The Right to Recover

The Voices of Professionals

Provision of therapeutic support for children & young people following sexual abuse in the West of Scotland

Alison Wales & Rachel Love
November 2017

EVERY CHILDHOOD IS WORTH FIGHTING FOR
## Contents

Acknowledgments 4  
Executive Summary 5  
Introduction 8  

**Assessment of children’s emotional health needs and referral to therapeutic support** 10  
Stages at which assessment and referral to therapeutic support may take place 11  
Reliance on social work for assessment and referral 13  
Parent/carers’ emotional health needs following sexual abuse 15  

**Perceptions of the availability of therapeutic provision** 16  
Local levels of service provision 16  
Level of provision for particular groups 17  
Vulnerable young people at risk of sexual exploitation 17  
Harmful sexual behaviour 18  
Referral processes and protocols 19  
Cost of services 20  
Knowledge of local services 20  
Perceptions about services 21  

**Perceptions about the role of Child and Adolescent Mental Health Services (CAMHS)** 22  
Perceptions of CAMHS 22  
Internal views of CAMHS 24  
Factors impacting on access to CAMHS 25  
Team structure/set up 25  
Interpretation of CAMHS referral criteria 26  

**Undetected child sexual abuse** 27  
Experience of sexual abuse ‘lost’ in a complex picture of abuse 27  
Information sharing 28  
Skills and experience, confidence and training 29  

**Role of the wider system around the child in therapeutic recovery** 32  
Non-abusing parent/carers’ role 32  
Role of CAMHS in the wider system 33  
Social work role in working therapeutically with children following sexual abuse 34  

**Concluding points of note** 36  

Appendix 1 - Methodology 40  
Appendix 2 - Recommendations from The Right To Recover 42
The Right to Recover – Provision of therapeutic support for children & young people following sexual abuse in the west of Scotland

Acknowledgements

First and foremost, we would like to thank all the professionals who participated in the discussion groups. We would like to acknowledge the dedication of those who work with the youngest survivors of sexual abuse and assault, and who do so currently within a very difficult climate for services. Despite constraints on their time and in many cases onerous workloads, professionals wholeheartedly took part in discussions, sharing practice, views and experiences with the research team and colleagues from other local authority areas. The range of expertise that professionals brought to the discussions, as well as the openness and sincerity with which they engaged in the process, brought this project to life.

This study was undertaken in partnership with George Laird, Manager of the West of Scotland Child Protection Managed Clinical Network and Ruth Sills, Development Manager of the Children 1st national initiative Stop to Listen. Both George and Ruth participated in the organisation and facilitation of the discussion groups. Their advice and input was of huge value throughout the project.

We would also like to say a special thanks to the organisations which helped with recruitment of our professional discussion groups, including Police Scotland, the Stop to Listen Pathfinder Steering Groups, the West of Scotland CAMHS Network and the Centre for Research on Families and Relationships at the University of Edinburgh.

Our thanks also go to the reviewers for their valuable comments and feedback on the first draft of this report, including the comments of the two anonymous peer reviewers.

Finally, many thanks to Susan Galloway, Senior Policy Researcher at NSPCC Scotland and lead author of the main Right to Recover study, who provided support and guidance throughout.

The content of this report is the work of the authors alone and cannot be regarded as the views of the organisations with which they have worked, or of the organisations which helped with its recruitment.

We would also like to thank the following organisations for their support:

- West of Scotland CAMHS Network
- Police Scotland
- Stop to Listen Pathfinder Steering Groups
- Centre for Research on Families and Relationships (CRFR), University of Edinburgh

We would also like to acknowledge the dedication of those professionals who participated in the discussion groups. We would like to acknowledge the dedication of those professionals who participated in the discussion groups. We would like to acknowledge the dedication of those professionals who participated in the discussion groups.

This is the companion report to The Right To Recover: Therapeutic Services for Children and Young People following Sexual Abuse. An Overview of Provision in the West of Scotland. This is the companion report to The Right To Recover: Therapeutic Services for Children and Young People following Sexual Abuse. An Overview of Provision in the West of Scotland.


Executive Summary

Introduction

This paper reports findings from qualitative research exploring the assessment and referral of children to therapeutic support following child sexual abuse. The aim was to explore these issues through the perspectives of various professional groups who work closely with children and young people who have experienced sexual abuse, at different stages in their journey.

It was undertaken as part of a wider NSPCC Scotland research project which investigated children’s access to face to face therapeutic recovery services following sexual abuse, as well as specialist support for those exhibiting worrying or harmful sexual behaviour.

The overall findings are reported in The Right To Recover: Therapeutic Services for Children and Young People following Sexual Abuse. An overview of Provision in the West of Scotland.

This paper explores in greater depth the themes that emerged from the professional discussion groups. It is a companion paper, intended to be read alongside the main research report, and does not contain any separate conclusions or recommendations.

Methodology

Five facilitated discussion groups were held with professionals from a range of disciplines, all of whom work closely with children following disclosure or discovery of sexual abuse. The groups comprised: social workers (2 groups), police officers, child and adolescent mental health service (CAMHS) practitioners, paediatricians and other health professionals. Participants were recruited with the support of key contacts at West of Scotland level and through the Centre for Research on Families and Relationships (CRFR), University of Edinburgh.

Topics for discussion were developed through an iterative process; these varied for each group, reflecting different professional roles with children. Broadly, the discussions sought to explore and understand how assessment and referral of children to therapeutic support currently happens, including different professional roles and processes there-in, and different professionals’ knowledge and views of therapeutic service provision.

The discussions also gave consideration to the specific support needs of non-abusing carers.

Supplementary text:

1 Service provision for children who exhibit worrying or harmful behaviour was included because of the risk posed to other children and young people, and because there can be, and often is, a link between child sexual abuse and harmful sexual behaviour (although it must be strongly emphasised that not all children who present with harmful sexual behaviour have been sexually abused and correspondingly not all children who have experienced sexual abuse exhibit harmful sexual behaviour).

Key Discussion Points

Assessment of children’s emotional health needs and referral to therapeutic support

Social work was identified as bearing lead responsibility for assessment and referral of children to therapeutic services following sexual abuse. This was a source of concern in some groups, at times in relation to social work capacity but more commonly to the fact that not all children who experience sexual abuse will have on-going social work involvement, making this ‘pathway’ to support for some children less relevant. Professionals were keen to explore solutions to ensure that the emotional needs of all children are assessed and responded to in a consistent way.

Perception of the availability of therapeutic provision

Professionals perceived considerable variation in service provision between local authority areas, with provision regarded as reasonable in some areas and very poor in others. Long waiting times for services were a key concern, including in areas where provision is adequate. Staff knowledge of provision can be patchy with little shared knowledge within teams. Across discussion groups professionals commented specifically on what they regarded as an almost complete absence of therapeutic services for very young children. Some professionals also identified a lack of provision affecting particular groups including children with disabilities, children from Black and Minority Ethnic (BAME) communities, and children with harmful or problematic sexual behaviour. Police officers specifically identified a gap in provision of longer term engagement work with vulnerable young people at risk of sexual exploitation.

The cost of services was also raised in some groups as impacting on referral decisions.

Perceptions about the role of Child and Adolescent Mental Health Services (CAMHS)

A lack of shared understanding was apparent regarding the role of CAMHS in providing therapeutic support to children following sexual abuse. Whilst there was acknowledgement that CAMHS teams were stretched, high levels of frustration were expressed regarding children being referred to CAMHS but not meeting the thresholds and/or being rejected for reasons relating to stability.

CAMHS professionals identified a range of issues around CAMHS structures, referral criteria and processes which may impact particularly on access to CAMH services for children experiencing sexual abuse and/or other childhood abuse or trauma, particularly where they may have complex behavioural presentations.

Undetected child sexual abuse

Professionals across social work, health and CAMHS discussion groups raised a number of issues relating to children’s experiences of sexual abuse going undetected and/or unrecorded. Children’s experiences of sexual abuse may at times become ‘lost’ in a complex picture of wider abuse, neglect and other adverse childhood experiences that often accompany sexual abuse. Difficulty in evidencing sexual abuse and lack of confidence and skills in identifying and/or raising concerns about sexual abuse were amongst factors identified by different professionals as potentially contributing to a child’s experience going undetected or unrecorded.

Issues around information sharing about child sexual abuse between and within agencies were also raised in discussion. Health professionals paint a complex picture whereby information recorded about a child’s experience of sexual abuse or suspected abuse, at different point in the child’s journey, may not be routinely shared with GPs/accessible to GPs.

Role of the wider system around the child in therapeutic recovery

Throughout the course of most discussions, professionals stressed the critical role of the wider system around the child–most vitally the non-abusing carer–in supporting their therapeutic recovery. Concerns emerged across groups, about the lack of capacity and resourcing in relation to supporting the wider system and wider system work.

Staff confidence, experience, skills and training

Issues around staff confidence and skills in working with children who have experienced sexual abuse or where abuse is suspected were identified during discussions as affecting different professions. Training needs were identified for staff in different settings and at different stages in a child’s potential journey following sexual abuse, including to support children’s access to services and the identification of abuse.
Introduction

Not all children and young people need a specialised service following an experience of sexual abuse, however, for those who do require help, therapeutic support can help them rebuild their lives. By providing children and young people with the opportunity to safely express and manage their feelings, therapeutic work can help them to understand and move on from difficult experiences. The early support of non-abusing parents and carers is critical to the child or young persons’ recovery and our service provision must also reflect this. The barriers to disclosure are such that very few children disclose experiences of sexual abuse. As few as 1 in 8 children are estimated to come to the attention of statutory agencies. Those children whose abuse does not come to light are therefore the ‘tip of the iceberg’ of a much larger number who are sexually abused whilst growing up. For these children, young people, and families we have the chance to act, and to prevent problems developing or enduring in adulthood, at substantial cost to the individual and society.

Provision of therapeutic support to children following sexual abuse has previously been found to be poor in Scotland and across the UK. With growing awareness of the life-long impact of Adverse Childhood Experiences (ACEs), such as sexual abuse, on physical and mental health, it is essential that therapeutic support is available to children and young people as and when they need it. This paper discusses findings from qualitative research which explored the emotional needs assessment of children following sexual abuse and referral to therapeutic services, including the needs of their non-abusing parent or carer. It contains facilitated discussion groups with professionals from a range of different disciplines, all of whom work closely with children who have experienced child sexual abuse, at different points in their journey.

Throughout the remainder of this report, for ease of reading, the term ‘child’ is used to refer to all children and young people aged 18 and under, and the term parent/carer refers to non-abusing parents, including foster carers.

This exploration of professionals’ experiences was undertaken as part of a wider NSPCC Scotland research project which also investigated children’s access to face to face therapeutic recovery services following sexual abuse, as well as specialist support for those exhibiting worrying or harmful sexual behaviour.

The findings are reported in the main research report, The Right To Recover: Therapeutic Services for Children and Young People Following Sexual Abuse. An overview of Provision in the West of Scotland. However, the valuable insights and testimonies from professionals working across different disciplines makes them worthy of specific attention. This paper explores in greater depth the themes that emerged from the professional discussion groups. It is a companion paper and intended to be read alongside the main research report.

Methodology

Five facilitated discussion groups were held in summer-autumn 2016. These comprised: one health group involving five practitioners, from different specialisms, working in four different NHS board areas; two social work groups involving in total eight social workers (seven statutory services, one 3rd sector) and one counsellor, from four local authority (LA) areas; one police group involving four police representatives from four local policing divisions and one Child and Adolescent Mental Health (CAMH) group involving five professionals from four NHS boards areas. Participants were recruited to the discussion groups with the support of key contacts at West of Scotland level and through the Centre for Research on Families and Relationships (CRFR), University of Edinburgh. A full methodology is available at Appendix 1.

