

Sexual abuse and therapeutic services for children and young people

The gap between provision and need

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Executive summary

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This is a summary of research carried out by the NSPCC and the University of Edinburgh into the availability and accessibility of therapeutic services for children and young people who have experienced sexual abuse in England, Wales, Northern Ireland and Scotland. The research involved searches of local and national information resources on services; a survey of service providers; follow-up interviews with providers and commissioners of services; and focus groups with young people. The full research report can be downloaded from www.nspcc.org.uk/inform

Background and aims

Working Together (DH, 1999) defines child sexual abuse as:

“...the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

the inducement or coercion of a child to engage in any unlawful sexual activity;

the exploitative use of a child in prostitution or other unlawful sexual practices;

the exploitative use of children in pornographic performance and materials.”

(DH, 1999)

Research with young adults in the UK has found that 16 per cent (11 per cent of males and 21 per cent of females) reported experiences of sexual abuse in childhood (Cawson et al, 2000). Article 39 of the United Nations Convention on the Rights of the Child (1989) sets out the State’s obligation to ensure that child victims of neglect, maltreatment, torture, exploitation or armed conflict receive appropriate treatment for their recovery and social integration.

Providing adequate services for children and young people who have experienced sexual abuse is therefore a requirement in the context of Article 39.

Childhood sexual abuse has been associated with both short- and long-term mental health problems such as anxiety, phobic reactions, guilt, substance abuse, difficulty trusting others, low self-esteem, and dissociation (Walker, 1988), depression, and even suicide (Briere and Runtz, 1987). *The Corston Report* (Home Office, 2007) highlights criminality as a very real potential consequence of these problems, revealing that a high proportion of female inmates have a history of sexual abuse. Research also suggests that individuals with a history of sexual abuse and victimisation are at a greater risk of re-victimisation (Messman and Long, 1996; Roodman and Clum, 2001). More recent research by Finkelhor et al (2007) found that a significant number of children experience more than one type of violence (referred to as “poly-victims”). Therapeutic services aim to address the mental health issues arising from such abuse that may ultimately lead to these consequences.

This research, which was generously funded by the Private Equity Foundation, aimed to address a gap in our knowledge by mapping the availability of therapeutic services that support children and young people affected by sexual abuse across the United Kingdom. A range of voluntary, statutory and private sector organisations provide services for children who have experienced sexual abuse. We know anecdotally that services do not match need but to date, there have been few attempts to systematically collect information to assess whether or not these impressions are correct.

The aims of the project were therefore to:

1. Map the current availability of therapeutic services for children and young people who have been sexually abused, raped or sexually exploited, which may include services for those who display sexually harmful behaviour.
2. Review the provision of services in relation to the identifiable demand and need.
3. Evaluate the accessibility and approachability of services to children and young people.
4. Consult with young people about the services that exist and the types of services they want.
5. Consult with professionals working in therapeutic services about the accessibility of services, inter-agency working, and how to deal with any areas of unmet need.

Methodology

Children and young people who experience sexual abuse may need access to a range of services or sources of support. There are everyday “universal” services for children and young people, such as schools, as well as the more specialist services provided to protect children and respond to needs. This research, however, focused on the availability of “responsive” services that exist in the statutory, voluntary and private sectors to help children and young people affected by sexual abuse to cope with and overcome the problems arising from it. Any service that defined their work as “therapeutic” support was included within the study.

We used a range of different qualitative and quantitative methods to collect data on service location, availability, scope and coverage across the UK. The data collection strategy included:

1. collecting information on location and type of service through desk-based research, and a geographical mapping exercise to plot the locations of the 508 services identified in relation to UK child population data
2. a structured questionnaire and follow-up telephone interviews with 165 service managers
3. semi-structured interviews by telephone with 21 service managers
4. semi-structured interviews by telephone with 11 service commissioners, and
5. focus groups with 10 young people about their views on services.

