Has consistency of relationships between staff and children.
- ▶ Is not time-limited, including an open door for future support.
- ▶ Has staff from different disciplines, with a range of skills.
- ▶ Has capacity (that is, no waiting list).
- ▶ Works with non-abusing parents and carers.
- ▶ Fosters aspirations.
- ▶ Provides fun and colour that reconnect children to life.
- ▶ Supports its workers.
- ▶ Is well-linked to other services.

The findings from the focus groups, following on from the groundwork done in the key informant interviews and rapid literature review, informed the sampling and design of our fieldwork for service visits discussed in the next chapter.



Ideally, the focus groups said, CSA services should foster aspirations and provide 'fun and colour that reconnect children to life'



## 5. Current service provision for children and young people affected by CSA

Drawing primarily on the interviews undertaken during our 12 site visits, this section describes the six types of CSA service featured in the knowledge review, the context in which they operate, and the way they currently evaluate their effectiveness. It also sets out the views of service users, managers and staff on the key outcomes and elements of successful services that the focus groups considered in the previous chapter, and the barriers that they face in achieving success.

### 5.1 The context of current CSA service provision

The context in which CSA services operate is continually evolving. Some key current contextual issues emerged from our key informant interviews and site visits, which are likely to affect the provision – and the evaluation – of CSA services.

The past 30 years have seen changes in how CSA is defined and prioritised. For example, during the 1980s CSA was a major concern of local authorities and was being increasingly identified as a central child protection priority: in 1984, 23% of child protection plans (CPPs) in England and Wales identified CSA as a significant concern. By 2017, this had reduced to 5% of CPPs, although it is widely accepted that this is explained not by a reduction in the incidence of CSA during this period, but by shifts in the issues that local authorities perceived as priorities and in recording practices (Kelly and Karsna, 2017). Issues that rose up the child protection priority list during this time included child neglect and, most recently, child sexual exploitation (CSE) – which went from being a category unrecognised in formal recording systems to a major priority, to the extent that in recent years the sexual abuse of teenagers has commonly been identified as CSE rather than CSA. Some of our key informants observed that referring a young person for concerns about CSE was one of the few ways of getting them some support, given the dearth of CSA services and the growth of specialist CSE provision.

Recently there has been a further reframing of CSE and other forms of CSA within children's services. For example, some children's organisations are more explicitly combining CSA and CSE services, sometimes along with services for children and young people displaying harmful sexual behaviour, on the basis that this enables a more holistic approach to young people's needs. At the same time, other rapidly emerging priorities are changing the landscape of commissioned services for children and young people. High among these is the criminal exploitation of children and young people and 'county lines'; similarities between the patterns of CSE and child criminal exploitation (CCE) have led to a push for specialist CSE services to broaden their remit to include CCE, evidenced by those we studied that are now called complex safeguarding services. It is perhaps too soon to assess the impact of this development.

Over the last decade there has been a major reduction in funding for local authority services. This has undoubtedly had an impact on the availability of support for children and families. At the same time, statutory children's services have been under pressure to improve their support to families, notably both to intervene earlier and to increase the quality of direct support to children affected by a range of complex safeguarding issues – see, for example, Munro (2011). The concept of 'complex safeguarding' has emerged, with a growing trend among local authorities to move away from specialist services towards multi-disciplinary teams (often with some specialist

Organisations are combining CSA and CSE services, on the basis that this enables a more holistic approach to young people's needs

workers) which can respond to the range of issues presented by families, including CSE and other forms of CSA alongside domestic violence and substance misuse and other issues (McNeish et al, 2017).

**“The National Audit Office estimate that local authorities in England lost roughly a third of their central government funding between 2010-11 and 2015-16, and a quarter of their total funding once council tax is included. It is clear that the scale and nature of these reductions in local authority resourcing writ large are having a significant impact: on thresholds for access to children’s social care; on access to children and young people’s mental health services; and on access to other services, including those delivered by the voluntary sector.”** (Chanon Consulting et al, 2018)

Alongside these developments, there have been parallel shifts in priorities within adult services. Notable among these are the funding and commissioning patterns for domestic and sexual violence services. There has been an increased policy focus on domestic violence, accompanied by investment in domestic violence services by national government departments, major charitable funders (such as the Big Lottery Fund, now renamed the National Lottery Community Fund) and local commissioners. These developments are welcome, but similar investment has not been made in sexual violence services (Towers and Walby, 2012; All-Party Parliamentary Group on Sexual Violence, 2018).

There is an irony here: at a time when public concern about current and historical sexual abuse has never been greater, funding for services to support victims and survivors of sexual violence has been squeezed ever tighter (Crees et al, 2016; Hunter et al, 2016). Many sexual violence services survive only by stitching together a patchwork of time-limited funding: a little Ministry of Justice money here, some Comic Relief funding there and the occasional locally commissioned provision, some of which is spot purchased. Many receive no or very little statutory funding. That said, they have not only survived but expanded in the last decade, both in terms of numbers of services and in the extent of provision for children and young people.

## 5.2 What do current services look like?

CSA services vary according to the type of organisation providing them, how they originated and have developed over time and how they are funded and/or commissioned. We visited 12 services as part of this review; while we would not claim this to be a fully representative sample of CSA provision, it does provide a reasonable snapshot of the range of services currently being provided to children and young people in England and Wales.

The children and young people’s services we visited were mostly staffed by between four and 12 workers (a number of whom were part-time) and had worked with between 30 and 100 children and young people in the previous year. There were three larger services working with higher numbers: all were rape crisis centres. It was difficult for some service providers to specify exact numbers of children and young people supported for sexual abuse because of the range of work they were doing on related issues. Some staff worked across different areas, and not all did direct work. (For example, some roles were primarily awareness-raising.) More information on the number of children and young people being worked with by CSA services is provided in the CSA Centre’s survey of service providers (Parkinson and Sullivan, 2019b).

Staff at the services visited had varied professional backgrounds. For example, some services employed only qualified therapists for therapeutic work, while similar work in other services was undertaken by social workers. Others had multi-disciplinary teams. And some made extensive use of volunteers for some aspects of their support work.



Most of the services visited had between four and 12 staff, and had worked with 30–100 children and young people in the past year



Services' funding arrangements also varied. Only the NSPCC project was funded almost entirely by voluntary donations (with some contribution from the local authority). Another was entirely funded as a statutory service. The other 10 were funded through a mixture of generally small amounts of commissioned services (local authority and some health) and a range of charitable trust monies (Comic Relief, Children in Need etc), with a few receiving some government funding (e.g. from the Ministry of Justice).

### 5.3 Types of services

We have grouped the services under six broad headings, which reflect what forms of abuse and which victims and survivors of CSA they work with:

- ▶ specialist CSE services providing support for children and young people
- ▶ post-abuse therapy services for sexually abused children and young people
- ▶ 'complex safeguarding' services for children and young people
- ▶ post-abuse therapy services for both adults and children
- ▶ sexual violence services providing post-abuse therapy and other support for adults and children.
- ▶ a specialist service providing support for young people with learning disabilities

#### *Specialist CSE services providing support for children and young people*

Because of the growth in the CSE field in recent years, there are probably more services nationally in this grouping than in any other (although, as noted in section 5.1, many of these services are changing). We visited three such services, which tended to have a number of common features:

- ▶ They work largely with young people aged 10 and over.
- ▶ They generally work flexibly with young people, providing both centre-based and outreach support.
- ▶ They are young person led in terms of the support they provide, and often focus on the issues facing young people in the here and now, including practical as well as emotional concerns.