The aim of the discussion groups was to explore the issue of therapeutic support for children and young people through the perspectives of various professional groups who work closely with children and young people who have experienced sexual abuse, at different stages in their journey. The research approach was based on participative inquiry and topics for discussion were developed through an iterative process; these varied for each group, reflecting different professional roles with children and young people. Broadly, the discussions sought to explore and understand:

• how children and non-abusing parents/carers emotional health needs are currently assessed following sexual abuse;
• how children are currently referred to therapeutic support where this is required;
• different professional roles and processes in the assessment and referral of children and young people;
• different professionals’ knowledge of and views about local therapeutic service provision.

Ethics Approval

Ethics approval for the professional discussion groups was obtained, through the NSPCC’s research governance process, because of the sensitive nature of the issues discussed.

Limitations

Given the constraints of resources and time, the aim was to capture some of the experiential knowledge of professionals and enable them to identify issues for further exploration, and not to conduct a systematic and comprehensive investigation of current practice. Very small numbers of professionals were involved in each discussion group and not all local authority areas across the West of Scotland were represented at every group. Resource and time constraints also meant that the group discussions did not involve every professional group which works with children experiencing sexual abuse, for example specialist nurses working with children and young people who are looked after and accommodated, young people’s sexual health specialist nurses, teachers and other education staff, General Practitioner’s (GP) and residential workers, all of whom have a potentially critical role to play in supporting children and young people experiencing sexual abuse and helping them access therapeutic support where required.

Consequently, there are no conclusions and recommendations attached to this report separate to those of the wider NSPCC study of which they formed part. Points of note for further exploration are identified at the conclusion, based on key themes and professionals’ testimonies in specific areas.


Assessment of children’s emotional health needs and referral to therapeutic support

Children and young people who have experienced child sexual abuse may come into contact with a wide range of professionals where abuse is disclosed/reported, including police officers, social workers and a range of health and medical professionals. Discussion groups sought to understand how assessment of children’s needs and referral to therapeutic support, where indicated, currently happens, and which professionals are involved.

There was consensus across discussion groups that social workers are in the vast majority of cases the lead professionals involved in the assessment and referral of children to therapeutic support, where this is indicated. Social workers in one discussion group stressed the joint nature of assessing children’s wellbeing needs, which they described not as a ‘formal’ one off event but a process based on extensive liaison and discussion with a range of professionals most closely involved with the child, as well as the child themselves wherever possible.

Whilst assessment of the child’s emotional needs can be informed by other agencies, the responsibility for the assessment and referral of a child to therapeutic intervention is overwhelmingly the role of social work – and instigated and led primarily by social work.

"As social work, you are reliant on hearing from everyone else that has a role with the child. You need to speak to all others around the child to see how they are coping: foster carer, teacher etc. They know the child much better than we do."

(Social Work Discussion Group 1)

"I would say assessment is informed by other agencies – but 9 times out of 10 the reality though, it is going to be the social worker that takes that on – does the referral – initiates the discussions around it”.

(Social Work Discussion Group 1)

"Families would also take a lead in it. If a child is in foster care, for example, it will be the foster carers who might push for something more . . . But I wouldn’t have experiences of other agencies really pushing it – or taking the lead. The expectation is that social work does this”.

(Social Work Discussion Group 1)

The social worker may also have the primary role in the emotional assessment and referral of children for support, in the very small number of cases where children undergo forensic medical examination. According to one consultant paediatrician, the focus at forensic examination is on the physical assessment of the child and an evidence gathering. A baseline assessment of the child’s physical needs will be carried out at this point, as well as an automatic assessment for neglect. The paediatrician then makes a written report detailing the findings of the examination, which is submitted to police and to social work, and with parental consent, the GP. At this stage, the allocated social worker takes over to deal with any ongoing needs, including any wider support needs and referral for therapeutic input, if necessary. Working relationships with social work were described by this consultant as very good, with high levels of confidence in children’s support needs being met. However, there does not appear to be a standard approach to the assessment of a child or young person’s emotional health comparable to, for example, the assessment of physical health and neglect which takes place at forensic stage. According to social work professionals in some local authority areas, there currently is no detailed separate assessment of a child’s emotional well-being as standard where children have experienced sexual abuse, although practice may vary across areas. Rather, a standard general social work wellbeing assessment will take place for all children who are in the care of social work, which in some cases may focus on the child’s emotional health.

"If the social worker completing the assessment is very emotion focused then an assessment of the child’s emotional wellbeing may pull through in the reporting. Otherwise, this form would only present generic information, for example child’s progress at school".

(Social Work Discussion Group 2)

The social work professional may also have the primary role in initiating the discussions around the emotional wellbeing of the child, which is the basis for any wider support needs and therapeutic input. If a child is in foster care, for example, it will be the foster carers who might push for services. Social workers described how discussions about therapeutic support may take place.

"If the social worker completing the assessment is very emotion focused then an assessment of the child’s emotional wellbeing may pull through in the reporting. Otherwise, this form would only present generic information, for example child’s progress at school”.

(Social Work Discussion Group 2)

"It (referral to services) comes from the case conference or case discussion, depending on what the disclosure/ concerns were – it would be recommended that social work go out and look at what therapeutic support is out there – depending on what the circumstances are surrounding the disclosure. Depends very much on what concerns there are about the child”.

"Same in (local authority). If a sexual abuse concern is reported there will be a CP case conference. Would see therapeutic support coming up/ being firmed up at this core group meeting – which obviously happens within first 10 days of concern. It would be generated as a task at the case conference then firmed up at core group meeting”.

Conversations Within Social Work Discussion Group 1

Stages at which assessment and referral to therapeutic support may take place

Out-with the forensic setting, one group of social workers described the different stages that assessment of a child’s emotional needs and consideration for therapeutic support may happen. In many cases, discussions about the potential need for therapeutic support will happen early on – at case conference or case discussion stage.

"It (referral to services) comes from the case conference or case discussion, depending on what the disclosure/concerns were – it would be recommended that social work go out and look at what therapeutic support is out there – depending on what the circumstances are surrounding the disclosure. Depends very much on what concerns there are about the child.”
There are also cases where a child’s needs for support may be considered well out-with these parameters. For example, both police and social workers described cases of suspected child sexual exploitation where young people may need considerable emotional support to enable them to engage with the child protection and criminal justice processes – and ultimately to understand that they are a victim of abuse in the first place. In some cases, this may mean referral to some form of therapeutic support at a very early stage. Social workers also discussed cases where any need for referral may not happen until much later in a child’s journey following abuse, for a range of reasons revolving around how they appear to be coping.

Social workers also discussed cases where any need for referral may not happen until much later in a child’s journey following abuse, for a range of reasons revolving around how they appear to be coping.

Some concern was expressed in the health discussion group about what one professional described as a ‘wait and see’ approach which might particularly impact on young children. There was a view that practitioners, like parents, can tend to assume that if a young child is not showing too many signs of distress it indicates they are coping and things can be left, without considering any need for therapeutic support. The evidence around the impact of child sexual abuse on both adolescent and adult mental health, however, indicates that children’s emotional health needs should always be considered in cases of sexual abuse.

"Depending on how a child or young person is – it can happen much later down the line – depending on how they are coping with things. Might be when they start to show difficulties – when they start struggling – or when they would be open or willing to talk to someone else for their support."

"If the child is away from home in foster placement there’s a lot going on. We don’t want to do everything at once: it would be too much for the child to cope with."

"Also – they can be too young – we may not want to start this at first (therapeutic intervention) until we know how they are coping. Ultimately, it depends on each individual case and the needs of that child. It’s individual."

Conversation Within Social Work Discussion Group 1

Where a child appears to be coping, social workers may continue to assess any need for emotional support as it arises, in cases where they remain involved with families. Above all, social workers stressed the individuality of each case and the individual needs of the child and their wider circumstances, particularly the capacity of their parents/carers to support their needs, as dictating the approach.

Reliance on social work for assessment and referral

The ‘heavy’ or ‘sole’ reliance on social work in the assessment and referral of children to therapeutic support was a source of concern across several discussion groups, at times in relation to the sheer pressure of work on Children and Families Teams but more commonly to the fact that not all children and young people who experience sexual abuse will have ongoing social work involvement, making this ‘pathway’ to support for some children at least, less relevant.

While there was some evidence that co-ordination of therapeutic support may be more difficult in these cases. In one Sexual Offences Liaison Officer’s (SOLO) experience, it can be harder to ensure children and family’s needs for support are met where social work is not involved in an on-going way. This may particularly impact on children and young people who have experienced ‘non-familial’ sexual abuse. Both police and health discussions identified that cases of ‘stranger rape’ – where children have been raped in the local community for example – can tend to be regarded as ‘one off incidents’, with ongoing social work involvement more unlikely. According to professionals, the young person is still highly likely to need support either early on or at a later stage, when they may begin to experience emotional problems related to the abuse. However, the lack of social work involvement means no clear pathway for support. It was clear from the police discussion that police officers – particularly Sexual Offences Liaison Officers – may regularly be involved in advising parents/carers and young people about potential sources of therapeutic support, or directing them to their GP because of emotional health needs.

Both health and police discussion groups considered potential ‘solutions’ to ensuring children’s emotional wellbeing is fully considered in all cases of child sexual abuse, even when there is no on-going social work involvement.

There was a view in the police discussion group that it could be helpful if another agency was involved that police could ‘hand over’ to following their initial response, to address the on-going advocacy and support needs of children and non-abusing carers. This could be particularly important in cases which go to court.

"I think we rely too heavily on social work because not all of the children who make a disclosure will end up being allocated a social worker … "

(Health Discussion Group)

There was some evidence that co-ordination of therapeutic support may be more difficult in these cases. In one Sexual Offences Liaison Officer’s (SOLO) experience, it can be harder to ensure children and family’s needs for support are met when social work is not involved in an on-going way. This may particularly impact on children and young people who have experienced ‘non-familial’ sexual abuse. Both police and health discussions identified that cases of ‘stranger rape’ – where children have been raped in the local community for example – can tend to be regarded as ‘one off incidents’, with ongoing social work involvement more unlikely. According to professionals, the young person is still highly likely to need support either early on or at a later stage, when they may begin to experience emotional problems related to the abuse. However, the lack of social work involvement means no clear pathway for support. It was clear from the police discussion that police officers – particularly Sexual Offences Liaison Officers – may regularly be involved in advising parents/carers and young people about potential sources of therapeutic support, or directing them to their GP because of emotional health needs.

Both health and police discussion groups considered potential ‘solutions’ to ensuring children’s emotional wellbeing is fully considered in all cases of child sexual abuse, even when there is no on-going social work involvement.

There was a view in the police discussion group that it could be helpful if another agency was involved that police could ‘hand over’ to following their initial response, to address the on-going advocacy and support needs of children and non-abusing carers. This could be particularly important in cases which go to court.

"I think we rely too heavily on social work because not all of the children who make a disclosure will end up being allocated a social worker … "

(Health Discussion Group)

There was some evidence that co-ordination of therapeutic support may be more difficult in these cases. In one Sexual Offences Liaison Officer’s (SOLO) experience, it can be harder to ensure children and family’s needs for support are met when social work is not involved in an on-going way. This may particularly impact on children and young people who have experienced ‘non-familial’ sexual abuse. Both police and health discussions identified that cases of ‘stranger rape’ – where children have been raped in the local community for example – can tend to be regarded as ‘one off incidents’, with ongoing social work involvement more unlikely. According to professionals, the young person is still highly likely to need support either early on or at a later stage, when they may begin to experience emotional problems related to the abuse. However, the lack of social work involvement means no clear pathway for support. It was clear from the police discussion that police officers – particularly Sexual Offences Liaison Officers – may regularly be involved in advising parents/carers and young people about potential sources of therapeutic support, or directing them to their GP because of emotional health needs.