The mapping research in England and Wales was conducted by NSPCC researchers based in London (Debra Allnock, Jane Ellis) and an independent researcher (Avril Price) based in Lincoln. Data collection on health service-based provision was made difficult by a long approval process required by health authorities, due to which these services are underrepresented in the sample (please see the full report for a comprehensive discussion of the methodological issues). Additionally, it was particularly difficult to get information on therapeutic services in Wales, possibly because a review of Child and Adolescent Mental Health services was being undertaken jointly by the Wales Audit Office and Healthcare Inspectorate Wales while this research was being done.

The research in Northern Ireland was done by the Northern Ireland NSPCC research team, led by Lisa Bunting. The research in Scotland was completed by Anne Stafford and Natalie Morgan Klein of the Centre for Learning in Child Protection at the University of Edinburgh. This summary presents findings for the whole UK study. Separate reports on Northern Ireland and Scotland will also be published in due course.

Key points

- **The overall level of specialist provision is low.**

Our mapping exercise revealed significant geographical gaps in provision both nationally and locally.
- **There is a huge gap between the estimated need for services and service availability.**

Potential shortfalls in provision range from 88,544 therapeutic places for children and young people at our most liberal calculation, to 51,715 places at our most conservative. Providers also consistently reported that demand for services exceeded their capacity, which suggests that many children and young people do not get the help and support they need to help them cope with and overcome the harmful consequences of sexual abuse.
- **Specialist services are not only too few but they are often offered too late.**

Services are offered mostly when a child or a young person is already showing symptoms of mental health or behavioural problems.
- **There were few services available for young people who have been raped or seriously sexually assaulted.**

There is a gap between services for sexually abused children who are referred via the child protection route, and adult services for rape and sexual violence.
- **Services are less accessible for some groups of young people.**

This applies particularly to young people living in rural areas, those from ethnic minorities, and those who have disabilities or learning difficulties.
- **There is a lack of information on the need for services and on what services and interventions are effective.**

Information on what interventions are effective in improving outcomes for children and young people who have been abused is urgently needed to guide efficient commissioning and provision of services at the national and regional level.

The shortfall in provision

Therapeutic support for children and young people who have experienced sexual abuse are provided via statutory, voluntary and private sector agencies. The organisations range from very small, specialising in therapies for children and young people who have experienced sexual abuse (eg five therapeutic “places” for children at a given time) to very large settings (residential homes which may provide therapeutic intervention for some children, but not all). Many other organisations do not specialise in sexual abuse interventions, but provide them alongside a range of support and intervention covering a range of mental health problems (“generic settings”). Only a small proportion of services are specialist post-sexual abuse services. A majority of work in relation to child sexual abuse is subsumed within service provision that deals with a wide range of mental health issues.