- ▶ Young people's participation is usually a key feature of these services, and this may include peer support.
- ▶ Their work may include support to parents and carers.
- ▶ They often include an element of preventive education – for example, healthy relationship education to individuals and to groups of young people in schools.
- ▶ Their work includes an independent sexual violence adviser (ISVA) role in supporting young people through processes of police interviews, prosecutions and court cases.
- ▶ While they provide emotional and psycho-educational support, they do not usually provide formal therapy.

#### *Post-abuse therapy services for sexually abused children and young people*

Some services – such as those provided by the NSPCC – specialise in providing post-abuse therapy for children and young people, often with support for their families. The common features of these services are as follows:

- ▶ They provide therapy for children and young people post-abuse, i.e. where CSA has already been identified and investigated.
- ▶ They provide a structured therapeutic intervention based on specific approaches or combinations of approaches.
- ▶ They are usually open to referrals of children of all ages, but therapy is less common for very young children.
- ▶ Sessions are usually of a specified duration (e.g. up to 20 weeks) and usually, though not exclusively, provided at a service base.
- ▶ The therapy may be provided by a qualified therapist but is often provided by other professionals (e.g. social workers) who have received additional training.
- ▶ The work usually includes support for non-abusing parents/carers.
- ▶ There are usually some preconditions – notably, for children to be in a safe, stable situation – that must be met in order for therapy to be provided.

### *‘Complex safeguarding’ services for children and families*

As noted in section 5.5, many local authorities have adopted the concept of complex safeguarding, which recognises that children and families are rarely, if ever, affected by a single issue. Young people identified as sexually exploited, for example, may have been sexually abused when younger, and may be living with domestic violence, mental ill-health and/or substance misuse.

There is a growing trend for local authorities to respond to this via multi-disciplinary teams with access to specialist support, rather than whole teams specialising in a particular issue. We visited a well-established example of such a team. There is too much variation between local authorities, and too few descriptions of services, to offer a definitive list of common features, but such teams may have some or all of the following:

- ▶ Teams are made up of staff from a range of backgrounds including social workers, other health and youth work professionals – this is sometimes reflected in joint funding of services, e.g. between the local authority and health.
- ▶ There is access to specialist expertise within the team, e.g. a clinical psychologist.
- ▶ There is co-working of cases both within the team and with other workers – for example, a case may be held by a local area team social worker, with the complex safeguarding team providing either co-working or case consultancy.
- ▶ Attempts are made to reduce caseloads, in order to enable more direct work with children and families.
- ▶ There is access to clinical supervision and group supervision.
- ▶ There has been development of staff with a range of therapeutic skills.
- ▶ A mixed-service provision combines some centre-based one-to-one therapy with outreach.
- ▶ Access is generally via a multi-agency assessment process, so that families will need to meet certain threshold criteria (e.g. children on a child protection plan).

### *Post-abuse therapy services for both adults and children*

A number of UK services provide post-abuse therapy to both adults and children. As we discuss below, many of these also offer other forms of support such as an ISVA service. However, there are fewer services which are exclusively therapeutic in focus; we visited one of them. Features of these services are:

- ▶ They provide separate one-to-one therapy services for adults and children, with staff therapeutically trained and qualified and provided with clinical supervision.
- ▶ The work with children is usually provided by specialist child therapists.
- ▶ The therapy is provided post-abuse, i.e. where CSA has already been identified and investigated.
- ▶ The work is usually very ‘boundaried’ in approach, i.e. therapy at set times and locations.
- ▶ The range of therapies may vary – for example, cognitive behaviour therapy, eye movement desensitisation and reprocessing (EMDR), or play therapy. Regardless of the therapeutic intervention used, the work is almost always described as trauma-informed, with attachment being a strong feature of work with children.
- ▶ There is usually some provision for work with non-abusing carers/parents.

A number of UK services provide post-abuse therapy to both adults and children, but fewer are exclusively therapeutic in focus

### *Sexual violence services providing post-abuse therapy and other support for adults and children*

Some services combine a specialist therapy service (as described above) with other forms of support for both adults and children. Many of these are part of the federation of Rape Crisis Centres; they often have an adult and a child ISVA service, support groups (e.g. for adult survivors or for parents) and a helpline. We visited five of these services. Common features of them are:

- ▶ The therapeutic services tend to be similar to the therapy services described above, with an emphasis on power relations and perpetrator tactics.
- ▶ There is no ‘gap’ when young people reach 18, as the services work across age groups.
- ▶ These services are more likely to include group support, including ongoing support post therapy.
- ▶ They have a range of outreach and advocacy provision; some is linked to criminal justice system cases, some is more wide-ranging case advocacy with young people.
- ▶ For most of these services, the helpline provides access to confidential support as a first step.

### *Specialist service for people with learning disabilities*

“The main adaptation is time – with a much longer assessment period. Many of the children have huge attachment difficulties and establishing a therapeutic relationship is therefore much more difficult – there can be weeks on end where nothing seems to shift and there’s no development of relationship. The parents mostly come with a lot of needs themselves and the whole situation is often complex and there’s a need for a lot of advocacy and liaison with other services.” (Key informant)

Some of the above services also provide support to people with learning disabilities and adapt their provision accordingly. For example, the NSPCC has developed an adapted version of ‘Letting the Future In’ for children and young people with learning disabilities (Jessiman and Carpenter, 2018), and other services referred to having therapists with additional training in learning disability. One of the services we visited, Respond, specialises in supporting people with learning disabilities (see box).

## Respond

Respond is a specialist therapy service for adults and children with learning disabilities who have experienced abuse or trauma, as well as those who have abused others. It provides a central London psychotherapy and advocacy service, an ISVA service and training and consultancy to other professionals nationally. The young people’s service has a range of staff trained in drama, dance/movement, and art therapies. Trust funding enables it to provide free or subsidised services, but it also generates income through training, forensic work and contracts with schools.

The service uses a case management model, with a separate worker for the family (or foster carers) and a therapist for the young person. The ‘case manager’ provides a bridge between the confidential therapeutic work and the client’s parents, carers and everyday support network.

Respond calls its model of psychotherapy an ‘Attachment-based Systems Approach’. It is based on two key assumptions:

- ▶ To bring about long-term change, the wider support network has to be in place and agreeing to become an integral part of the therapeutic process.
- ▶ Professionals and carers want to be given time to learn, reflect and share experience; this improves wellbeing and engenders healthier relationships between people.

“[In terms of what’s different, we are] less likely to be seen sitting and talking (though we do that too). We use lots of other creative ways of communicating, building relationships and helping people to ... make sense of their feelings and actions and get a better understanding of their experience of being ‘them’. It’s a much warmer approach – very human – playful – more active than traditional psychotherapy ... Our approach is informed by understanding of the effects of inequality and social justice models. Even if we can’t make a difference to their experience, we name the fact that it is unfair.” (Staff member)

“For many young people with learning difficulties, the boundaries of their body have been eroded by the personal care they’ve needed to receive from other family/carers. So, strengthening their personal boundaries and ownership of physical space is part of the therapy.” (Staff member)

## 5.4 The ethos of services

The above broad grouping of services derives from our observations of the type of support offered, and to whom. But we also observed differences in the ethos of services, deriving largely from the traditions out of which they had evolved. We have identified these as broadly ‘therapeutic’, ‘youth work’ or ‘feminist’ in their ethos, although – as Figure 1 illustrates – there is some overlap between these with, for example, some therapeutically oriented services being more or less feminist in their ethos. One service was positioned in the centre, combining aspects of all three.

Services that are predominantly **therapeutic** in their ethos tend to:

- ▶ be structured and boundaried in their approach
- ▶ take most of their referrals from external agencies (with few self-referrals)
- ▶ focus on the psychological impacts of CSA, with a particular emphasis on trauma and attachment
- ▶ be individualised in approach, with the therapy hinging on the relationship between therapist and client.