Both health and police discussion groups considered potential ‘solutions’ to ensuring children’s emotional wellbeing is fully considered in all cases of child sexual abuse, even when there is no on-going social work involvement.

There was a view in the police discussion group that it could be helpful if another agency was involved that police could ‘hand over’ to following their initial response, to address the on-going advocacy and support needs of children and non-abusing carers. This could be particularly important in cases which go to court.

"I think we rely too heavily on social work because not all of the children who make a disclosure will end up being allocated a social worker … "

(Health Discussion Group)
The named person role was also discussed as potentially important in identifying on-going emotional wellbeing needs and supporting children to access help where required, especially in cases where there is no on-going social work involvement. Some concerns were raised around named persons having the capacity and/or skills and experience to fulfil this role.

Professionals in the health discussion group identified a need for a more joined up response to children who experience sexual abuse overall. Currently, there is a perception that different professionals, ‘do their own bit then move on’, with potential for some children to fall through the gap. Various models of joined up working were discussed including a ‘Children’s House’ model and an ‘expert contact’ model. Support for non-abusing parent/carer was regarded as a fundamental aspect of a holistic response.

There was also strong consensus in the health group about the need for a standard approach to the assessment and referral of children to therapeutic services. A clear pathway of referral for all children experiencing sexual abuse, regardless of ‘type’ and of contact with social services, was considered fundamental.

Professionals briefly discussed when an emotional assessment might best take place. There was broad agreement that early assessment in the immediate aftermath of trauma – for example at forensic stage – would be inappropriate and a gap of at least a few weeks necessary before assessment could meaningfully be conducted.

Parent/carers’ emotional health needs following child sexual abuse

Children’s responses to sexual abuse can differ. For example, the existence of protective factors, such as, the presence of a consistent and supportive adult can help to explain why some children are able to cope with adverse life experiences such as sexual abuse better than others. However as with children it is normal for adults to react in different ways to disclosures of abuse and this can therefore significantly impact their ability to support their child effectively.

It was clear throughout the course of discussion across most groups that a parents/carer’s emotional wellbeing – in relation to how they cope following sexual abuse and respond to their child’s emotional needs – is considered a critical factor in a child’s therapeutic recovery. Ensuring that carers are supported is thus considered by many professionals as a core aspect of responding to children’s emotional wellbeing needs following sexual abuse.

Health professionals identified information and support for the non-abusing parent/carer as being critical from the very earliest stages following abuse, where they are specifically felt to lack information about the potential emotional impact on the child, in the immediate or longer term at key developmental stages. The group felt strongly that support for carers should form part of a holistic response to children who have experienced abuse, where the needs of child and the non-abusing parent/carer are considered in the round.

Social work and CAMHS discussion groups described the ‘basics’ of a stable, loving family environment as the best resource or therapeutic intervention for a child following abuse.

CAMHS Discussion Group

“...a really good foster placement, or a birth parent, is the best therapeutic intervention for a child. Sometimes we are always thinking of referring to something, but sometimes the best resource is there in terms of dealing with things.”

Social Work Discussion Group 1

“So, if we get down to the basics of what do children who have been traumatised need? They need as stable as possible caregivers—or if they can stay with the original family, lots and lots of support for those carer givers. And I think we often think a lot about what we can do up the chain — rather that is what is happening with the basics that the child needs.”

Health Discussion Group

“I think the bare minimum that we need is a pathway. It would be nice to have a National Centre of Excellence in child sexual abuse, but a pathway is the bare minimum; this is what needs doing.”

Health Discussion Group

“I feel that the child should have a baseline (emotional health) assessment to determine where we go from here, do we need to have active hands on input at this stage, or shall we leave it and come back to it? Every child is different, every situation is different. But it would be good to know if there is a centralised place where we can refer these children (for emotional health assessment) – because I’m not a psychologist and I think they would need a baseline assessment and look at all of the circumstances and then the intervention tailored according to their need at this stage, according to their age, according to their families’ circumstances as well.”

Health Discussion Group

“There should be a consideration of ‘this is the health and wellbeing of a child, a young person – and there is equal if not greater responsibility on health services to be considering that and assessing it, rather than social work’.

Health Discussion Group

There was also strong consensus in the health group that early assessment and support for children’s emotional wellbeing following sexual abuse, in all cases where abuse comes to light, with an enhanced role for health.

Health Discussion Group

“The group also proposed a standard response to the assessment of children’s emotional wellbeing following sexual abuse, in all cases where abuse comes to light, with an enhanced role for health.”

Health Discussion Group

11 The ‘Children’s House’ or Barnahus, is a model which originated from the United States Child Advocacy Centres and has been carried to countries around the world including Ireland and South Africa. It was one of the models of practice considered by the 2015 report of the Evidence and Procedure Review in Scotland and according to HMICS, the model is now being considered by the Scottish Government, Police Scotland and the Scottish Court Service. This model provides child-centred and holistic response to children who have experienced abuse, in all cases where abuse comes to light, with an enhanced role for health.

Perceptions of the availability of therapeutic provision

Local levels of service provision
Discussion groups were asked to consider the provision of therapeutic support services for children experiencing child sexual abuse, in their own areas. A wide range of views were expressed regarding the level of service provision in different areas, which ranged from ‘fairly good’ and ‘adequate’ to ‘extremely poor’. Professionals were of the view that there is considerable variation in service provision between local authority areas, with some areas regarded as reasonably well served and others very poorly served. Distinctions were made in several groups between rural and urban areas, with urban areas regarded as having better provision in most cases.

Waiting times for services were identified as problematic in several discussion groups, including in local authority areas where service provision was considered adequate. A few professionals mentioned waiting times for CAMHS services: some delegates commented that referrals to CAMHS were best made through general practitioners, as this resulted in shorter waiting times for children. Long waiting times were regarded as particularly problematic for children and young people because, in many cases, there may be a short ‘window of opportunity’ within which a young person will be ready and/or willing to engage with a service.

Level of provision for particular groups
Some professionals identified service provision for particular groups of children as being especially poor. Social workers mentioned lack of specific provision for children with disabilities and for children from minority ethnic groups. There was consensus across most discussion groups that young children in particular were likely to be significantly disadvantaged in relation to service provision, with many professionals commenting on the lack of services for children under the age of twelve or thirteen.

Perceptions of the availability of therapeutic provision

Vulnerable young people at risk of sexual exploitation
The police group discussed the vital importance of long-term engagement work with vulnerable young people, to build trusting relationships and support them to engage with child protection and criminal justice processes, as well as therapeutic support. On-going engagement work was regarded as fundamental to protecting these children, as well as for their emotional and mental wellbeing. Whilst police regarded on-going engagement as a core aspect of their role, they identified considerable challenges to this long-term work.

"I have used (name of 3rd sector organisation) for all CSE enquiries. We use them consistently. But if I do have a concern about what happens when we don’t manage to keep young people engaged I am not disputing that this is our role; it is absolutely our duty to keep trying to engage with young people who are the potential victims. But it is so hard, especially further down the line. I am concerned that there is no specific strategy that we would adhere to when children will not engage. It really needs someone who knows how to break down these barriers with young people”.

"Support (therapeutic) is available to children and young people but only where they want to engage. The cases of grooming and CSE – getting that child to see that they are being exploited – this is the key challenge. There is a significant gap there – in keeping young people engaged. We are lucky – we have an outstanding SOLO officer in our team who goes above and beyond the call of duty – but you have to try so hard at it for so long."

"This is a huge gap for us, particularly for young people who have been through the care system”.

"I've had experiences when I've been trying to access a play therapist – then that can be much more difficult, in relation to getting funding and getting approval and all that sort of thing – that can take much longer".

"The real gaps that are there are for younger children. With young people aged 13 and above, there are things there. But for younger children there is really nothing at all. There really needs to be something in place, where there is intensive support that can be offered".

"Gaps in services do vary from region to region. There are stark differences between geographical areas and within geographical areas – and differences in referral systems. For example, it’s very difficult in (location) and (location) – and there are obviously many more services in (location)".

"It is all about timing. I mean a child can be ready to see someone – but then it takes that service 6 months to be seen by the right person. So, it’s not necessarily the assessment or the referral part – it’s the actual waiting to get the service. It’s a resource issue I think – a lot of the time".

"This is a huge gap for us, particularly for young people who have been through the care system”.

"The cases of grooming and CSE – getting that child to see that they are being exploited – this is the key challenge. There is a significant gap there – in keeping young people engaged. We are lucky – we have an outstanding SOLO officer in our team who goes above and beyond the call of duty – but you have to try so hard at it for so long."
There was clear concern about a lack of provision in long(ter) term engagement work for vulnerable young people at risk of sexual exploitation. One police representative described a vulnerable young people’s forum which meets monthly in her area, with significant support and input from a 3rd sector organisation, working on long term engagement. Police in other areas were not aware of similar provision in their areas and commented that it would be extremely useful.

“Any partner agency can nominate any individual to a VYP (Vulnerable Young Person) discussion meeting, where we all sit down together to discuss young people’s needs. In (location), we have had 3 VYP discussions since January this year. They have all resulted in CSE investigations.”

“I am not aware of VYP meetings in my area. It sounds similar to MARACs (Multi Agency Risk Assessment Conferences) – it sounds very helpful. If we were able to sit round a table – and if there were agencies getting involved to encourage children to engage – that would be really great.”

Conversation Within Police Discussion Group

Harmful Sexual Behaviour

Harmful sexual behaviour was considered as part of this study due to the risk HSB can pose to other children and young people, and because there can be, and often is, a link between child sexual abuse and harmful sexual behaviour. The issue of HSB was naturally raised in conversation throughout discussion groups.

The police discussion group highlighted a concern around lack of services for children with harmful or problematic sexual behaviour, as did the health group. Early intervention with children in this area was regarded as critical in meeting children’s need for support and in underpinning abuse prevention. Police, in particular, regarded early intervention as not working for children in some areas.

“I can think of lots of cases where we refer children to social work because of sexually inappropriate/problem behaviour, at a young age. Social work will assess and where they consider mum and dad to be acting responsibly, nothing happens; there is no pathway to support. A lot of times we will end up referrings these children to the reporter, but again, where mum and dad are seen to be acting appropriately, we have them referred back to us. There’s nothing being done at that early stage. There are no agencies working with this at an early stage; no support for these children.”

(Police Discussion Group)

Social workers in a follow up discussion group had not experienced referrals of this nature and commented that early intervention services for children with sexually worrying behaviour are unlikely to exist within social work. This is because the level of concern around a child’s maladaptive behaviour needs to be very high – representing a significant risk of harm – before a referral will be made to or accepted by social work.

“For a young person to get a service at statutory level it has to be hitting high levels/threshold or they won’t get access to it.”

(Social Work Discussion Group 2)

Issues around referral processes were also raised in the health discussion group, specifically in relation to CAMHS. CAMHS services are likely to be involved in referring children and young people to alternative sources of support where they are assessed as not meeting CAMHS criteria. One professional described a process in her NHS board area where CAMHS may make a recommendation for an alternative service, but must refer the child back to the original referrer – most commonly the GP - with the recommendation. Consent must be obtained from the young person and/or the parent in order to share the full assessment with the GP. This process inevitably results in longer waiting times for children and young people in need of emotional support and may undermine access in some cases.

Time-consuming referral processes were described by some social workers as potentially affecting their referral decisions. One social worker described regularly using a (3rd sector) service in her area because of the straightforward nature of the referral process in comparison to, for example, making a CAMHS referral.