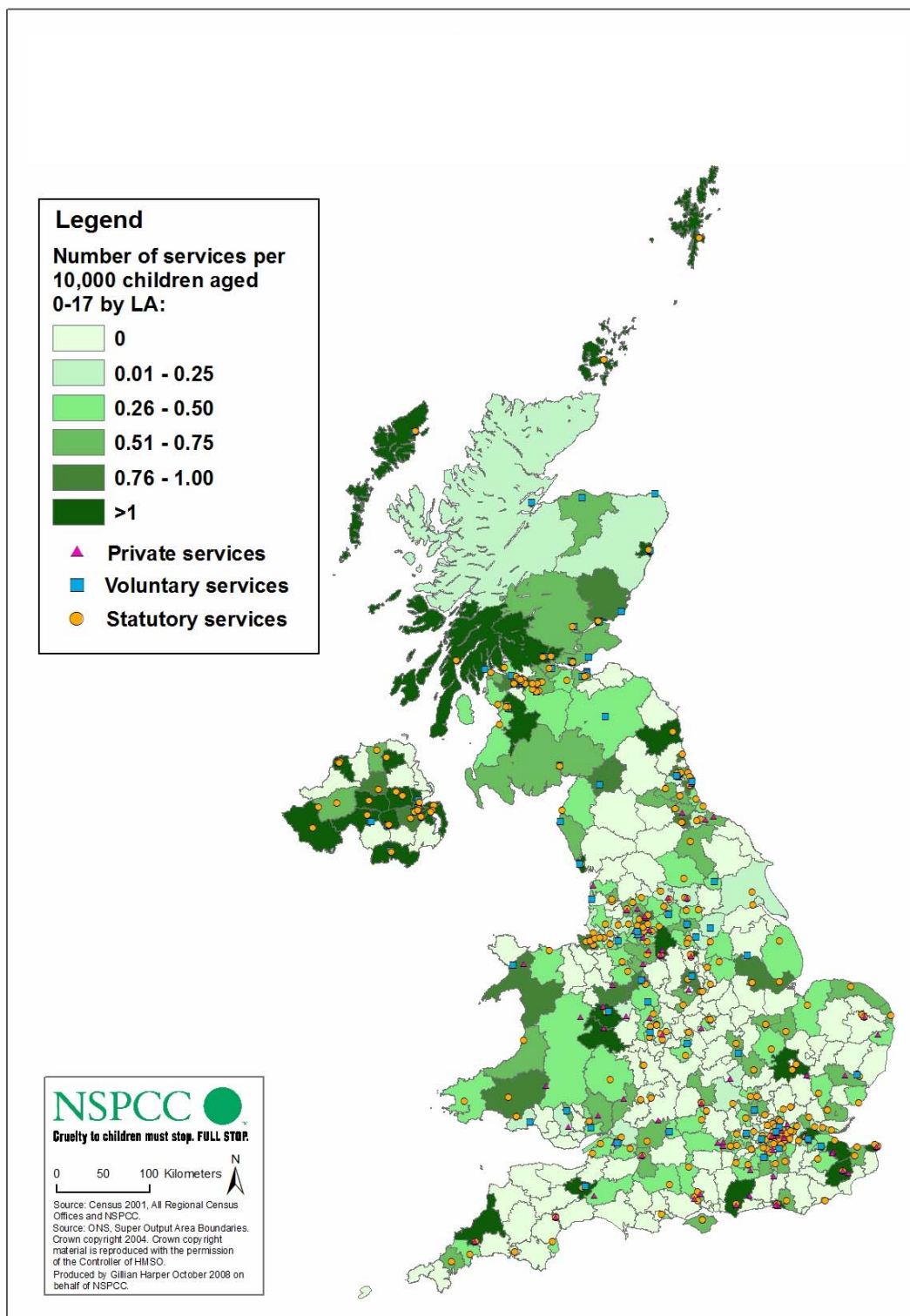
Our research findings indicate that there is a significant shortfall in provision for children and young people who want or need services after suffering sexual abuse. The geographical mapping exercise shows there are gaps in service provision nationally and regionally. The overall number of services per 10,000 children and young people is low, with an average of 0.37 services per 10,000 children and young people across England, Northern Ireland and Scotland – in other words, there is less than one service available per 10,000 children and young people across these three nations. In some areas of England, Northern Ireland and Scotland, there appear to be no services at all (see Figure 1, below).

Services are particularly scarce in rural areas. Even though some children in these areas may be eligible to attend the nearest service available, the distance may prohibit or put rural children at a significant disadvantage in accessing it. These gaps in accessibility are confirmed by information provided by service managers in interviews.

It is difficult to estimate the need for services because of the difficulty in estimating the true numbers of children who have experienced sexual abuse. Much sexual abuse remains concealed, and only a small number of studies have attempted to estimate its prevalence. Nevertheless, the need for and shortfall of services was calculated using the following data: UK population figures; estimates of levels of contact and non-contact abuse in the total population; average number of referrals from services that supplied this information; and conservative estimates of service take-up. The least conservative estimate was calculated to include all four nations in the UK and both contact and non-contact abuse and reveals a shortfall of 88,544 places. The most conservative estimate excludes Wales from the estimation (due to data collection complications) and only includes estimates of contact

sexual abuse. This results in a shortfall of 51,715 places per year. Thus, even a conservative approach to calculating need and shortfall indicates a very significant deficit of provision in the UK.