Services that are predominantly **youth work** oriented in their ethos tend to:

- ▶ be flexible about access to support, i.e. will support young people at home and other settings including drop-in and outreach
- ▶ focus on providing practical and emotional support in the here and now
- ▶ have an emphasis on advocacy and participation, which may include peer support
- ▶ work mainly with young people (i.e. those aged over 10) rather than with younger children
- ▶ have their origins in the children and young people’s sector.

Services which are explicitly **feminist** in their ethos tend to:

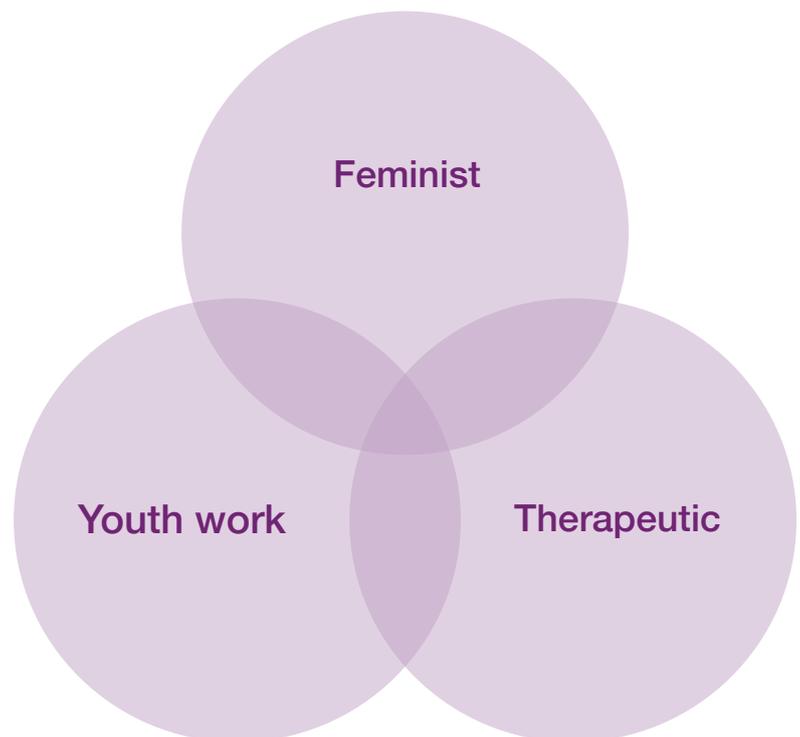
- ▶ focus on both the psychological and the social consequences of CSA
- ▶ take a holistic and trauma-informed approach

- ▶ have a more explicit emphasis on the impact of inequalities (gender, race and their intersections)
- ▶ usually be open to self-referral, e.g. via a helpline
- ▶ place greater emphasis on the value of peer support and group work
- ▶ often combine centre-based support with outreach
- ▶ have origins in the women’s movement.

“An intersectional feminist approach: to work on CSA you need to understand power and the goal of liberation, this will inform how you have conversations. Through it you will offer a wider context for personal experiences, it is not just them as an individual.” (Key informant)

“The added value of feminism is the understanding of power, powerlessness and safety that it brings and what those are like for women and children. Also, that sexual violence is systemic – not personal, not an aberration and you are really not alone in what’s happened to you. That helps dissolve shame.” (Staff member)

Figure 1. Differences/overlaps in the ethos of services



## 5.5 How services think about success

When asked about ‘success’, staff across the 12 services tended to refer to the things they perceived as ‘most significant changes’ in terms of children and young people’s relationships to themselves and others, rather than identifying more concrete ‘outcomes’. They saw post-abuse therapy as being most successful when children and young people:

- ▶ no longer blamed themselves for what had happened to them
- ▶ had a positive sense of self (no shame)
- ▶ felt confident to speak out and make decisions
- ▶ were willing to trust
- ▶ had reduced trauma symptoms.

Such changes were often indicated by the fact that the child or young person began to smile, could make eye contact or was walking/standing differently. Being able to express anger about what had happened to them and being able to say ‘no’ – including to therapy – were also highlighted, along with the (re) emergence of playfulness. It was frequently noted that none of these was an indicator of change that could easily be captured on a pro forma, nor are they part of the existing outcome frameworks used by agencies.

“I guess it’s eye contact, feeling the relational shifts – you might start joking around more, they might tease you, something like that. It can be very verbal – stating their feelings more, because they can be very frozen, with smaller ones when they come into the room they are very frozen. So a playfulness can come back, even with teenagers. It isn’t verbal so much for me, it is relational and playful things.” (Staff member)

For younger children, staff generally believed that the most significant change that therapy could facilitate was a strengthened attachment relationship with a non-abusing parent or carer – usually their mother. This was held to be so important for three reasons:

- ▶ Young children are not able to internalise the positive relationship with a therapist to the extent that young people and adults can.

- ▶ The parental relationship is the one that continues beyond the short period of therapy and can support ongoing recovery as the child grows up.
- ▶ A positive relationship with a non-abusing parent/carer is well-evidenced as underpinning resilience and a range of positive life outcomes.

Success for older children and young people was seen very much in terms of enabling them to move on from the abuse and into the next stage of their lives. Crucial to this was understanding the dynamics of abuse (including perpetrators’ strategies) and the effects of trauma, being able to manage their own feelings, and having increased confidence in themselves and hope for the future. A positive relationship with a parent or carer was viewed as an asset, but not usually a core focus, and the relationship with the therapist/worker was considered the primary tool for effecting change.

Staff working with children and young people with learning disabilities identified similar features of successful services, but emphasised that relationships with parents, carers and other professionals continued to be crucial at any age – and that educating/supporting the team around a child or young person was often more important than any direct work. The importance of services understanding the impact of learning difficulties on a child’s everyday life was similarly emphasised in the boost sample, alongside the need to recognise how signs of trauma can manifest and how to see beyond behaviour to recognise these signs and symptoms of abuse (Franklin et al, 2019).

Some differences in responses between participants across this review seemed to be the result of different perspectives because of their roles. Therapists foregrounded the psychological changes on which their work is focused, while service managers tended to prioritise the safeguarding outcomes of a stable placement, trusted adult, no abuse – as policymakers and commissioners did in the focus groups. Interestingly, other ‘concrete’ changes such as ‘not going missing’ or ‘engagement with education’ tended to be seen (by the interviewees and the focus groups) either as indicators of improved confidence, willingness to trust and reduced trauma symptoms (rather than direct outcomes of the work), or as longer-term outcomes which might occur some time after the therapeutic work was completed.

## 5.6 Features of successful services

As part of our interviews, both with key informants (see section 3.2) and with service staff and managers during site visits, we sought to identify what they saw as the common features of successful services. Respondents were generally cautious about the promotion of specific models but we found a good deal of consensus across all types of services about the core characteristics of effective approaches.

“Different models matter very little except as they embody core values. All meta-analysis of therapy says the same – it’s the underlying relationship – the ‘therapeutic alliance’, core values and understanding of impact of trauma, power and control that matters.”  
(Key informant)

Services spoke about the need to have an **ethos of empowerment**. Part of that means ensuring that children and young people should have as much choice and control within the service as possible, including the nature of the support and the worker providing it.

“Sexual abuse is about control and choice being taken away. We aim to give it back, both in practical terms – what room they want to work in, what we do when they are here, they can choose the activities. [And] the work is child-led, if they want to do something else, we will do that, we review frequently and give the child a voice in their sessions.”  
(Service manager)

“The first time in play therapy a little one says ‘no’, inside you are thinking ‘yes, yes, yes!’ They start off looking to you for what they should play with, what they should build or draw, and slowly through the process that changes so that they say ‘today I am doing this’ or ‘no, I don’t want to do that’. They have a voice, we are really talking about what you want – that is fabulous.” (Staff member)

The **relationship with a trusted worker** is believed to be the fundamental building block for any successful therapeutic or support work with children and young people.