“My (3rd sector service) do loads – they always seem to be there. We do the referral, we just pick up the phone and they take it on from there. They take the basic details. And that can be a barrier to a lot of different resources – trying to do the referral forms and all the information that is required. And then when you have a service that can just take it on – take the basic information that they need to take it forward – it works much better and it’s much quicker”

(Police Discussion group)

Referral processes and protocols

Professionals across groups discussed a range of issues around referral processes and protocols which may impact on children and young people’s access to services. Police identified differences in local protocols around the direct referral of young people to Rape Crisis services. In some areas, police can refer young people aged 13 and over to Rape Crisis services, whilst in others direct police referral can only take place with young people aged 16 and over. Direct referral is regarded as particularly important, given that social work may be less likely to be involved in the on-going care of children in non-familial abuse cases. The picture across the whole of Scotland regarding direct police referral is unclear.

Police also discussed whether it might be helpful for them to have the capacity to refer young people directly to wider therapeutic support services: a view which may potentially be reflected in other agencies. One police delegate described a recent meeting between senior CAMHS clinicians and police in his area, where it was proposed that police should refer young people directly to CAMHS services, rather than going through traditional referral routes. Most commonly GP CAMHS clinicians were concerned that children experiencing sexual abuse should be referred to CAMHS services at a much earlier stage – at the point where abuse is uncovered – although it was not clear from the discussion to what ends early referral had been proposed, for example for expert assessment, therapeutic input or support via consultation to wider networks.

The ‘value’ of early police referral to CAMHS, however, appeared to be viewed in part by this professional through the lens of whether it would support the evidential needs of a police investigation, rather than a child’s therapeutic recovery specifically.

“CAMHS service said they were working with 2 children just now who they have been working with for years (sic), and they (the children) have still have not engaged (with police). So, why would I use them if they can’t help?”

(Social Work Discussion Group 1)
Cost of services

Cost of services was raised in both social work and CAMHS discussion groups as impacting on referral decisions, where decisions are likely at times to be dictated by cost rather than the appropriateness of the service/intervention. Social workers in one discussion group said they would refer primarily to intensive family support projects within their own sector or to third sector services, because referring out-with would incur cost to the local authority. One social worker described a child being directly referred by a consultant paediatrician, to a service that would have been inaccessible had she made the referral, due to cost.

“We had a recent case of a wee boy, who had been abused by his father...At the forensic medical examination - the consultant paediatrician – made a referral to [name of service]...it’s something we (social work) would not have been able to do this without a cost. We have our own family support project within social work that we would use – that offers support for people who have been sexually abused or any kind of CSA of children. That would be our first port of call. But at the time of the forensic medical – his decision was to refer to [name of service].”

(CAMHS Discussion Group)

Knowledge of local services

“...the consultant paediatrician – made a referral to [name of service]...it’s something we (social work) would not have been able to do this without a cost. We have our own family support project within social work that we would use – that offers support for people who have been sexually abused or any kind of CSA of children. That would be our first port of call. But at the time of the forensic medical – his decision was to refer to [name of service].”

(Social Work Discussion Group)

“...the consultant paediatrician – made a referral to [name of service]...it’s something we (social work) would not have been able to do this without a cost. We have our own family support project within social work that we would use – that offers support for people who have been sexually abused or any kind of CSA of children. That would be our first port of call. But at the time of the forensic medical – his decision was to refer to [name of service].”

(CAMHS Discussion Group)

Perceptions about services

Professionals were not asked to discuss their perceptions about the quality of provision in individual services for ethical reasons. On the whole, where participants spoke about individual services they had positive experiences. Professionals also clearly appreciated the opportunity to hear about other services and exchange information about what was available in their areas.

A broad issue around ‘hearsay’ did emerge in some groups in the sense that hearing negative things about specific services (rather than directly experiencing this) can put professionals off using them. Conversely and unsurprisingly good relationships with services were conducive to using them.

At a more strategic level, CAMHS professionals raised concerns about the model of therapeutic service provision for children experiencing sexual abuse and trauma, where much of the service provision is in the third sector. Professionals across the group stressed having many experiences of good practice in third sector services; however, issues around governance and insecure funding were regarded as problematic.

One health professional commented that lack of knowledge about service provision may at times result in professionals not discussing the potential value of

“One health professional commented that lack of knowledge about service provision may at times result in professionals not discussing the potential value of

“I remember when I had some people that didn’t know where to refer on, and didn’t know what to do with it, so they just don’t [mention it]. They just hope you don’t bring it up and somebody else picks it up.”

(Health Discussion Group)

“...the consultant paediatrician – made a referral to [name of service]...it’s something we (social work) would not have been able to do this without a cost. We have our own family support project within social work that we would use – that offers support for people who have been sexually abused or any kind of CSA of children. That would be our first port of call. But at the time of the forensic medical – his decision was to refer to [name of service].”

(Health Discussion Group)

“...the consultant paediatrician – made a referral to [name of service]...it’s something we (social work) would not have been able to do this without a cost. We have our own family support project within social work that we would use – that offers support for people who have been sexually abused or any kind of CSA of children. That would be our first port of call. But at the time of the forensic medical – his decision was to refer to [name of service].”

(CAMHS Discussion group)

Perceptions about services

Professionals were not asked to discuss their perceptions about the quality of provision in individual services for ethical reasons. On the whole, where participants spoke about individual services they had positive experiences. Professionals also clearly appreciated the opportunity to hear about other services and exchange information about what was available in their areas.

A broad issue around ‘hearsay’ did emerge in some groups in the sense that hearing negative things about specific services (rather than directly experiencing this) can put professionals off using them. Conversely and unsurprisingly good relationships with services were conducive to using them.

At a more strategic level, CAMHS professionals raised concerns about the model of therapeutic service provision for children experiencing sexual abuse and trauma, where much of the service provision is in the third sector. Professionals across the group stressed having many experiences of good practice in third sector services; however, issues around governance and insecure funding were regarded as problematic.

One health professional commented that lack of knowledge about service provision may at times result in professionals not discussing the potential value of

“...the consultant paediatrician – made a referral to [name of service]...it’s something we (social work) would not have been able to do this without a cost. We have our own family support project within social work that we would use – that offers support for people who have been sexually abused or any kind of CSA of children. That would be our first port of call. But at the time of the forensic medical – his decision was to refer to [name of service].”

(Health Discussion Group)

“...the consultant paediatrician – made a referral to [name of service]...it’s something we (social work) would not have been able to do this without a cost. We have our own family support project within social work that we would use – that offers support for people who have been sexually abused or any kind of CSA of children. That would be our first port of call. But at the time of the forensic medical – his decision was to refer to [name of service].”

(CAMHS Discussion group)
Perceptions about the role of child and adolescent mental health services (CAMHS)

Perceptions of CAMHS

CAMH services vary in structure, team set ups and referral criteria across Scotland\(^2\), an issue considered in the main report. It is important to mention that specific CAMH services for children experiencing sexual trauma have and still do exist in Scotland\(^3\). In addition, best practice models developed to ensure a holistic response to children following child sexual abuse include at their heart early access to CAMHS with no threshold, for children and non-abusing parents/carers where indicated.

The association between childhood sexual abuse and long term poor outcomes for children, particularly mental health problems, was stressed in most discussion groups. Sexual abuse is understood in many cases to be one aspect of a wider picture of trauma and adverse childhood experiences impacting on child mental health. Many professionals highlighted the particular relationship between childhood sexual abuse and poor mental health, some specifying the challenges associated with children who experience both.

Later intervention is understood as being critical, to help children recover and prevent the long term mental health problems associated with sexual abuse. Contrastingly, perceptions about the role of children and adolescent mental health services in providing therapeutic support to children following sexual abuse, emerged across discussion groups. At a basic level, there were clear differences in the extent to which professionals regarded CAMHS as a core component of the service landscape in relation to children experiencing child sexual abuse.

One professional in the health discussion group, for example, stressed that CAMHS does not provide a therapeutic service for children following sexual abuse per se as the remit is to work with children only where there are clinical indicators for mental health problems. As sexual abuse is not in itself a mental health problem, children who are referred to CAMHS following abuse but who do not meet thresholds will generally not be accepted.

Conversely, some front-line professionals with a role in advising families about therapeutic support regarded CAMHS as a core therapeutic service for children and young people following sexual abuse. Police professionals described CAMHS as being ‘critical’ in the therapeutic landscape, although it is not clear whether this reflected a perception of the role of CAMHS with children following sexual abuse, rather than direct experience of service provision, given police are not involved in direct referral.

In contrast, professionals across both social work discussion groups did not appear to regard CAMHS as central in the therapeutic landscape, primarily because of the accessibility of services. Although one or two social workers mentioned referring children to CAMHS at times – generally via the GP – overall CAMHS services were regarded as inaccessible to children who had experienced child sexual abuse and other forms of childhood abuse, due to thresholds around referral criteria and waiting times.

Earlier intervention is understood as being critical, to help children recover and prevent the long term mental health problems associated with sexual abuse.

“CAMHS are absolutely critical. I cannot imagine any child who experiences sexual abuse not having a sort of mental health impact”

“In (local authority area), CAMHS play a critical role. But police are not actually referring directly to CAMHS, although we may give out information to families. The police would always route referrals through social work or through GPs. I have given parents information about CAMHS and how to go about getting them. But I did notice recently that 5 months down the line, CAMHS support still was not in place; so, I don’t know what is happening there”

Conversation Within Police Discussion Group


\(^3\) There are some specialist CAMH services specifically for children and young people experiencing emotional problems following sexual trauma in Scotland. For example, the Child Sexual Abuse Team, a CAMHS service at the Royal Hospital for Sick Children in Edinburgh, provides therapeutic support for children up to 16 and their parents who are experiencing emotional/behavioural/mental health difficulties secondary to a history of sexual abuse or assault. Until recently, an NHS Lothian CAMHS service (The Meadows team) provided a multi-disciplinary approach to children and their families experiencing emotional/behavioural/mental health difficulties following sexual abuse, as well as a service for children with problematic sexual behaviour. The Meadows team recently merged with The Rivers Centre, a specialist trauma service for people of all ages, dedicated to addressing the health, social and welfare needs of people affected by psychological trauma, including people who have experienced traumatic events such as childhood abuse and neglect, rape and sexual assault. Specialist child sexual trauma services are not provided across NHS Board areas, however, and appear to be extremely rare in Scotland.
Social workers in one group described many experiences of children being rejected for a CAMHS service for reasons around their ‘stability’. Examples included a young person being rejected because they had recently changed foster placement; a referral being rejected because a child’s adoption placement was in the process of being finalised; a referral of a child being rejected because there were suspicions that the child may still have contact with the perpetrator (father), although there was no concrete evidence and the child’s mother had denied this.

Social workers in this group also described what can typically happen, in their experience, when a child is referred to CAMHS and does not receive a service. They invoked a ‘revolving door’ process whereby children are referred to CAMHS, then referred by CAMHS back to the original referring agency – usually social work, G.P. or school – with no other options available for therapeutic support.

"There will be endless meetings and discussions about meeting the child’s needs and how the child’s needs should be met, without any actual resources at the end".

(Social Work Discussion Group 2)

It is important to point out that social workers who discussed this concern had also identified an acute lack of therapeutic provision in their local authority areas, for children experiencing sexual abuse.

Internal views of CAMHS

The view of CAMHS as not a core part of the therapeutic services landscape for children experiencing sexual abuse was also partially reflected in the CAMHS discussion group.

One professional directly addressed the issue of children needing to be stable before receiving a CAMH service, as follows.

"That is a common thing that I still hear within the CAMHS team (that a child must be stable before receiving a service). But surely, we should at the very least be bringing the child in for a consultation – a basic mental health assessment, to get affirmation, to then assist our social work colleagues to go to the children’s panel and say ‘actually . . . ‘

(CAMHS Discussion Group)

Some professionals were of the view that CAMH services as a whole may not have fully accepted or grasped its role in relation to child sexual abuse - or more specifically to childhood trauma in general.