Figure 1 Location of private, voluntary and statutory therapeutic services in the UK, by number of services per 10,000 children aged 10 to 17



The demand for and accessibility of services

The current average referral rate of young people for the 110 services that participated in our survey is 32 each year. This varies widely however, depending upon the size of the service, the length of therapeutic work being undertaken with a child, and the suitability of services for the child in question. Waiting lists for a service average three months, although this also varies quite significantly and can be as long as a year. Services prioritise children with the most severe symptoms and problematic behaviour, as they lack the resources to quickly see all children who have experienced sexual abuse. Some services are managing excess demand by closing their waiting lists.

In view of this, it is unlikely that many services could support policies for early intervention, as the majority of staff already hold full caseloads. Services also do not reach out to the public and to hard-to-reach groups, fearing that they will not be able to meet increased demand levels with current resources. Hence, the reported referral rates include disproportionately low numbers of children from minority ethnic backgrounds and disabled children. Moreover, there are children who have complex needs that services are unable to accommodate.

There has been little work across the UK, either regionally or nationally, to appropriately assess the demand for provision for children who have experienced sexual abuse, resulting in a lack of guidance for commissioning these services.

Finally, dealing with child sexual abuse has not been adequately prioritised by Child and Adolescent Mental Health Services (CAMHS), Local Area Agreements (LAAs) and Local Safeguarding Children Boards (LSCBs). This has been reflected in, for example, the inability of CAMHS to accept referrals expressly related to sexual abuse, as well as the fact that their recording systems do not actually include a category for children who have experienced sexual abuse.

The nature of provision

Across the UK a wide range of therapies are on offer. Work with families is provided where possible, depending on available resources, but this work tends to be ad hoc support rather than organised therapeutic interventions in a recognised family therapy framework.

Interventions include a variety of different approaches in addition to counselling and cognitive behavioural therapy (CBT), such as creative therapies used in both group and individual contexts. Some therapies, such as CBT and counselling, are chosen because research evidence points to their effectiveness in improving outcomes, but the study showed that there is insufficient long-term research on a range of interventions, presenting a possible barrier to both efficiency and service development.

Although a range of client outcome measures is used, there is little consistency in how this is done across services. Most commonly, services review their work through feedback from children and young people. The resulting lack of reliable baseline measurements makes comparisons difficult.

A majority of the services reported that they have either formal agreements or informal strategies to help young people transfer to adult services.

The quality of provision

By and large, staff providing therapeutic services are professionally qualified, the majority as social workers who have had additional therapeutic training. Some are trained counsellors. A small percentage of services involve non-professionally qualified staff and unpaid volunteers in the delivery of therapeutic work.

Serious problems were reported in recruiting sufficient numbers. When recruiting staff, managers assign equal priority to technical skills (eg skills in delivering therapies) and child-centred personal qualities; skills and experience of safeguarding children are generally much lower down the priority list. These are, however, crucial in protecting the wellbeing and safety of this vulnerable group of children.

Managers had mixed feelings about the quantity and quality of staff training, and while line supervision was generally perceived as “good”, concerns were expressed in respect of

unequal access to clinical supervision. These concerns form part of the wider challenges that services face in terms of assessing the quality of clinical supervision.

Funding, commissioning and joint working arrangements

Therapeutic services have complex funding arrangements, often having two or more sources of income that tend to be short-term, unstable and insecure. Shortfalls in resources resulting from such unstable and short-term funding are of significant concern to managers across all sectors of provision, as they interfere with the nature of therapeutic work, which often is long-term. Any loss of funding will affect the overall outcome of the therapeutic work if that work must be terminated early.

This instability also means that services are constantly searching for new sources of funding and have to spend much time on trying to renew and renegotiate existing funding, which in turn interferes with the actual day-to-day delivery of services to children and young people.