“Sometimes, we are the first person who models some of that behaviour in a boundaried, safe way. The fact that someone will listen to you, not judgementally, listen with curiosity and test out things out with you. Someone who will be there when they say they’ll be there. Not only that, they’ll hold you in mind when they’re not. We’ll text and say, ‘Hope you’re having a good day. I’m thinking of you.’ So crucial. We know relationships are change factors. If we can teach, re-teach young people how to be in relationships with all the bumps that brings, that should help them navigate the next chapters of their lives.”  
(Staff member)

Services need to be underpinned by an **understanding of the dynamics of abuse and the impacts of trauma** (and helping young people and parents to understand this is also important).

“There is an approach that all the team signs up to. Being trauma informed – the ethos is about what has happened to you, not what is the matter with you... Hope for recovery is central.”  
(Staff member)

The **physical environment** of services is important. Support needs to be provided in places which feel **safe** and where children and young people have a **sense of belonging**.

Services need to have staff who are **skilled in a range of approaches**, including an ability to interpret non-verbal communication with children.

“The counselling room is a permissive space, with few rules, and the child uses the space to communicate. We offer a safe space in which they don’t have to worry about us, they can act out and we hold it in the room... The work is like being a detective trying to understand what a child is telling us, from their clues, and then give it back to them in a way they can digest. We look for what the child is trying to let you know by their behaviour.” (Staff member)

“For the little ones, it is very hard for them to say the words, they don’t understand the words. But they know it felt bad, it felt awful – and now they know it was wrong, because everyone tells them it was wrong, but they don’t have the language. They can create a scene, that helps them and then we can talk about what would they change, so Wonder Woman beats up whomever. That child put Mr Mustacio in prison – we have a little prison over there. It is working that out for themselves, how they can explain that and how they can resolve it.” (Staff member)

Alongside a broad range of skills, staff need to be **well-supported and supervised**.

“We have incredibly high standards here for staff, but that is coming from support and empowerment for survivors, we want them to have the best service... I am tough, I have fired people who I thought were not able to do the work well... They have to do supervision, two hours a fortnight in groups of three or four, they have to attend, and compulsory CPD three times a year.” (Service manager)

Services need to be **flexible and responsive to the individual child’s needs**. Ideally this includes not being time-limited and having an open door for future support, being able to offer therapy when a child is ready to undertake it, alongside a range of other support such as advocacy for young people.

“Finding the thing. What works for them... If we did the traditional talking stuff straight away, kids wouldn’t come back through the door.” (Service manager)

Ideally, services would have the **capacity** to provide the above without long waiting lists.

“To do trauma work, you need the time to do it. So we don’t put time limits on but we also review cases and make decisions to stop, on the basis that they can come back.” (Staff member)

Support should include **fun** activities which can reconnect children to the positive things in life.

“Good services want to offer opportunities to young people and are willing to take some risks. They feel open and transparent. They put young people at the heart of what they do. They trust young people.” (Key informant)

Services should be **well-linked to other agencies** and be able to use these to access a wider range of support.

As found in the focus groups, **work with non-abusing parents/carers** was considered as one of the key active ingredients in effective services. However, only four of the services we visited had formalised work with non-abusing parents/carers, and another worked with mothers if they too were survivors of CSA. Three of these services were Rape Crisis centres; their capacity to provide this work was undoubtedly connected to the fact that all of them were funded through trusts and grants, and they were able to use these monies as they saw fit.

The forms of support services offered to non-abusing parents were varied, and included:

- ▶ information and ad hoc support for parents, to help them understand the process their child was going through
- ▶ a combination of psycho-education on abuse/trauma and (time-limited) one-to-one therapy, to help them deal with their own feelings
- ▶ dyadic therapy (e.g. working with mother and child together), especially with young children, and close ongoing contact with child’s therapist
- ▶ parent education and peer support groups
- ▶ therapy for parents who are themselves survivors of CSA.

There is a knowledge base stretching back to the 1980s which suggests that being believed and supported by a close family member mediates the impacts and legacies of CSA (Finkelhor, 1986). Therapy for children should ideally be supported by work with non-abusing parents/carers. This work may take a variety of forms, depending on the needs of particular families and the age/wishes of the child or young person. In addition to the support noted above, it may also include family support meetings involving siblings/other close family members.

“Relationship with Mum is usually very important, so enabling Mum to support and understand the child is the best long-term outcome for most younger children.” (Staff member)

“Young people are happy that their parents are getting help, that the carer is able to give the right messages to the child. You can see when their relationship with their carer is getting better.” (Staff member)

## 5.7 Priorities of children and young people

“Professionals working with children must respond to and recognise children’s own resources and resilience, communicate hope, and support children’s wider identities beyond that of ‘victim’. One of the strongest messages to come from children and young people was a desire to access a sense of ‘normality’ in spite of dealing with experiences that were themselves far from normal; this means recognising children’s wider lives and needs, providing holistic support, connection (direct or otherwise) to others who have experienced sexual abuse in the family environment, and challenging stigma.” (Warrington et al, 2017)

We interviewed 12 young people (four young men and eight young women) as part of our site visits to seven services, and three young people in a further two services completed a short survey. They had all received one-to-one support, and some had also been involved in groups. (Three services were unable to identify any young people who were willing to be interviewed within the timescale of our review.)

Our interviews focused on what the young people felt was most important about the support they had received. For the most part, their priorities were similar to those identified by staff, but they emphasised the following characteristics which they valued about services.

The **relationship with staff**, usually with one key worker, was most important.

“Without C [name of worker]... they could have given me a different worker, but I wouldn’t have been here today without C. It is her human touch and compassion, it is about the person themselves, being committed, they must want to do the job. She could have been any professional but it’s the human touch... the service is good, but it’s C herself what moves things on.” (Young person)

One young man described the components of the relationship with his worker that had been central for him. At the outset, the worker had gone to great lengths to stay in touch when he hadn’t wanted to engage (because he had been wary of anyone who tried to take control of his life or was condescending). The worker had understood this: he had ‘got him’ and focused on building his creativity and

strengths, helping him envisage a future for himself and think about the ways to get there. In addition, the worker had responded to practical issues and got him access to things he needed. The young man felt cared for:

“He was invested in my problems whereas a lot of people wanted to shut me down, or control me, or tell me I was this or I was that.” (Young person)

**The atmosphere of the service**, including the warmth of other staff and the physical environment, was also highlighted. Feeling safe, belonging in a space, was a strong theme in what enabled engagement.