One professional described the (historic) journey within adult mental health services towards a full recognition of the impact of childhood experiences of abuse and trauma (ACEs) on adult mental health which eventually leads to routine questioning within adult mental health services.

"It feels like the energies have not been put into children’s (mental health) services in terms of children’s experiences of abuse. But we know it has such a huge impact on ongoing mental health. It’s part of almost every psychiatric condition. It is such an important risk factor".

(CAMHS Discussion Group)

Factors impacting on access to CAMHS

During the course of discussion CAMHS professionals identified a range of factors potentially impacting on children’s access to CAMH services where they have experienced sexual abuse and other childhood trauma, which are worth noting in some detail. It is important to point out that the CAMHS discussion often centred around looked after and accommodated children who have experienced sexual abuse, reflecting the experience of the professionals taking part and the complex nature of the cases they often work with.

"We have shifted a bit recently; there was a looked after children team that would be more dedicated to meeting the needs of the population and what these are, rather than putting these barriers. But recently we have shifted to all referrals coming through the locality teams – and I think the demands that are facing teams, people’s experience of working with trauma, their ability to recognise trauma – then a layer before they can get up (to specialist CAMHS services)."

(CAMHS Discussion Group)

Team structure/ set-up

Professionals described variations in team structures and referral systems which may impact on the likelihood of children who have experienced sexual abuse being accepted for a service. ‘Open’ and closed’ referral systems were discussed. One professional described an ‘open’ system in her specialist team, which encourages referrers with any concerns about (LAAC) children’s mental/ emotional health to refer and where initial referral involves in-depth consultation between CAMHS specialist and the referrer (usually social work). In contrast, a more common ‘closed’ referral system operating across other NHS board areas was described, where all children and young people referred to CAMHS are initially assessed within a generalist, locality team. According to professionals, this system may lead to significant variations in how children who have experienced CSA and other complex childhood trauma will be assessed and whether they will be accepted for a service.

The group acknowledged current work underway to establish trauma as core CAMHS business and support staff in responding. One professional also described working in a be-spoke trauma recovery team, where the skills mix in the team reflects the different therapeutic and support needs of the child, at different stages in trauma recovery, and includes staff skilled in working with the systems around the child at safety and stabilisation stage.

"The group acknowledged current work underway to establish trauma as core CAMHS business and support staff in responding. One professional also described working in a be-spoke trauma recovery team, where the skills mix in the team reflects the different therapeutic and support needs of the child, at different stages in trauma recovery, and includes staff skilled in working with the systems around the child at safety and stabilisation stage.

It is important to point out that social workers who discussed this concern had also identified an acute lack of therapeutic provision in their local authority areas, for children experiencing sexual abuse.

Internal views of CAMHS

The view of CAMHS as not a core part of the therapeutic services landscape for children experiencing sexual abuse was also partially reflected in the CAMHS discussion group.

One professional directly addressed the issue of children needing to be stable before receiving a CAMH service, as follows.

"That is a common thing that I still hear within the CAMHS team (that a child must be stable before receiving a service). But surely, we should at the very least be bringing the child in for a consultation – a basic mental health assessment, to get affirmation, to then assist our social work colleagues to go to the children’s panel and say ‘actually . . . ‘

(CAMHS Discussion Group)

Some professionals were of the view that CAMH services as a whole may not have fully accepted or grasped its role in relation to child sexual abuse - or more specifically to childhood trauma in general.

One professional described the (historic) journey within adult mental health services towards a full recognition of the impact of childhood experiences of abuse and trauma (ACEs) on adult mental health which eventually leads to routine questioning within adult mental health services.

"It feels like the energies have not been put into children’s (mental health) services in terms of children’s experiences of abuse. But we know it has such a huge impact on ongoing mental health. It’s part of almost every psychiatric condition. It is such an important risk factor".

(CAMHS Discussion Group)

Factors impacting on access to CAMHS

During the course of discussion CAMHS professionals identified a range of factors potentially impacting on children’s access to CAMH services where they have experienced sexual abuse and other childhood trauma, which are worth noting in some detail. It is important to point out that the CAMHS discussion often centred around looked after and accommodated children who have experienced sexual abuse, reflecting the experience of the professionals taking part and the complex nature of the cases they often work with.

"We have shifted a bit recently; there was a looked after children team that would be more dedicated to meeting the needs of the population and what these are, rather than putting these barriers. But recently we have shifted to all referrals coming through the locality teams – and I think the demands that are facing teams, people’s experience of working with trauma, their ability to recognise trauma – then a layer before they can get up (to specialist CAMHS services)."

(CAMHS Discussion Group)

Team structure/ set-up

Professionals described variations in team structures and referral systems which may impact on the likelihood of children who have experienced sexual abuse being accepted for a service. ‘Open’ and closed’ referral systems were discussed. One professional described an ‘open’ system in her specialist team, which encourages referrers with any concerns about (LAAC) children’s mental/ emotional health to refer and where initial referral involves in-depth consultation between CAMHS specialist and the referrer (usually social work). In contrast, a more common ‘closed’ referral system operating across other NHS board areas was described, where all children and young people referred to CAMHS are initially assessed within a generalist, locality team. According to professionals, this system may lead to significant variations in how children who have experienced CSA and other complex childhood trauma will be assessed and whether they will be accepted for a service.

The group acknowledged current work underway to establish trauma as core CAMHS business and support staff in responding. One professional also described working in a be-spoke trauma recovery team, where the skills mix in the team reflects the different therapeutic and support needs of the child, at different stages in trauma recovery, and includes staff skilled in working with the systems around the child at safety and stabilisation stage.

"The group acknowledged current work underway to establish trauma as core CAMHS business and support staff in responding. One professional also described working in a be-spoke trauma recovery team, where the skills mix in the team reflects the different therapeutic and support needs of the child, at different stages in trauma recovery, and includes staff skilled in working with the systems around the child at safety and stabilisation stage.

It is important to point out that social workers who discussed this concern had also identified an acute lack of therapeutic provision in their local authority areas, for children experiencing sexual abuse.

Internal views of CAMHS

The view of CAMHS as not a core part of the therapeutic services landscape for children experiencing sexual abuse was also partially reflected in the CAMHS discussion group.

One professional directly addressed the issue of children needing to be stable before receiving a CAMH service, as follows.

"That is a common thing that I still hear within the CAMHS team (that a child must be stable before receiving a service). But surely, we should at the very least be bringing the child in for a consultation – a basic mental health assessment, to get affirmation, to then assist our social work colleagues to go to the children’s panel and say ‘actually . . . ‘

(CAMHS Discussion Group)

Some professionals were of the view that CAMH services as a whole may not have fully accepted or grasped its role in relation to child sexual abuse - or more specifically to childhood trauma in general.

One professional described the (historic) journey within adult mental health services towards a full recognition of the impact of childhood experiences of abuse and trauma (ACEs) on adult mental health which eventually leads to routine questioning within adult mental health services.

"It feels like the energies have not been put into children’s (mental health) services in terms of children’s experiences of abuse. But we know it has such a huge impact on ongoing mental health. It’s part of almost every psychiatric condition. It is such an important risk factor".

(CAMHS Discussion Group)

Factors impacting on access to CAMHS

During the course of discussion CAMHS professionals identified a range of factors potentially impacting on children’s access to CAMH services where they have experienced sexual abuse and other childhood trauma, which are worth noting in some detail. It is important to point out that the CAMHS discussion often centred around looked after and accommodated children who have experienced sexual abuse, reflecting the experience of the professionals taking part and the complex nature of the cases they often work with.

"We have shifted a bit recently; there was a looked after children team that would be more dedicated to meeting the needs of the population and what these are, rather than putting these barriers. But recently we have shifted to all referrals coming through the locality teams – and I think the demands that are facing teams, people’s experience of working with trauma, their ability to recognise trauma – then a layer before they can get up (to specialist CAMHS services)."

(CAMHS Discussion Group)
Interpretation of CAMHS referral criteria

There was a view amongst some professionals that interpretation of CAMHS referral criteria can vary across teams/services in response to resource constraints and pressure on teams. This was seen to carry particular risk for children with externalising behavioural presentations, which may be common amongst children who have suffered childhood sexual abuse as part of a complex range of adverse childhood experiences.

Pressure on teams may also result in some CAMHS services becoming more ‘diagnostically driven’, that is where a child or young person’s access to CAMHS depends on them presenting with a ‘diagnostic label’; a concern also raised by social workers in discussion. Again, CAMHS professionals raised concern that this may impact particularly on children and young people who have suffered abuse and trauma, with difficult behavioural presentations.

CAMHS professionals stressed the imperative of children with complex, behavioural presentations having access to assessment by specialist CAMHS, rather than generalist CAMHS.

Interpretation of CAMHS referral criteria

It’s the kids that come in with the behavioural (presentations). Now, there is a criteria for CAMHS – severe, enduring problems – but it depends on what CAMHS team you come in to. It’s like social work: their tariff goes up and up and up, the less and less staff they have. I think if you are a very stressed CAMHS team it’s how you interpret ‘severe and enduring’ and behavioural – so I would suggest it depends which CAMHS team you go to, as to whether that case would be accepted. And I find that very worrying – and it depends on the skill base to assess.”

(CAMHS Discussion Group)

“I think the difficulty more recently is that the more stressed CAMHS teams get – the less staffing and the less money – then the more diagnostically driven it becomes. Complex trauma, early trauma – they are not diagnostic labels. And we are not looking for diagnostic labels. But it feels as if we are on the trajectory of having the diagnostic label before you get in – rather than coming to CAMHS for an understanding.”

(CAMHS Discussion Group)

Undetected child sexual abuse

Professionals across social work, health and CAMHS discussion groups raised a number of issues related to children’s experiences of sexual abuse going undetected and/ or unrecorded. Some CAMHS professionals described sexual abuse at times being lost in a child’s journey through services, which may impact on the professional’s response and access to services.

Issues were identified at different stages in a child’s potential journey, both early on at referral stage or where a child presents at acute health services/ forensic examination, to later on where a child may be referred to CAMHS services for assessment. Concerns coalesced around the recording of information about sexual abuse/suspected sexual abuse and the sharing of information between and within agencies.

Experience of sexual abuse ‘lost’ in a complex picture of abuse

CAMHS, social work and health groups all discussed the highly complex picture of wider abuse, neglect and other adverse childhood experiences that can often accompany a child’s experience of sexual abuse. According to some professionals in CAMHS and social work groups, a child’s experience of sexual abuse may at times become ‘lost’ in this complexity, where the professional focus may be on wider issues impacting on the child, rather than sexual abuse.

Specifically, some CAMHS professionals stated that difficulty in evidencing sexual abuse may lead to a focus on other abuse/ adverse experiences.

“I (sexual abuse) is lost because of the complexity of cases and it’s lost because it is harder to evidence. Physical abuse and neglect are easier to evidence and I think they just forget about sexual abuse.”

(CAMHS Discussion Group)

A social worker in one discussion group spoke about very low numbers of children being referred to child protection services because of concerns about sexual abuse. In her role as a Reviewing Officer, she had experienced only two referrals to child protection services in the last 3-4 years, where sexual abuse was recorded as the cause for concern. Whilst this dearth of referrals may at least in part be due to an increased likelihood that children are diverted down a statutory route, it may also be a result of social workers lacking confidence in raising concerns about sexual abuse. According to this professional, social workers can lack confidence in raising concerns about abuse both with children and with management. In complex cases, practitioners need time and space to build trusting relationships with children before they feel confident enough to explore their concerns with the child, for example the underlying causes of high risk behaviours. Where social workers have a ‘hypothesis’ about sexual abuse, they can also lack confidence in formally raising their concern with management, for fear that cases may be escalated to child protection case conference stage, without sufficient evidence or a disclosure. Evidencing abuse and neglect is described as extremely difficult and challenging for social workers.