Funding for commissioned services is dependent upon the commissioner's assessment of need, but this need is not always understood adequately by the commissioning bodies. Commissioners struggle with the prioritising of funding for sexual abuse services, as there is a perceived lack of guidance to help make the right judgements about levels of need and what interventions work. This is a significant impediment to providing adequate services for children and young people who have experienced sexual abuse. Recent developments within the UK government's sexual violence delivery plan that take into account the specific needs of these children and young people are a welcome development. However, our research clearly shows the need for the UK and devolved governments to support local initiatives as well.

As in other areas of service provision, working together is neither a straightforward nor an easy task. Services aspire to work collaboratively with other organisations, and activities such as signposting, referring to and consulting with other professionals are occurring regularly. However, there are a number of barriers at the most crucial stages of work with children and young people who have experienced sexual abuse. Shared delivery of services and continued involvement of agencies with those children and young people who are receiving therapeutic intervention present particular challenges.

Conclusions and recommendations

The research has revealed a significant gap in the provision of therapeutic services for children and young people who have experienced sexual abuse in England, Northern Ireland and Scotland. Despite concerns that children with disabilities and special needs may be more vulnerable to abuse, a high proportion of services are unable to accommodate such children.

Notwithstanding the difficulties in accessing information about therapeutic services in Wales, those that were identified and the anecdotal evidence we uncovered point to similar issues to those in the other nations. The difficulty in accessing information or receiving responses about services in Wales is in itself a concern.

The NSPCC recommends the following:

1. We recommend that specialist service provision for children and young people who have experienced sexual abuse is expanded nationally.

It is recognised that in a period of recession funds are limited. However, the future savings that could be made by providing services to distressed children in a timely manner should be considered. The Scottish Executive has invested in providing services for children living with domestic violence, and a report showing the impact this has had on outcomes for children is forthcoming. Governments across the United Kingdom should invest in these as core services.

2. We recommend an expansion of resources to increase the likelihood of early responses to sexual abuse.

Early responses will save money in the longer term. Currently, waiting lists are too long, leaving children without any service. CAMHS should be required to ask service users about experiences of abuse, so that young people who have experienced abuse can have their needs for services assessed.

- 3. We recommend that workforce expansion is accompanied by innovative service provision that provides more flexible services based around the needs of children and young people, for example:**
 - a. The costs of transport to bring clients from rural areas to service premises as part of outreach work should be factored into the commissioner/provider “bidding” process.**
 - b. Consideration should be given to forming area or even regional clusters to ensure a variety of therapeutic interventions are accessible across a range of providers.**
- 4. We recommend that agencies undertaking generic work with children and young people, such as CAMHS, include classifications of sexual abuse in their initial assessments.**

Adequate provision of therapeutic support for sexually abused children and young people will only be achieved if the need for such services forms an overt element of the initial assessment process. Our research reveals that there is little consistent or coordinated effort, either locally or across jurisdictions of the UK, to do so. However, this is particularly important because identifying this need is a prerequisite for referral to a specialist service. Thus, unless initial assessment considers sexual abuse, the extent of unmet need will remain concealed.

- 5. We recommend that classifications of sexual abuse are collected for submission to and inclusion in any national CAMHS mapping exercise.**

Information about sexual abuse assessment and provision would form a useful extension to the data currently collected through any CAMHS mapping process undertaken by the UK and devolved governments. It will provide an accurate picture of local need, which will inform local and national planning and assessment and enable individual and joint commissioners to identify an appropriate level of service provision. In addition, it can be aggregated into regional and national information and reporting systems, thereby enhancing the quality and detail of information currently available.

- 6. We recommend that where a child is successfully referred by local authority children’s services, a Health and Care Trust in Northern Ireland or CAMHS for a specialist sexual abuse service, the case must be allocated to a social worker or lead**

health professional, depending on the referring agency, and remain “active” until such time as work with the child or young person is complete.

The research identifies a number of aspects (both positive and negative) around collaborative working. Of particular concern is the common practice by referring agencies of “closing the case” once a child or young person has been referred to, and accepted by, a sexual abuse service. The research goes on to identify significant problems at very crucial stages of service delivery because of the failure of commissioners and other providers (children’s services and CAMHS in particular) to maintain their engagement with the child or young person.