“Lots of people to make it nice and warm, so that nobody feels like an outcast, outnumbered or just that one odd person. Everyone is equal and everyone’s the same. Nobody is judged. Nobody talks behind their backs. Anything like that. Everyone’s nice.” (Young person)

“They don’t discriminate and judge by the way you look or by whatever’s happened to you. Don’t talk about it as a bad thing. Respect. To have at least a nice heart so that it gives everyone a nice, warm feeling. The welcome here. It’s so welcoming here. It’s so nice. Everyone smiles at you. It makes you feel comfortable. Cosy in here and everything.” (Young person)

“Happy environment, friendly faces, no one was ever looking miserable. Colourful. If younger seeing toys, animals are really important... If this room were grey, it wouldn’t be a happy environment, makes you feel down. Even if the topic is not happy, colours are a massive part of it.” (Young person)

“Somewhere they feel at home, feeling safe. That was a massive thing for me, feeling safe, because you are here because someone has done something they shouldn’t have done. You have to trust your counsellor, you have to learn to trust.” (Young person)

**Being heard and understood** was very important to all the young people we talked to.

“Understanding, that was the biggest one for me. People understood me, whatever came out my mouth.” (Young person)

“I was actually quite scared about talking about it. It was embarrassing. I can’t explain. Eventually by talking about it, it got easier and easier. It wasn’t so much a big deal. When I look at it or think about it, I just think, ‘Well, it’s not such a big deal anymore.’ Now.” (Young person)

“The most important thing is the listening – their ability to listen and understand, they could have talked at me but they didn’t. I go to CAMHS – but it’s not the same. Here it seems more of a personal kind of... CAMHS is more clinical... No one ever denies what’s happened, they are like: ‘It happened, how can we help you feel the best that you can?’” (Young person)

**Peer support** was highly valued by those young women who had accessed this.

“[The group] definitely worked well for me. I could see where I was making progress, who I had connected with – we had all been through something quite different but all obviously linked, you kind of see who has similar feelings to you, you would bounce off that, it all works out. Before I came here, I thought no one is going to understand, then you come here and everyone is saying what I am thinking and it’s like yes! It is sad, but I can finally talk about it. There were different opinions on things, but no fallouts, everyone got to voice their feelings, but never had arguments, we had an understanding of each other... Being accepted is the best thing, ’cos when I am at home they just have no idea, so when I come here it’s like, we are just a group of people who know exactly how I feel, I don’t have to talk about it but they’ll understand, that feeling of being understood and listened to and not argued back at.” (Young person)

Group support was described as ‘empowering’ and ‘moving you on in life’. When asked “What changed for you as a result of the group?”, one young woman was able to document layers of shifts for herself, her relationships with others and her perspective on life.

“Confidence. They said I was independent, strong and resilient and eventually I believed them. It got easier to be brave – I left my job and got a new one. I got more ambitious and less afraid of stuff...”

“I cried a lot when the group ended. At the start I was very delicate, fragile, emotional and took everything to heart. I got much tougher – but I cried at the end ’cos it was a big goodbye...”

“I learned that people are there for you and that you can see things differently and pain doesn’t last forever. You can be part of the world again and what’s happened shouldn’t stop you doing anything. At the end I was a lot more whole, and what others think mattered less and what I felt mattered more. I can express my opinions and it helped me come out as a feminist!” (Young person)

However, three of the young men we interviewed told us they would definitely not have wanted to join a group, and that one-to-one support had been all they felt they had needed.

**Confidentiality** was really important to young people. They understood the boundaries of this, but feeling that their worker would maintain confidentiality was a central component of trust. One young woman told us that what had been most important to her was ‘trust’ and ‘safety’, and this had come from the feeling that she could talk to her therapist about things and they would not be talked about with anyone else.



Group support was described as ‘empowering’ and ‘moving you on in life’, although most of the young men said they would not have wanted it



**Being believed and believed in** gave young people the confidence to believe in themselves.

“Definitely, I am more sure of myself now. It’s OK to not be OK. I am more confident ’cos I suppose this place made me feel believed and more able in myself and that what happened wasn’t my fault, and that set me up nicely. I know myself better, carving my identity. Others did not believe me in my life.” (Young person)

**Choice about and consistency of worker** mattered; for many, this enabled both the building of trust and daring to speak about issues and explore complex emotions. The point was illustrated by a young woman who described interviewing a potential worker before committing to work with her.

“I had a temporary worker – I don’t support that because you can’t build a relationship with a temporary worker ’cos then they leave, that’s my opinion. I got another worker but they were temporary too, I had an interview with her and explained I didn’t want her as she was temporary and I like building up relationships. Then I was referred to [name of worker] and I interviewed her and I liked her. I asked her loads of questions, I gave her scenarios and ask how she would deal with it... I do that because I am very complicated, I don’t want to waste my time or a worker’s time when they could be helping another young person... Consistency is a big thing for me... It is important to see what you can offer and if I can stick to that... It has been very consistent and she doesn’t make any false promises.” (Young person)

**Support for parents and family** was also important. Several of the young people said that their own progress was greatly affected by how their families were feeling – if they thought their parents were getting support, they could relax and focus on what they needed for themselves.

“We need to change intervention at home – a lot of parents are uneducated and don’t understand their kids. We need to educate parents and they can understand, then they can get help from mum, dad and at home – need services to help parents. No one helped my mum, she needed to voice her opinions and get advice, mum had the logic in herself to change her parenting, but a lot of parents won’t change their parenting...”

Parents need help understanding their kid’s behaviour – that will help the child more when there isn’t services involved. Parents still have a lot of time with their kids, more than services have.” (Young person)

“My mum found it really helpful, she really struggled with me, she saw a lady who was teaching her how to handle me when I wasn’t okay, my mum didn’t know what to do... My mum found that really helpful. We were so close anyway, but after coming here it got so much better, because she really understands me now. Some days she knows it is best just to walk away, I will tell her, but before she couldn’t just walk away: ‘I need to know that you are alright.’ Now she just knows, which is helpful for both me and her – but we couldn’t have done it without these guys... She is a brilliant mum but she just didn’t understand.” (Young person)

“When there is a service involved with a vulnerable child, there should be someone who can talk to everyone in the house. My brother too, he needed someone to be there to speak to, to help him understand about the abuse – not just to parents, all the young people in the house. Maybe a family worker, someone to go to the house to explain my erratic behaviour – the worker can reassure the family, the family are then moving behind me.” (Young person)

If they thought their parents were getting support, young people said they could relax and focus on what they needed for themselves

**A variety of activities and approaches** was appreciated, with the young people liking therapeutic support which went at their pace and included different ways of communicating.

“We used to do lots of arts and crafts. There was this one where we cut out words out of a newspaper, cut out good words and bad words. Like ‘sad’ or ‘lonely’, those sorts of words, then we had ‘happy’, ‘joyful’, ‘exciting’, those types of words and put them separately. Then we mixed them up, and one week I would pick ones that said how I was feeling that day. Stuff like that helped ‘cos sometimes I wasn’t sure what I felt. It would help to put them into the words – instead of having to say them, I could just show them. It was easier than having to talk sometimes.” (Young person)

“Counsellors need to think about what the child wants to do, otherwise they don’t want to come. Some children adore colouring, while others might despise it.” (Young person)

**Being able to come back for more support** was important to several of the young people, and they did not like feeling that they could no longer access support once they reached 18. If they had accessed a service that provided support for adult survivors as well as children and young people, they valued the security of knowing they would be able to access the adult service in the future if they needed to.

“The only thing I struggled with was that when I turned 18 I couldn’t come back, that was hard... It was my safety net and the minute I turned 18 I couldn’t come any more, my safety net was taken away.” (Young person)

“It would have been better if I could have stayed after I turned 18 – I was literally out, I saw her [my worker] the week before. I really struggled with that. Apart from that, there was nothing I think they could have done to improve – but I know it is down to funding.” (Young person)

We asked young people whether there was anything else that should have been different or could have been better – almost all said it had been exactly what they needed. One young woman said that she would have liked to go outside more, because being outdoors and ‘in nature’ helped calm her down, and a couple of interviewees wished they had received help sooner.

“Earlier help, at the start when I showed signs of going off the rails and first came out with the sexual abuse – that’s when I should have got a service and support. Not CAMHS ‘cos they don’t understand, but definitely early intervention. I wouldn’t have had the awful years that I had. It’s only the last year that I can breathe again and feel myself [for the] first time in my life since I was six. Early intervention is important, trying to work with the first signs.” (Young person)

The outcomes that young people associated with the support they had received – and that they clearly valued – included increased self-worth, self-confidence and optimism about the future. They spoke of various strategies they had learned for coping with stress and distress, and the self-understanding they had gained. Improved relationships with significant people in their lives were also frequently referred to.