Concern about social workers’ confidence in exploring issues with children was reflected in the CAMHS discussion, where it was felt that social workers often don’t feel skilled enough in carrying out ‘routine enquiry’ around abuse.

Social work and CAMHS professionals also talked about difficulties at Children’s Hearings, where social workers can find it challenging to represent their concerns about abuse, in what at times feels like an adversarial setting. One social work professional pointed out that whilst the intention/ethos of the system is to work collaboratively with panel members, there are times when even sound assessments of abuse will be picked to pieces and social workers feel ‘attacked and humiliated’. Whilst progress has been made through multi-disciplinary training there is considered still more to be achieved.
Information sharing

Issues around information sharing about child sexual abuse between and within agencies were raised in the health discussion group, which largely coalesced around information not being shared with the GP.

Following forensic examination, paediatricians’/medical forensic examiners send a full report to police and to social work but require parental permission to share full forensic reports with GPs. According to a paediatrician, this means that in many instances partial reports are sent.

Further down the line, where a child who has experienced child sexual abuse may be referred to CAMHS, permission from both the young person and from their parent/carer is required before CAMHS can share their full assessment with the GP.

Health professionals also commented that Initial Referral Discussion (I.R.D) information is not routinely shared with GP.

“We record it on a single template which is the three-way (I.R.D) discussion with the outcomes from it and that is uploaded onto the child’s record...we don’t use their (name of local recording system) at the moment but, we are looking at it in future, however it’s not accessible to GP. It is shared with paediatrics and Accident and Emergency if they chose to go in and look for it. There wouldn’t be a notification specifically.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

Whilst the issue of GP access to information about child sexual abuse was considered important, it was also acknowledged as a complex area in need of careful consideration.

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“We record it on a single template which is the three-way (I.R.D) discussion with the outcomes from it and that is uploaded onto the child’s record...we don’t use their (name of local recording system) at the moment but, we are looking at it in future, however it’s not accessible to GP. It is shared with paediatrics and Accident and Emergency if they chose to go in and look for it. There wouldn’t be a notification specifically.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“We record it on a single template which is the three-way (I.R.D) discussion with the outcomes from it and that is uploaded onto the child’s record...we don’t use their (name of local recording system) at the moment but, we are looking at it in future, however it’s not accessible to GP. It is shared with paediatrics and Accident and Emergency if they chose to go in and look for it. There wouldn’t be a notification specifically.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“We record it on a single template which is the three-way (I.R.D) discussion with the outcomes from it and that is uploaded onto the child’s record...we don’t use their (name of local recording system) at the moment but, we are looking at it in future, however it’s not accessible to GP. It is shared with paediatrics and Accident and Emergency if they chose to go in and look for it. There wouldn’t be a notification specifically.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“We record it on a single template which is the three-way (I.R.D) discussion with the outcomes from it and that is uploaded onto the child’s record...we don’t use their (name of local recording system) at the moment but, we are looking at it in future, however it’s not accessible to GP. It is shared with paediatrics and Accident and Emergency if they chose to go in and look for it. There wouldn’t be a notification specifically.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“We record it on a single template which is the three-way (I.R.D) discussion with the outcomes from it and that is uploaded onto the child’s record...we don’t use their (name of local recording system) at the moment but, we are looking at it in future, however it’s not accessible to GP. It is shared with paediatrics and Accident and Emergency if they chose to go in and look for it. There wouldn’t be a notification specifically.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“We record it on a single template which is the three-way (I.R.D) discussion with the outcomes from it and that is uploaded onto the child’s record...we don’t use their (name of local recording system) at the moment but, we are looking at it in future, however it’s not accessible to GP. It is shared with paediatrics and Accident and Emergency if they chose to go in and look for it. There wouldn’t be a notification specifically.”

(Health Discussion Group)

“Parents don’t want all the details to be passed onto the GP. We send full reports to police and social services, but to the GP we just tell them an examination has been done because of child sex abuse investigation and whatever medical investigations have been done and results of these. So, the GPs may not know a lot about the circumstances of the incident.”

(Health Discussion Group)

“This is quite complex. You could then say, ‘right if they do all come through the I.R.D discussion process we’ll send them (the GP) a copy’. What do they then do with it, do they file it away? All these GP practices with alerts on their system, who do they alert? Is it the parents, the child’s record? What do they do with it, how would they make sense? It [would] need a bigger discussion.”

(Health Discussion Group)

Skills and experience, confidence and training

Issues around staff skills, experience and confidence in working with children who have experienced sexual abuse were raised in several discussion groups, as potentially impacting on the professional response to children and on children’s access to therapeutic services. Some training needs were identified for staff in different settings and stages in a child’s potential journey following sexual abuse.

The health group identified a specific need for training during the early, middle and late stages in a child’s potential journey following sexual abuse.

Nurse chaperones are often not trained in working with children who have been sexually abused, which can make them vulnerable. They may feel a great deal of uncertainty about how they should interact with children and families at this acute stage, what they can and cannot say. The group discussed the potential need for a designated nurse chaperone role or, given the low number of cases making this unlikely, comprehensive training and support for nurses potentially performing this role. One NHS board area represented at the discussion is considering how to take this forward.

CAMHS professionals identified an issue around staff in generalist/locality teams potentially lacking skills and experience in working with children affected by sexual abuse and other childhood abuse and trauma. There was a view that staff in generalist teams may lack experience in recognising children’s externalising problem behaviour as symptomatic of abuse and trauma, meaning these children may be less likely to be assessed as meeting the criteria for a CAMHS service.

“I think whether children who have been sexually abused are offered a service depends on the symptoms they are presenting with and the symptoms that are noticed. That is a real worry for me.”

(CAMHS Discussion Group)

“I think in our team things have progressed a lot over the years, certainly not just with these difficulties but with other problems. But it can sometime depend on who is on duty on the day – who sees the referral as it comes in the door – as to whether or not that young person is accepted. That is improving – we are trying to improve consistency there but it is still an issue.”

(CAMHS Discussion Group)

“I think in our team things have progressed a lot over the years, certainly not just with these difficulties but with other problems. But it can sometime depend on who is on duty on the day – who sees the referral as it comes in the door – as to whether or not that young person is accepted. That is improving – we are trying to improve consistency there but it is still an issue.”

(CAMHS Discussion Group)
Some concern was expressed that certain children may be more affected, specifically, children where child sexual abuse has not been formally identified and children who are not in the looked after and accommodated population. In some areas, for example, all looked after and accommodated children referred to specialist CAMHS teams for initial assessment will be automatically assessed by specialist CAMHS, whilst children referred from home backgrounds will be assessed by staff in a generalist/locality team.

The CAMHS group also discussed a parallel issue where potential referrers may lack skills and experience in recognising the behavioural symptoms of sexual abuse and/or lack skills and confidence in carrying out routine enquiry.

"Part of the difficulty is the referrer – usually social work – don’t feel skilled enough to do things like routine enquiry or ask about basic psychological functioning, for example like asking about more traditional symptoms like flash backs. It worries me that referrals (to CAMHS) can be batted off before they even arrive."

CAMHS professionals stressed their own role in training and supporting social work colleagues – as well as other staff and carers in the wider system around the child – to better understand childhood trauma, including sexual abuse, and the impact of trauma on children. This is understood as critical in equipping practitioners to confidently represent their concerns about abuse and trauma, in children’s best interest.

"Actually, if I was going to do it again (set up a specialist team), I would probably say we would not do any direct work with referrals we would just do training. Because we are rolling out basic introductions to attachment, to trauma: what it looks like, how it presents, what does it mean, what can you do if you are worried – that sort of stuff. Then we do much more intensive work with foster carers and with social workers. This is the foundation that lets you build the rest on top of all that."

"Yes! Then you have the shared understanding, the shared language: you have the relationships with the other incredible but stressed professionals – social work – you know, you give them a platform. Actually I am already seeing the difference because they have a language to talk to people like children’s hearing system… or to talk to CAMHS even if the child isn’t looked after: they have language and they can speak to CAMHS – here’s why I am worried… and they are more likely to get them through the door."

Conversation Within CAMHS Discussion Group
Role of the wider system around the child in therapeutic recovery

Professional groups were convened primarily to discuss issues around the provision of therapeutic support services for children experiencing sexual abuse and the assessment and referral of children to such services. Throughout the course of most discussions, however, professionals stressed the critical role of the wider system around the child in supporting their therapeutic recovery, at times understood as of more fundamental importance than specific therapeutic interventions per se. Concerns emerged across groups about lack of capacity and resourcing in relation to supporting wider systems.

Non-abusing parent/carer’s role

As previously identified, the role of the primary carer in providing a stable, loving environment for children who have experienced sexual abuse was recognised by many professionals as the most important ‘therapeutic intervention’ a child could have. Support for non-abusing carers to help them respond to a child’s emotional needs is considered a bottom line in therapeutic intervention for children experiencing sexual abuse.

Discussions in social work and CAMHS groups at times focussed on the role of foster carers in supporting children’s therapeutic recovery, reflecting the complex circumstances of many children they are working with, who have often experienced a range of adverse childhood experiences and abuses, including child sexual abuse.

CAMHS professionals stressed support for foster carers / non-abusing primary carer as the most critical factor in a child’s therapeutic recovery. One professional pointed out that whilst a naïve interpretation that ‘traumatised children just need a loving environment’ was unhelpful, the imperative of carers being fully equipped and supported in their vital role could not be overstated.

Social workers reflected on the on-going support needs of foster carers, vital in supporting them to respond to children’s emotional needs and cope with difficulties as they arise. According to social workers in one discussion group, the foster carer/foster care supporter relationship should mirror the ideal social work supervision model.

Role of CAMHS in the wider system

CAMHS professionals extensively described support for the wider systems around a child as an integral part of their role with children experiencing sexual abuse and trauma, as also documented in different stages of this report.

Perceptions about the quality of supervision that foster carers currently receive varied across areas. One social worker described provision in her local authority area in highly positive terms, where foster carer supervisors do so on top of onerous workloads. Professionals in this group also raised concerns about an approach in some local authority areas where the foster carer role has become so ‘formalised’ and ‘professionalised’ that it barely represents a caring relationship but is rather a ‘job’.

A range of factors were identified as ‘squeezing’ their capacity to work systemically, given its highly time-consuming nature. Most importantly these included lack of staffing/ resource constraints on teams; pressure of workloads, including the routine assessment work that professional’s carry out on top of carrying case loads, and the necessity to meet targets.

For me it’s about having access so that you can do a robust, systemic formulation - OK what is it this child needs? What do we need to provide to meet those needs – within CAMHS, or are we looking at outside agencies to come in and assist? The time that that takes? Because it is the systemic work that is actually more beneficial for that child than the individual work: the social work meetings, the children’s panel meetings etc. I think everyone round this table knows having one kid that’s under that umbrella is like having 3 ‘ordinary’ cases.

“It’s the flexibility to work with agencies in that way (systemic work); and that is such a key part of working with this population. And it’s important and relevant to their external safety that work with other people. This is much harder to do when there are other time pressures. I think that is a concern for people who know these vulnerable children and young people.”

(CAMHS Discussion Group)

“We all know that children with trauma and attachment difficulties are the very hardest to love and they ask for love in the most unlovable ways...”

How to support foster carers to look after – or whatever alternative care gives – to look after these children: this is key. We all know that children with trauma and attachment difficulties are the very hardest to love and they ask for love in the most unlovable ways...”

“The reflective relationship social workers should ideally have with their supervisors, promoting reflective thinking: discussing how they are dealing with individual cases; being challenged to think about what they are doing and how it might be impacting, advising on alternative approaches.”