7. We recommend that consideration is given to the issuing, or reviewing, of joint guidance concerning the commissioning of services for children and young people who have experienced sexual abuse. This guidance should:

- a. locate accountability for the commissioning of such services with the relevant partnerships or statutory agency**
- b. recommend a minimum commissioning period.**

A recurrent theme emerging from our research is the issue of short-term commissioning (frequently referred to as “funding”) particularly in secondary or tertiary services. The research also revealed the complex and insecure nature of funding arrangements, with services supported by a number of different income streams from a number of diverse sources. Finally, the research highlights the lack of a clearly accountable body for the commissioning of such services. This complexity and uncertainty is a particular concern for small specialist providers, who are less likely to have the requisite business management skills and capacity.

Joint commissioning bodies provide an ideal framework for simplifying the commissioning of such services. However, the process of commissioning must be founded on an understanding of the complex and often long-term nature of therapeutic support services. Providers must be enabled to give a sustained and reflective service, which allows them to develop their practice, provide informed feedback for research and evaluation purposes, and to provide long-term therapeutic support where appropriate. This will require commissioners to consider how commissioning arrangements might be satisfactorily entered into for significantly longer than the one- to three-year periods cited in the course of this research.

- 8. We recommend that UK government's sexual and domestic violence action plans specifically address the needs of young people to access services. In particular, sexually abused, raped and sexually exploited young people should be able to access confidential advice and support, and to self-refer to specialist services.**

The *Cross-Government Action Plan on Sexual Violence and Abuse* (2007) brings together the measures underway and in planning stages to a) maximise prevention of sexual violence and abuse; b) increase access to support and health services for victims of sexual violence and abuse; and c) improve the criminal justice response to sexual violence and abuse. One purpose of this plan is to identify gaps in existing work that require further consideration. In particular, the plan should consider the needs of children and young people in light of the gaps in provision revealed in this piece of research. Rolling out and evaluating Sexual Assault Referral Centres (SARCs) for children's services are particularly welcome in this context.

- 9. We recommend that governments across the UK ensure that their budgeting process enables sustainable funding to be prioritised for the provision of services to children and young people who have experienced abuse, including sexual abuse. This should be accompanied by outcome indicators to ensure delivery locally.**

Local partners must be in no doubt about the importance that governments across the UK place on the provision of services to abused and sexually abused children and young people. The simplest and most immediate way of achieving this is by ensuring the inclusion of appropriately focused performance indicators.

The lack of an appropriate performance indicator to drive the quality and quantity of services for children and young people who have experienced abuse, including sexual abuse, is reinforced by the findings of the research, which reveal the relatively low priority given to sexual abuse. The absence of clear levers for sexually abused children, (indeed children who have experienced any form of abuse) is notable.

- 10. We recommend that plans related to the development of the children's workforce in each part of the UK explicitly consider how to increase capacity in this sector of the workforce.**

The research revealed a need for higher staffing levels and a more diverse skills-mix, if any impact on waiting lists is to be made. This would also provide for expansion in

provision to otherwise hard-to-reach groups of children, for example those with particular needs or living in rural areas.

11. We recommend that the UK government and the devolved administrations work together to commission research into the effectiveness of a range of therapeutic interventions in respect of sexual abuse, with the objective of expanding the existing evidence on what works.

The research highlighted the need for more information on the range and effectiveness of different types of therapeutic support for children and young people who have experienced sexual abuse. The intervention with the most robust evidence is cognitive behavioural therapy (CBT). However, while there is some evidence that CBT-based treatments can improve mental health outcomes for sexually abused children with post traumatic stress disorder (PTSD), anxiety or depression, there is conflicting evidence on its effectiveness in reducing child behavioural problems (Macmillan et al, 2008).

This leads us to question why at times very limited evidence appears to justify the use of particular types of therapeutic support. It points to the need to improve and expand our knowledge of a wider range of therapeutic support models, particularly taking into account young people's own views about the services they receive and the support they would like to have.

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