“We have done a lot of self work, I understood myself quite well but had a lot more to understand, I thought a lot about myself and now I can reflect on my actions and reactions, put myself in other people’s shoes. My relationships with my mum and brother have really improved, ‘cos it was volatile and that was down to me... That has drastically changed and I have great relationships with them now.” (Young person)

Several of the young people said they did not like feeling that they could no longer access support once they reached the age of 18

## 5.8 Barriers to success

There was considerable agreement across all the services visited in terms of the main barriers to success. At the most basic level, engagement is the necessary precursor to all other outcomes. Engagement of younger children is reliant on parent/carer engagement, and their ability to bring children to appointments is crucial. Practical barriers include:

- ▶ time – especially when the parent/carer and child live geographically distant from the service
- ▶ money – especially the costs of transport and needing to take time off work, and the competing needs of other children in the household.

There can also be emotional barriers to parental engagement, particularly if a child's therapy triggers a parent's own issues and their needs for support are not being met. 'Therapy fatigue' can also set in when a child's behaviour seems to deteriorate, or distress increases as a result of therapy, or alternatively at a point where parents see 'good enough' improvement and want to 'put the abuse behind them'.

For children in care, the limited engagement of foster carers can be a barrier. Foster carers are often trying to meet the needs of more than one child experiencing difficulties and different needs can compete. Services felt that, in general, foster carers were less likely to engage – partly because they sometimes had support and advice from elsewhere (so didn't need a service for themselves), and partly because the child or young person was often placed short-term so their relationship was of a quite different order from that of a parent.

The sheer complexity of life in the aftermath of sexual abuse, or when abuse is current, can be a barrier to both parent/carer engagement and engagement of young people. In particular, teenagers going through a criminal justice process, care proceedings or changes of placement can be overwhelmed by the chaos and uncertainty in their lives as well as by a barrage of appointments with different professionals.

However, the biggest barrier to the engagement of young people (particularly those in care) was seen to be their previous experience of adults in general and professionals in particular. Without a reliable adult to encourage and facilitate their attendance, teenagers were liable to 'vote with their feet' unless staff could overcome their mistrust.

A number of services described referrals from other services being made 'too early' – e.g. from the police or a sexual assault referral centre while a family was still reeling from a disclosure, or from child and adolescent mental health services (CAMHS) when self-harm/suicide risk was extremely high. Good assessment focused on whether a child/family was in a position to engage with therapy. Answering key questions – Is the timing right? What else is going on in their lives? Are the needs of parents/siblings able to be met? – was seen to be crucial in minimising early drop-out.

The behaviour and attitudes of other agencies could be barriers to success in a number of ways, ranging from misdiagnosis to disrespect.

"Schools, children's social care, the police – and the incredible victim blame and punitive responses if [young women] are outside [the] norm... The level of danger that police and social workers are prepared to tolerate for young women makes it difficult for us to do therapeutic work. As an advocate, I can spend five weeks getting housing for a 15-year-old who is supposed to be looked after. You spend a lot of time having to advocate for basic things."  
(Staff member)

There can be emotional barriers to parental engagement, particularly if a child's therapy triggers a parent's own issues

## 5.9 How are CSA services currently evaluating their effectiveness?

We asked staff and managers at the services we visited about their current systems for evaluating their work – both what they currently did and what they thought about the usefulness of tools and systems they used.

It was interesting that staff in most services still regarded evaluation activities as things that were done because current or potential funders required them, and felt that evaluation tools had been chosen in order to meet external demands rather than because of their value to the service (e.g. by having ‘clinical utility’ in helping therapists assess and review work with clients, or by providing data that is useful in planning/reviewing resource or service development needs).

Managers tended to have a more positive attitude towards evaluation, and understood its utility in service planning and development as well as in providing essential evidence for funders. However, they too acknowledged that the systems they were using were often a poor fit with their actual work and objectives.

All services had some kinds of monitoring and evaluation in place. The two most commonly used standardised tools were CORE and the Trauma Symptom Checklist for Children/Young Children (TSCC/TSCYC).<sup>2</sup> A couple of therapists described using CORE to reflect routinely on client wellbeing.

“[CORE] is good for keeping track of where you’re at – you can plot scores and discuss them with kids. It’s not so great at showing outcomes, but it’s useful to have something rather than nothing and we can cherry-pick which ones we report.” (Staff member)

A tension was sometimes described between using tools to produce data for the purposes of reporting to commissioners and funders, and developing ways of evaluating work which would inform practice development. For example, one service had previously used CORE, but had decided it wasn’t appropriate because it was considered too generic, overly focused on mental health ‘symptoms’, and a poor fit with the process of overcoming experiences of sexual violence. In common

with a number of the other services we visited, it used the TSCC/TSCYC – which includes eight sub-scales and screens for post-traumatic stress disorder and dissociation and enables changes in trauma symptom levels to be tracked. Practitioners were unsure of its appropriateness, including whether it could be used at the initial meeting with the child or young person.

“It’s long and involved and doesn’t really say anything about where the child is at... Seeing a child for the first time, the assessment form we have to fill in is ridiculous. We are supposed to ask young children these questions, which they probably do not understand.” (Staff member)

The consistency with which standardised measures were used varied. For example, CORE was being used in one service at the beginning and end of therapy, while another was using it at 12-week intervals. Services also observed that use of these instruments is expensive: for example, there is a subscription fee for the TSCC, its use has to be overseen by a chartered clinical psychologist, and test booklets have to be purchased from the provider.

Many therapists/counsellors felt much more confident of their case notes as providing a meaningful record of changes (although services were rarely in a position to aggregate data from these for evaluative purposes).

“After every session we... write what the child did, what they said... When you read your notes back, you can see the progress. Putting it into a scale is really hard. So many of the measures are: ‘Is she engaging with adults?’ ‘Is she regularly attending school?’ Those things will come after we have done the work... but it is so much more that has happened for a child whilst she has been here.” (Staff member)

<sup>2</sup> Access information on CORE at [www.coreims.co.uk/About\\_Core\\_System\\_Outcome\\_Measure.html](http://www.coreims.co.uk/About_Core_System_Outcome_Measure.html) and TSCC information at [www.nctsn.org/measures/trauma-symptom-checklist-children](http://www.nctsn.org/measures/trauma-symptom-checklist-children)

One service that had always been funded entirely by charitable trust grants “had never been under pressure for that kind of [outcomes] evidence”. The CEO was interested in evaluation but reluctant to adopt or impose measures on her team unless they were both necessary and useful. One manager observed that harmful sexual behaviour services had a long history of using psychometrics and clinical scales, but that this wasn’t the case for CSE services.

What is striking about staff discussion of evaluation in their services is how alienated they generally felt from the process and the specific tools in use. There seemed to be very little link between the activities associated with evaluation – about which most practitioner views were negative – and activities related to reflective practice (supervision, regular reviews with clients, case notes and case analysis), about which they were extremely positive. The former were regarded as an unwarranted distraction from their real work and of no benefit to themselves or their clients, except indirectly in conforming to the requirements of a parent organisation or external funders.

There were three exceptions to this pattern. The NSPCC project we visited had been part of the ‘Letting the Future In’ randomised control trial (RCT), and staff shared a clear commitment to evidence-based working: “We need to know that what we are doing makes a difference and the way to do this is through research, evaluation and reflection – continuous learning.” They were engaged with the findings of the RCT and believed it was important, for parents and professionals externally but also for the development of the service: “Our focus is changing because of it – [working with] parents can’t ever be an optional extra any more.”

The second exception was Respond, which had worked with consultants to develop a theory of change last year, using a grant from the CSA Centre’s Evaluation Fund.