“(Social Work Discussion Group 2)

“it is psycho-educational work that you are doing with them for the child – explaining what is happening for this child; explaining what happens when a child is traumatised – “let’s think about what to do; how to respond”. Even really basic techniques like grounding techniques, like mindfulness techniques – that carers can use with the child.”

“Non-abusing primary carer as the most critical factor in a child’s therapeutic recovery. One professional pointed out that whilst a naïve interpretation that ‘traumatised children just need a loving environment’ was unhelpful, the imperative of carers being fully equipped and supported in their vital role could not be overstated.”

(CAMHS Discussion Group 1)
Crucially, professionals pointed out that whilst working with wider systems around the child is a vital aspect of their work with children experiencing sexual abuse and trauma, it nevertheless does not count towards meeting CAMHS targets, as it does not represent face to face contacts with a child.

**Social work role in working therapeutically with children following sexual abuse**

There was considerable discussion in both social work groups about the social worker’s own role in ‘working therapeutically’ with children who have experienced sexual abuse. Engaging with vulnerable children and building trusting relationships is a critical aspect of a child’s recovery, regarded by professionals as particularly important in relation to child sexual abuse, not least because children’s disclosures can typically happen further down the line of social work involvement, when a trusting relationship has been built up.

Across both discussion groups, professionals identified social workers as the people who have, in many cases, developed a key, trusting relationships with individual children and who are at times best placed to carry out emotional focussed work to assist in the child’s therapeutic recovery. Several professionals questioned any automatic rational that ‘referring children on’ to therapeutic recovery. Several professionals questioned any automatic rational that ‘referring children on’ to therapeutic support services is necessarily in the best interests of the child.

A counsellor in one discussion group expressed a strong view that there is clear distinction between the support work that social workers engage in with children and a therapeutic intervention provided by a qualified therapist.

One social worker agreed with a distinction between traditional therapy and support work, but stressed that it is through support work that social work is working therapeutically with children, providing emotion focussed work, for example life story work. In many cases, opportunities for social workers to engage in one to one work may be limited. Whilst one social worker described having capacity to undertake focussed support work with individual cases, due to a priority being placed on this within her team, the overwhelming consensus was that this was very difficult due to heavy caseloads.

Protected time for on-going pieces of support work was also described by some as being under constant attack, because of social work’s crisis intervention role. One professional commented that she had, on average, one normal day in every week where case work does not have to be abandoned for crisis intervention. Across both discussion groups’ social workers expressed a great deal of frustration that they could not perform what they regarded an integral part of their role, with some also describing an associated frustration at being de-skilled in the process.

Despite chronic lack of capacity to work therapeutically, some participants felt that social workers can at times become ‘protective’ about their relationship with children and young people, and in some instances, may try to ‘take on everything’. Where a strong, trusting relationship with a child has been carefully developed and ‘hard won’, workers in some cases can want to ‘hang on’ to children, both because of their desire to do emotion focussed work but also essentially, because there is a risk in referring a child on to a service with which they might not be able to engage.

One social worker raised a concern about the child having little or no choice about who is working with them. According to this professional, where a child had developed a trusting relationship with a social worker in the past, that worker would have been allocated time and space to remain involved.

**Social work role in working therapeutically with children following sexual abuse**

There was considerable discussion in both social work groups about the social worker’s own role in ‘working therapeutically’ with children who have experienced sexual abuse. Engaging with vulnerable children and building trusting relationships is a critical aspect of a child’s recovery, regarded by professionals as particularly important in relation to child sexual abuse, not least because children’s disclosures can typically happen further down the line of social work involvement, when a trusting relationship has been built up.

Across both discussion groups, professionals identified social workers as the people who have, in many cases, developed a key, trusting relationships with individual children and who are at times best placed to carry out emotional focussed work to assist in the child’s therapeutic recovery. Several professionals questioned any automatic rational that ‘referring children on’ to therapeutic support services is necessarily in the best interests of the child.

A counsellor in one discussion group expressed a strong view that there is clear distinction between the support work that social workers engage in with children and a therapeutic intervention provided by a qualified therapist.

One social worker agreed with a distinction between traditional therapy and support work, but stressed that it is through support work that social work is working therapeutically with children, providing emotion focussed work, for example life story work. In many cases, opportunities for social workers to engage in one to one work may be limited. Whilst one social worker described having capacity to undertake focussed support work with individual cases, due to a priority being placed on this within her team, the overwhelming consensus was that this was very difficult due to heavy caseloads.

Protected time for on-going pieces of support work was also described by some as being under constant attack, because of social work’s crisis intervention role. One professional commented that she had, on average, one normal day in every week where case work does not have to be abandoned for crisis intervention. Across both discussion groups’ social workers expressed a great deal of frustration that they could not perform what they regarded an integral part of their role, with some also describing an associated frustration at being de-skilled in the process.

Despite chronic lack of capacity to work therapeutically, some participants felt that social workers can at times become ‘protective’ about their relationship with children and young people, and in some instances, may try to ‘take on everything’. Where a strong, trusting relationship with a child has been carefully developed and ‘hard won’, workers in some cases can want to ‘hang on’ to children, both because of their desire to do emotion focussed work but also essentially, because there is a risk in referring a child on to a service with which they might not be able to engage.

One social worker raised a concern about the child having little or no choice about who is working with them. According to this professional, where a child had developed a trusting relationship with a social worker in the past, that worker would have been allocated time and space to remain involved.

**Social work role in working therapeutically with children following sexual abuse**

There was considerable discussion in both social work groups about the social worker’s own role in ‘working therapeutically’ with children who have experienced sexual abuse. Engaging with vulnerable children and building trusting relationships is a critical aspect of a child’s recovery, regarded by professionals as particularly important in relation to child sexual abuse, not least because children’s disclosures can typically happen further down the line of social work involvement, when a trusting relationship has been built up.

Across both discussion groups, professionals identified social workers as the people who have, in many cases, developed a key, trusting relationships with individual children and who are at times best placed to carry out emotional focussed work to assist in the child’s therapeutic recovery. Several professionals questioned any automatic rational that ‘referring children on’ to therapeutic support services is necessarily in the best interests of the child.

A counsellor in one discussion group expressed a strong view that there is clear distinction between the support work that social workers engage in with children and a therapeutic intervention provided by a qualified therapist.

One social worker agreed with a distinction between traditional therapy and support work, but stressed that it is through support work that social work is working therapeutically with children, providing emotion focussed work, for example life story work. In many cases, opportunities for social workers to engage in one to one work may be limited. Whilst one social worker described having capacity to undertake focussed support work with individual cases, due to a priority being placed on this within her team, the overwhelming consensus was that this was very difficult due to heavy caseloads.

Protected time for on-going pieces of support work was also described by some as being under constant attack, because of social work’s crisis intervention role. One professional commented that she had, on average, one normal day in every week where case work does not have to be abandoned for crisis intervention. Across both discussion groups’ social workers expressed a great deal of frustration that they could not perform what they regarded an integral part of their role, with some also describing an associated frustration at being de-skilled in the process.

Despite chronic lack of capacity to work therapeutically, some participants felt that social workers can at times become ‘protective’ about their relationship with children and young people, and in some instances, may try to ‘take on everything’. Where a strong, trusting relationship with a child has been carefully developed and ‘hard won’, workers in some cases can want to ‘hang on’ to children, both because of their desire to do emotion focussed work but also essentially, because there is a risk in referring a child on to a service with which they might not be able to engage.

One social worker raised a concern about the child having little or no choice about who is working with them. According to this professional, where a child had developed a trusting relationship with a social worker in the past, that worker would have been allocated time and space to remain involved.
As indicated at the outset of the paper, there are no conclusions or recommendations attached to this paper separate to those in The Right To Recover study, into provision of therapeutic services for children and young people following child sexual abuse, of which these discussion groups formed just one part. The recommendations from the Right To Recover report are contained at Appendix 2.15

The wider study found a patchy and inadequate picture of therapeutic service provision across the West of Scotland area with significant gaps in provision for specific groups of children and no clear integrated pathway to therapeutic support. This overall picture of service provision was found to be broadly unchanged since a 2008 NSPCC mapping study16, despite major improvements in the remit, of children and no clear integrated pathway to therapeutic service provision across the West of Scotland. This small study provides limited information as to how this is happening. Whilst it is clear that assessment can happen at different stages after sexual abuse, and that in some cases there is no formal assessment of a child’s emotional wellbeing taking place separate to or out-with a general social work assessment, there is no in-depth insight provided. Qualitative work exploring current practice in assessment and referral would be helpful in answering some of the questions raised by discussion groups: how is any assessment of children’s emotional wellbeing needs currently undertaken; how are wellbeing indicators and/ or trauma symptoms checklist being applied in assessment; what criteria or thresholds staff are using for referral of children to specialist services; how and when are the needs of carers considered?

The evidence from some discussion groups that early referral of children to therapeutic support following sexual abuse may not be considered the best course of action, for a number of reasons, including the child appearing to be coping and/or the absence of behavioural ‘symptoms’ and children being considered too young for therapeutic support, needs further exploration.

Some children do cope following sexual abuse, with the presence of key protective factors important in determining this. Nevertheless, it is important to understand the extent to which staff knowledge and understanding of the theoretical models around how children make sense of child sexual abuse experiences underpins assessments that children are coping.

Staff confidence and skills

Issues around staff confidence and skills in working with children who have experienced sexual abuse – or where abuse is suspected – were identified during discussions as affecting staff in different professional groups. The increasing recognition of trauma and the introduction of the trauma training framework in Scotland17 will undoubtedly contribute towards meeting some staff training needs. Training around trauma recognition and assessing the behavioural symptoms of trauma, for example, may support a wide range of staff to better understand traumatic presentations in children, including child sexual abuse.

Quantitative work would help establish if the dearth of referrals to child protection services, where sexual abuse is the cause for concern, as witnessed in one locality, is reflected throughout Scotland18.

Qualitative work with social work professionals could further explore specific concerns expressed in these discussion groups, including that professionals may lack confidence both in raising with children their concerns about abuse, and in bringing these concerns to the attention of management. And further, that difficulties in evidencing child sexual abuse may lead to a focus on other forms of abuse/ neglect in child protection referrals. Any work of this nature must pay close attention to the context within which social workers are operating, including workload, as well as issues practitioners may be encountering at children’s hearings which may impact on their confidence in presenting evidence. Broad concern about a changing ethos within the Children’s Hearing System, including that hearings may be becoming increasingly ‘adversarial’ in nature, in the light of the introduction of legal representation for parents, are recently documented in the report of a recent Scottish Parliament Inquiry19.

Undetected child sexual abuse

Concerns regarding child sexual abuse going undetected have recently been raised by social workers elsewhere in the UK. In a 2014 NSPCC study, conducted in response to evidence from child protection data that the current focus on CSA is significantly lower than two decades ago20, social workers identified that cases of child sexual abuse might go undetected when more evident indicators of neglect or physical abuse accompanied concerns about sexual abuse. Social workers in this study talked about the pressure of role and raised concerns that in some cases they can be working without the knowledge, training and support they need to ensure the identification of sexual abuse and the protection and well-being of extremely vulnerable children.

Specific training and support needs are identified in discussions that are not necessarily fully addressed within this remit, including the role of the chaperone nurse in acute settings. These staff may be, in some cases, the first professionals that children come into close contact with following sexual abuse; children may disclose or make further disclosures in this setting. The setting may also be particularly challenging for non-specialist professionals, as parents will often be present, at times the abusing parents. The reaction and response of professionals to children after disclosure has an impact on how well children will do10, exploring what specific support and training nurses may need in this setting is undoubtedly important. The coalescing of CAMHS and social work professionals’ concerns around child sexual abuse going un-detected and/or un-reported, in particular social workers’ lack of confidence and skills in raising concerns about CSA, also requires further attention.