“It was brilliant. Previously we just had one way of evaluating – we collected data on change in psycho-emotional outcomes for individuals. We’re now looking at a wider range of changes – including in relation to young people’s self-made goals. Some of these are measures that therapists use week on week. Staff have responded well to collecting data because they can see the relevance of it. Staff want to be able to articulate the difference they make and do that in digestible form.”  
(Service manager)

The other partial exception was another service funded by the CSA Centre’s Evaluation Fund to work with a consultant to develop and pilot an outcomes measurement tool. Staff here still described evaluation as something imposed upon them by commissioners/funders – as onerous form-filling – but saw their current tool as something that they owned and was clearly linked to their theory of change.

“It was consulted on with young people and staff, [and] the theory of change mentions empowering young people and staff are always working towards it. We asked, ‘What can we measure? What’s important? What makes a difference?’ We created the outcomes tool... It’s still in the pilot phase, so watch this space, [but] feedback from staff is great. A lot better than we had before. The one before measured what you couldn’t measure... Staff don’t like completing so much paperwork but can see the value of it.” (Service manager)

Staff in most services still regarded evaluation activities as things that were done because current or potential funders required them

## 6. Views on a potential multi-service evaluation

The three focus groups were asked to consider what kinds of evidence from a multi-service evaluation they would most like to see. They highlighted the following:

- ▶ Evidence that could inform commissioning.
- ▶ What children and young people (and parents) say about services.
- ▶ Longitudinal evidence of outcomes over the life-course.
- ▶ Information on what works for whom, when and how – including for specific groups.
- ▶ The detail of how services work – what the interventions consisted of, what the challenges were.
- ▶ Findings on what changes were important for individuals rather than just focusing on pre-identified outcomes
- ▶ Identifying what doesn't work as well as what does.

Key informants had identified a similar set of priorities. They emphasised that any really useful evaluation would need to look at longer-term outcomes, focus on what matters to young people themselves and describe the detail of interventions.

“I'd want to know about young people's experience of the service and about what counted for them. I'd like really good descriptions of the practicalities of what was done and how it was done. I want to know which bits of the systems had impacts in what contexts. I'd want to be able to understand the whole of the service or intervention and the role of different parts within it.” (Key informant)

“It would need to tell us what are the fundamental elements/key ingredients that make the difference to children and young people. For older young people, do they stay the course and are they more positive about life as a result? For younger children it's carer/parent understanding that's probably more important than anything, so I would want that evaluated.” (Key informant)

Given the often negative experiences of and attitudes towards in-project evaluation, it is not surprising that the possibility of involvement in a multi-service evaluation was not welcomed enthusiastically by all managers and staff interviewed during our site visits. Some struggled to answer a question about what they would like to see come out of such an evaluation. Although almost all saw value in learning from what other services were doing, both in terms of service provision and in measuring effectiveness, there were considerable concerns about what any multi-service evaluation would be aiming to achieve and the methodologies it might adopt.

Participants across the review considered that the main opportunities presented by a multi-service evaluation would be its ability to answer questions such as:

- ▶ How are outcomes affected by the nature/structure of the service?
- ▶ What does really good work with sexually abused children/young people look like?
- ▶ How important is dyadic work (or a focus on attachment)?
- ▶ What difference does it make if child is involved in a criminal justice process?
- ▶ What are the outcomes three or four years on?
- ▶ Does it matter that it is a CSA or CSE specialist service?
- ▶ What did the child/young person get from the service? How did they grow? What did it feel like?
- ▶ Where are the gaps? What went wrong? Who let them down? What could have been done earlier?
- ▶ What enables services to adapt their responses to meet the needs of those with a learning disability?
- ▶ Do formal therapeutic services get better outcomes, or are they just providing for a different population of abused young people?

One service felt that the best thing to come out of a multi-service evaluation would be “a simplified, shared outcomes framework that was rooted in CSA and its impacts adapted by age”. Another observed that a cost analysis – equivalent to the Women’s Aid maps for its Change That Lasts campaign on domestic abuse<sup>3</sup> – would be valuable.

In the focus groups, the main challenges associated with a multi-service evaluation were:

- ▶ differences between services in terms of scale of service and types of intervention/provision – the danger of trying to compare apples with pears
- ▶ the complexity of issues in children and young people’s lives – services are often addressing multiple layers of issues within which the CSA is embedded
- ▶ service user involvement in an evaluation (Is it in their interests? Does it conflict with appropriate ending of therapy?)
- ▶ having a large enough sample to be able to look specifically at subgroups, especially for lesser-heard groups such as BAME young people; lesbian, gay, bisexual and trans young people; and boys
- ▶ the work it would involve, notably time and money – services would have to be convinced it was going to be relevant to their survival and really valuable to the world at large
- ▶ the many subtle differences between services as well as obvious ones – could an evaluation account for those?
- ▶ a lack of central coordination (as the NSPCC’s Letting the Future In evaluation *did* have) – these would all be independent services
- ▶ competition for funding – a lot of the information that services would be required to share would be commercially sensitive.

Some services thought they would be at a much greater ‘risk’ than others if they were involved in such an evaluation, and would need to make a careful assessment of whether involvement would be of advantage to them.

“The landscape can change in a heartbeat. We would be worried that what comes out of a national evaluation is that ideal services are described, and we don’t fit the bill and get excluded.”  
(Service manager)

Among the 12 services we visited, the one with the greatest experience of evaluation was an NSPCC project. While staff were positive about the outcomes of the ‘Letting the Future In’ randomised control trial (RCT), they were also clear that it had been a challenging experience.

Letting the Future In employs a guide, not a manualised approach. This means that it has an overarching structure but takes a person-centred approach tailored for each individual. However, there is a clear model of working – largely based on the ‘recovery and regenerative’ model (Bannister, 2003)<sup>4</sup> – and a set intervention length of 24 weeks, both of which were crucial in facilitating evaluation. The RCT design, using a waiting list control group, ensured that a clear counter-factual could be established (what would have happened in the absence of the intervention) – but dealing with the ethical implications and making the case to staff for such a design was a complex process. This was illustrated by the fact that responding to staff concerns about the reality of conducting the evaluation within their systems and practice led to a year’s delay in commencing the evaluation and the evaluation manual going through 14 iterations before it was finalised.

The NSPCC project’s experience was important to reflect on, in considering options for multi-service evaluation in this sector.

Professionals had concerns about the possible aims of any multi-service evaluation and the methodologies it might adopt

3 See [www.womensaid.org.uk/our-approach-change-that-lasts/](http://www.womensaid.org.uk/our-approach-change-that-lasts/)

4 The approach works to rebuild disrupted attachments and counter the abuse of trust inherent in the experience of abuse; it emphasises the power of play and the importance of therapeutic relationships as central to children’s recovery. It’s also rooted in Finkelhor’s description of traumagenic dynamics and sees stigmatization and betrayal as particularly important to address. Basically, the process involves the delivery of key messages such as ‘you are not responsible for what happened’ and modelling a relationship of trust and respect.

## 7. Conclusions and implications

This section summarises what the knowledge review found in relation to the CSA Centre's original research questions.

### *What are the key elements of practice that facilitate success?*

Across the interviews with services and key informants, and the focus groups, there was considerable agreement on the key elements of effective support for sexually abused children and young people. Those elements which were also emphasised by young people appear in italics.

- ▶ *A trusting relationship with staff.*
- ▶ *Consistency of staff.*
- ▶ An ethos of empowerment – creating opportunities for choice and control.
- ▶ Longer time frames.
- ▶ *Flexible – in frequency and level of contact, utilising a range of activities, and including having fun.*
- ▶ *Being believed and believed in.*
- ▶ Addressing abuse directly.
- ▶ *Peer support.*
- ▶ *Support for parents.*
- ▶ *Spaces which feel safe and in which children and young people feel welcome.*
- ▶ Knowledgeable, skilled and well-supported staff.
- ▶ Approach informed by understanding of power, inequality and trauma.
- ▶ Capacity to minimise waiting lists.

### *Are these elements different for those who are in or have left care and/or have learning difficulties/disabilities?*

It was not that the elements were different for those with learning difficulties or experience of care, participants believed; it was rather that there were more challenges in achieving success. They identified the following additional challenges when providing services for these groups:

- ▶ The work takes longer for children with learning difficulties, and workers need to be able to adapt their communication styles.
- ▶ For looked-after children, engagement can be more challenging, since they have had many experiences of being let down by adults and their living situations are often unstable/temporary. The commitment of adults in their lives (foster carers, social workers) to facilitate their access and attendance is also sometimes missing.
- ▶ Work with parents is essential for children with learning difficulties, whereas for looked-after children this is often difficult if not impossible.

This question was explored in more depth in the separate study interviewing a boost sample of children and young people with learning difficulties or experience of care; the findings are set out in Franklin et al (2019).

There was considerable agreement between both professionals and young people on the key elements of effective support

### *What are the challenges to achieving success?*

Participants identified two main groups of challenges to achieving success: the capacity for engagement from the child or young person or their parents and carers, and capacity issues limiting what services are able to provide.

Lack of engagement by parents and carers, especially where services have insufficient resources to work with them, could limit their children's attendance. The complexity of some children and young people's lives could act as a barrier to taking up support: one of the services we visited had introduced the possibility of a 'rest' for the young people they worked with, meaning that they could withdraw for a period and then return. The transition to adult services for young people was reported to be rarely seamless, except where these were provided within the same service, and often interrupted progress that had been made. And reaching out to under-identified groups such as BAME and refugee children and young people was seen as requiring more time, resources and diversity of staff than services typically had.

Resources inevitably limited what services could offer – both how long they could work with children and young people (although all of these services provided a minimum of 20 sessions) and, critically, how many they could work with at any one time.

### *How should effectiveness be measured in any evaluation study?*

There was a clear consensus that meaningful evaluation should focus on measuring what matters to young victims and survivors of CSA, that their perspectives should inform what is considered effective and what counts as success. Workers were interested in being able to plot the process of change, including shifts in children's behaviours, relationships and embodied experience. Some argued for more nuanced approaches to evaluation which could increase understanding of what works for whom, when and how. There was recognition that what constitutes effectiveness differs across a number of dimensions: the age of the child/young person and the nature of the inequalities they are experiencing; the forms and contexts of abuse; and the internal, relational and material resources they could draw on.

### *What are the outcomes considered most important by service users and staff of CSA specialist services?*

Again there was considerable consensus among professionals, but also some variation here:

- ▶ No longer being abused.
- ▶ Not blaming self.
- ▶ *Being heard and understood.*
- ▶ *A more positive sense of self.*
- ▶ *Reduced trauma symptoms.*
- ▶ *More positive coping strategies.*
- ▶ *Positive relationships and friendships.*
- ▶ *Can imagine a positive future.*
- ▶ *Confidence to speak out and making decisions.*
- ▶ A stable living situation.
- ▶ Feeling safe.
- ▶ Comfortable in own body.
- ▶ Playfulness and ease in relation to others.

Outcomes in italics above were also highlighted as important in interviews with young people.

Some professionals argued for more nuanced evaluation which could increase understanding of what works for whom, when and how

### *Do models of service fall into coherent groups (e.g. based on needs, age bands, type of abuse)?*

This research question sought to understand whether there were types of service responding perhaps to particular needs, based on types of abuse, age groups or other factors, seeking to clarify a suitable focus for a study. Based on the research undertaken in this study we have created an overview of six types of services, which to some extent distinguish between work with victims and survivors of different ages, and between CSA generally and CSE specifically. While this grouping creates a clearer picture of the sector, there were services that worked across all age groups and forms of abuse. There was no single dimension that could distinguish types of service without there being exceptions or outliers.

### *Which service models are believed to be showing particular promise and why?*

Given the range of services, their different approaches and ways of working, and the limited evaluation of most of them, it is not possible to specify models, and indeed many of our research participants warned against this. There was no consensus from the literature or the key informants on a concrete model for an effective service, with reasoning articulated as to why diversity may be valuable. However, key elements of practice that facilitate success and key outcomes for children were identified, as above.

### *Is there sufficient interest in/appetite for a national evaluation?*

Our conclusion is that, based on those consulted in this study, there is an appetite for better knowledge in three main areas:

- ▶ **What happens to children and young people who receive services over the longer term?** The absence of longitudinal data was highlighted by numerous participants.
- ▶ **How do services achieve the outcomes that are of greatest value to children, young people and families themselves?** There was concern that current outcomes frameworks focus more on what matters to organisations (and funders) rather than what matters to young victims and survivors. There was a strong call to put children and young people's perspectives at the heart of any evaluation and of outcomes frameworks which are built out of this.
- ▶ **What do services actually do to achieve change?** There is considerable interest in learning more about the detail of what works, for whom, when and how.

However, this overall interest in greater knowledge is counteracted by some serious concerns about what the impact would be on services of participating in an evaluation and how findings would be interpreted by funders/commissioners. In a field of such shortage, professionals are concerned about comparative evaluations which could suggest that one 'model' is better than another. This knowledge review has shown not only that there is a range of types of service, but also that the concept of finding 'a model' of support was considered unhelpful.

The fact that there has already been a UK randomised control trial in this field (of the Letting the Future In programme) is also a factor to be considered. Although that study (Carpenter et al, 2016) did not provide a long-term follow up of outcomes, any other evaluation in this area would need to be clear about what it was adding to existing evidence.

*Are there enough services doing similar things to enable an evaluation to be designed?*

Our conclusion here is that, while there is no model of practice being consistently delivered by a large number of services, there are some clusters of services and some features of success that are widely shared. There appears to be a reasonable degree of consensus about the core outcomes that are important and about the key features of services that are central to their success, from the point of view of both staff and service users. However:

- ▶ There is a dearth of services in the first place and they exist within a rapidly changing landscape. With the concern for the lack of funding expressed by numerous participants, a serious risk in any evaluation in this field (particularly one which aimed to achieve the longitudinal dimension referred to above) is that some services would either cease to exist or would be reshaped into something quite different during the evaluation period.
- ▶ There is considerable diversity between the broad service groupings we have outlined in this report. For example, the specialist CSE services are generally very different from the post-abuse therapy services in their approach, and it is difficult to see how both groups could be included in a single evaluation.

*Are there service groupings which have not already been evaluated which have sufficient commonality to lend themselves to a shared evaluation?*

Potentially, there are two groupings within this range of services which could fit the bill.

The first is the group of services providing post-abuse therapy alongside other forms of support for adults and children. There has been very little evaluation of services that offer support across the life-course and are ‘holistic’ in their approach (i.e. offering both therapy and advocacy, one-to-one and group work under the same service umbrella).

The second grouping constitutes services supporting young people affected by CSE. Most of these appear to have a similar model of work and similar outcomes, as identified by the CSA Centre’s survey (Parkinson and Sullivan, 2019b). However, some of these services seem to be undergoing changes in focus – such as extending their remit to complex safeguarding – so the CSA Centre would need to be confident that there was sufficient stability within this cluster to enable some evaluation work to be pursued.



There has been very little evaluation of services that offer support across the life-course and are ‘holistic’ in their approach



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The logo features a vertical rectangular background with a geometric, low-poly pattern. The colors transition from dark purple at the top to bright green at the bottom. The text is white and positioned on the left side of the rectangle.

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