Direct police referral of children to rape crisis services

Discussion groups confirm that police – particularly sexual offences liaison officers – can perform a crucial role in the direct referral of children to Rape Crisis services. This pathway may support many of particular importance in some cases, where police are involved with children and families in cases of ‘non-familial’ sexual abuse and/ or there is non-going social work involvement.

15 The NHS Education Scotland website has a webpage dedicated to the Framework and outlines the aims and intentions of the project as well as timescales for completion. This can be found at http://www.nhsed.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training/framework.html


18 Establishing whether there is a long term downward trend in recorded concerns about child sexual abuse, such as that documented in England, Northern Ireland and Wales, is not straightforward in Scotland due to changes in recording procedures since 2012. The number of concerns about child sexual abuse at the case conferences of children who are on the child protection register is lower now than it was 5 years ago (Concerns about child sexual abuse recorded in 9% of all cases in 2012 and 1.7% of all cases in 2016. see: NSPCC, 2016. How safe are children? An overview of child protection concerns in Scotland in 2016, 4th report. NCP/HP, National Children’s Panel and the NSPCC. www.parliament.scot/documents/research-reports/how-safe-children-2016-report.pdf

Social workers’ role in ‘working therapeutically’ with vulnerable children experiencing sexual abuse

The levels of frustration felt by some social workers in not being able to carry out focussed support work with vulnerable children in their care who have experienced abuse and other trauma was at times palpable during discussion groups.

Social workers stressed throughout discussions that they are often ideally placed to provide focussed work, towards a child’s therapeutic recovery, where they have carefully built up the essential trusting relationship that allows a child to engage, and where they are experts in building these trusting relationships.

Discussions groups did not explore what kinds of focussed support work social workers are involved in, although there were mentions of ‘emotional focussed work’ and life story work with children. It would be helpful to explore further what kinds of focussed work social workers within statutory services may currently be doing with children who have experienced sexual abuse, as well as their capacity to do so. This would help towards building a picture of how and where focussed support work delivered by social workers within statutory settings – where they have capacity to deliver such work – might ‘fit in’ with the wider landscape of therapeutic services and interventions available to children and non-abusing carers following sexual abuse.

It also seems important to raise awareness generally of models of therapeutic intervention which place the importance of the therapeutic relationship, or alliance, between the child and practitioner as central to addressing the child’s experience of sexual abuse, most importantly Anne Bannister’s Recovery and Regenerative model. This model has received increasing attention in the literature, whilst a therapeutic intervention based on relationship centred interventions, which social workers are largely engaged in delivering, and which challenge a more traditional view of what ‘therapy’ is and who can provide it, which was occasionally apparent in discussion groups.

Information sharing with General Practitioners (GPs)

Health professionals paint a complex picture whereby information recorded about a child’s experience of sexual abuse or suspected abuse, at different points in the child’s journey, may not be routinely shared with GPs/ accessible to GPs. Some professionals are concerned that GPs, as the universal practitioner highly likely to encounter children and families in their journey following abuse, lack basic information. Whilst it is fully acknowledged that access to information in and of itself is not necessarily helpful, it may be worth further exploring practitioner concerns about GP access to information from wider health and child protection procedures, including exploring GPs own views about access to information and how information usefully informs GP decision making in working with children and families where there are concerns about sexual abuse.

This is not in any sense to propose that social work professionals should be delivering interventions whilst performing statutory functions. Pressure of work in Children and Families teams, well-documented and acutely reflected in these discussions, may indeed be a core factor undermining relationships between children and families and social workers in child sexual abuse cases, identified in recent research.

However, it is important to raise awareness of the importance of relationship centred interventions, which social workers are largely engaged in delivering, and which challenge a more traditional view of what ‘therapy’ is and who can provide it, which was occasionally apparent in discussion groups.

Role of CAMH services with children experiencing sexual abuse

Discussion groups suggest a lack of shared understanding of CAMHS role in relation to the provision of therapeutic support for children who have experienced sexual abuse and at times high levels of frustration where children referred to CAMHS do not meet the thresholds and/or are rejected for reasons around stability.

Potentially ‘rigid’ understandings of CAMHS as having no role with children experiencing sexual abuse per se contrast with accounts of teams with open referral structures and which actively encourage open consultation with all those professionals with concern regarding CSA (and other issues) and the concern of CAMHS professionals to work with support networks around children experiencing CSA to enhance their capacity.

As identified in the main report, The Right To Recover, a better understanding of the role of CAMHS is particularly important at this point in Scotland, as the Government has identified investment in CAMHS as the main vehicle for improving access to support services for sexually abused children, within the updated National Action Plan on CSE.


Appendix 1: Methodology

Facilitated discussion groups were held with 5 groups of professionals who may work closely with children at different stages following sexual abuse: Health Professionals (n = 1), Social Workers (n = 1), Police (n = 1), CAMHS (n = 1) and Social Workers (n = 2). Ethics approval was obtained through the NSPCC research governance process. The aim of the discussion groups was to explore the issue of therapeutic support for children and young people through the perspectives of various professional groups who work closely with children and young people who have experienced sexual abuse, at different stages in their journey. The research approach was based on participative inquiry and topics for discussion were developed through an iterative process; these varied for each group, reflecting different professional roles with children and young people. Broadly, the discussions sought to explore and understand:

- how children and non-abusing parents/carers emotional health needs are currently assessed following sexual abuse;
- how children are currently referred to therapeutic support where this is required;
- different professional roles and processes in the assessment and referral of children and young people;
- different professionals’ knowledge of and views about local therapeutic service provision.

Discussions ranged in length from between one and a half hours to three hours; all groups were facilitated by members of the research team. With the informed written consent of participants, four of the group discussions were recorded and transcribed for analysis. In the case of the 2nd social work group, (held at a seminar exploring community responses to child sexual abuse) a full note was taken of the discussion with the verbal consent of participants, and written up immediately after the event.

A thematic analysis of each transcription was manually undertaken, independently, by two members of the research team. The two researchers collaborated to cross-check findings and agree on key themes for each of the individual transcriptions. A manual analysis of cross-cutting themes was conducted by one researcher and discussed and refined collectively by members of the research team.

Limitations
This was a small-scale exploratory study. Given the constraints of resources and time, the aim was to capture some of the experiential knowledge of professionals and enable them to identify issues for further exploration, and not to conduct a systematic and comprehensive investigation of current practice. Very small numbers of professionals were involved in each discussion group and not all local authority areas across the West of Scotland were represented at every group. Resource and time constraints also meant that the group discussions did not involve every professional group which works with children experiencing sexual abuse, for example specialist nurses working with children and young people who are looked after and accommodated, young people’s sexual health specialist nurses, teachers and other education staff. General Practitioner’s (GP) and residential workers, all of whom have a potentially critical role to play in supporting children and young people experiencing sexual abuse and helping them access therapeutic support where required.

Child and Adolescent Mental Health Services
Seven CAMHS professionals from four NHS Board areas participated in the CAMHS discussion group. The group comprised of clinical psychologists and family therapists, some within LAAC teams or services. Participants were recruited through the West of Scotland CAMHS Network, which facilitated contact with the clinical directors for CAMHS in each of the five NHS Boards which fall within the geography of this study. Invitations were passed to appropriate colleagues within CAMHS teams with experience and interest in working with children who had experienced sexual abuse. Broadly, the discussion explored the role of CAMH services in working with children and young people experiencing sexual abuse, children and young people’s access to CAMHS services and professional’s around barriers to access.

Health Professionals
Five health practitioners from three NHS Board areas participated in a facilitated discussion. The group was recruited via the West of Scotland Child Protection Managed Clinical Network and included a consultant paediatrician, a nurse consultant, a CAMH service manager, a senior staff nurse in an emergency department, and a child protection nurse advisor. Broadly, the discussion explored health professional’s roles in supporting young people who had experienced sexual assault; health involvement in the assessment and referral of children to therapeutic support; perceptions of therapeutic service provision for children and young people in their local area and areas for improvement.

Police Officers
Four police professionals from four Police Scotland divisions participated in a facilitated discussion group. Participants were recruited with the assistance of the Stop to Listen Pathfinder Steering Groups in the West of Scotland and Police Scotland. Broadly, the discussion explored the police role in working with children and young people who have experienced any kind of sexual trauma, including any role in facilitating access to services, perceptions of children’s needs and the availability of therapeutic recovery services for children in their local areas.

Social Workers (2 groups)
Nine social work professionals participated in two separate discussion groups held to gather experiences from both statutory and third sector social work practice. The first group involved three social workers from three local authority areas; all working within Children and Families teams, who were recruited through the Stop to Listen Pathfinder Steering Groups. A second ‘opportunistic’ group was recruited with the assistance of the Centre for Family and Relationships Research at Edinburgh University from mixed participants attending a CRFR seminar on community responses to child sexual abuse. Participants included four social workers working within statutory sector one social worker working within a 3rd sector therapeutic organisation and a counsellor working with children and young people. The two groups explored processes locally and social workers’ role in the assessment and referral of children to therapeutic support services; social workers’ own potential role in working therapeutically with children and young people following sexual abuse; professionals’ impressions of local service provision and potential barriers to children accessing services.

----

Appendix 2: Recommendations from The Right To Recover

The Right to Recover – Provision of therapeutic support for children & young people following sexual abuse in the west of Scotland

Recommendations

1. Following a disclosure of sexual abuse, every child should receive an expert assessment of their emotional and mental health needs and, in line with GIRFEC, this should consider the support needs of the child’s non-abusing parents and carers (see point 3).

The expert assessment and the standards around this should be developed, preceded by discussion of who should be involved in developing these, at which point in time the assessment should be undertaken, who should undertake the assessment, and associated training needs.

2. Because the impact of abuse may not be evident immediately, there should be routine follow up of each child at set points, to review changes in their needs over time. The evidence base indicates this is necessary, as for a range of reasons, the full impact of abuse often does not affect a child until a later developmental stage, when they are able to understand what has happened to them.

The model for this process could be the assessment and routine follow up which occurs (in some areas) whenever a child is hospitalised following an incident of self-harm.

3. Standard information, advice and support should be available to non-abusing parents and carers following disclosure so that they are equipped to know and understand how their child is likely to be feeling and behaving, and are able to make sense of and respond supportively. A named point of contact for any queries or help down the line should be made available to them.27

4. In every local area there should be an integrated therapeutic care pathway for children following disclosure of sexual abuse. This could be specific to sexual abuse, or integrated into a broader local care pathway for children’s emotional and mental health needs.

5. Strategic coordinated action at national, regional and local level is needed to ensure that, wherever a child lives, they have access to the right help, in the right place, at the right time from specialist children’s services after sexual abuse. Detailed planning work is required giving attention to the following gaps:
   • Services for younger children (under 12s) with a particular focus on care-giving relationships;
   • Child-focused services for older children (12 years +);
   • Tailored provision for disabled children, including learning disability and communication difficulties;
   • Child sexual exploitation services able to do the arduous, persistent work needed to engage with children identified as at risk, working with police and social work;
   • Intensive therapeutic services for the most vulnerable children.

6. Central collation, routine updating, and dissemination of information about available services to the multi-agency professionals who need this.

7. This mapping of service provision, including provision for harmful sexual behaviour, should be carried out for the rest of Scotland, to complete the national picture. It is vital that this includes a thorough exploration of the role of specialist CAMH services throughout Scotland in supporting children with sexual trauma, as the Scottish Government has identified this as the main vehicle for improving access to support services for sexually abused children.

8. Improvements in data recording, collation and reporting by agencies and services about child sexual abuse should be undertaken. The Scottish Government should investigate how to fill the gaps in knowledge about the population prevalence and incidence of child sexual abuse in Scotland and maximise the potential of existing data sources to help our understanding of the nature of child sexual abuse and the contexts in which it takes place.

27 The role of the named person could be considered here.