SAFER FUTURES

SEXUAL ABUSE THERAPEUTIC & ASSESSMENT SERVICE

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FINDING THE SILENCED

MAPPING THE GAPS IN SERVICES FOR CHILDREN UNDER TEN WHO HAVE BEEN SEXUALLY ABUSED AND THEIR FAMILIES

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CHILD SEXUAL ABUSE – CORE PRIORITY PROGRAMME 2018-2021

Acknowledgements

We would like to thank everyone who contributed to our work, helping us better understand the very complex issues for arguably the youngest and most vulnerable children in our society; those who trust and are let-down, those who learn some very distorted messages about trusted adults, and who often spend years feeling (wrongly) that somehow they were responsible, which for some can be compounded by the way they are responded to by the very systems meant to support and protect. Your time and reflections were much appreciated and will add to evidence that continues to push forwards and highlight the issues raised about systems, interventions, gaps and fragmentation in legislation, systems and understanding of need, for children under ten who have been sexually abused and their families.

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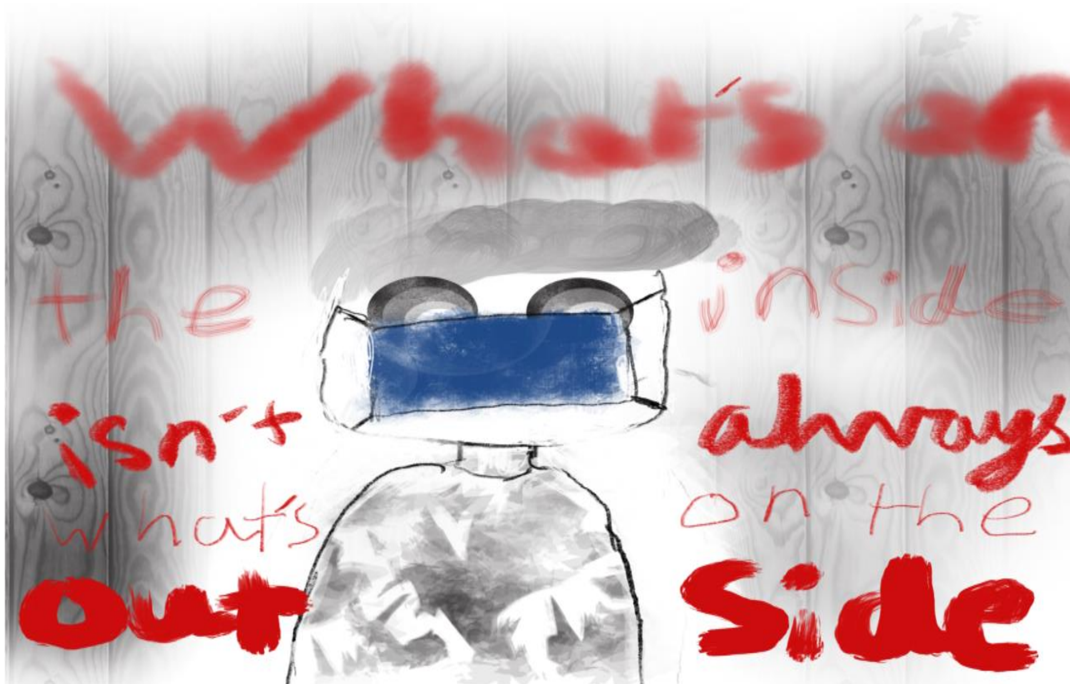
Also a huge thank you to all the children who contributed their art work, reminding us of some important messages for adults.



Executive Summary

Background

As part of Barnardo's programme of change and influence, Core Priority funding was awarded to the Safer Futures Sexual Abuse Therapeutic and Assessment Service (SATAS) to investigate one of the most overlooked and hidden groups at this present time: children under ten who have been sexually abused and their families.

Aims of the Research

- To examine whether children under ten who have been sexually abused and their families do constitute a hidden group; and
- To determine what the marginalisation of children under ten may mean in terms of the support they and their families receive following abuse.

Research Approach

The research started by mapping what we had learnt experientially across the 20-year period that the SATAS service has been running, focussing on what services had been delivered and what had not progressed beyond the enquiry stage. Our practice-based experience was then supplemented by an online questionnaire and a series of semi-structured interviews with multi-agency professionals to gain a snapshot of the prevalence, needs and access to services for children under ten and their families. Additionally, the questionnaire and interviews allowed us to consider practitioner knowledge, skills and confidence levels. To support and inform the empirical research, a team of researchers from the University of Bedfordshire were commissioned to conduct a rapid evidence assessment focussing on the following areas:

i) Child sexual abuse (CSA) disclosure among children under the age of ten;
ii) Post-abuse support for children under ten and their families; and
iii) Related gaps in services.

Key Findings and Learning Points

1. There is a **lack of research and criminal conviction data** relating especially to children under ten who have been sexually abused. There is limited data collection across multi-agency partnerships, including specific statistical data about the number of adults perpetrating CSA against children across this age range and at different developmental points. Without clearer statistical data and research to underpin understanding and protocols between agencies, fragmentation will remain and there will continue to be a lack of clarity around prevalence and risk. Children will continue to fall through the gaps the absence of this information creates, and will not be well served by those best placed to protect and support them.

2. There was a **lack of clarity from some practitioners around interventions**. Some identified CSA as a mental health issue, others referred into children's mental health services in the absence of a more targeted CSA service in their area. Some young children who displayed sexualised behaviours were excluded from therapeutic services due to being viewed/labelled as perpetrators – thereby doubly victimising them.

3. **It is not a child's responsibility to disclose;** adults need to be better informed and professionals better supported to develop role-based skills. Responding to child sexual abuse is everyone's business, not only the role of statutory or specialist services. The onus should not be on children to disclose or to manage the impacts themselves, but on adults to communicate more effectively, specifically with younger children and to better understand CSA dynamics. Participants identified the need for role-focussed training across multi-agency services to support professionals to feel more confident about identification, support, assessment, safeguarding and therapeutic responses to children and their families.

4. There was felt to be **no equality of access to services regionally or nationally**, and services that do exist may well exclude a significant proportion of children due to contract constraints around referral criteria or long waiting lists. Few services were identified as being adaptive and inclusive, with the ability to respond to a wider range of needs in order to reduce significant gaps and marginalisation of younger children and those with additional needs. Many children were signposted to 'best fit' services locally which may not meet the needs of the child in the longer term. No clear pathways were identified for children and their families to access appropriate, targeted services following sexual abuse and no clear assessment of need process for those involved with statutory agencies, where assessment tends to focus predominantly on risk.

5. **Disjointed decision making between child and adult services.** There are multiple systems across agencies for assessing and responding to sexual abuse and often a lack of a common language, protocols and understanding, that can lead to gaps and errors being made, which are avoidable. Decision making between adult risk management and children's safeguarding services can be disjointed, with decisions made in isolation leaving children vulnerable. The legal process still excludes some of the youngest and therefore the most vulnerable children who have experienced sexual abuse within the family environment, and special measures are not always available.

6. There is a **need for awareness raising and a broader national strategy around CSA**. Until awareness-raising is provided to the general population, misconceptions will continue to flourish where certain attitudes and values remain unchallenged. If adults are expected to protect children more effectively, adults need to understand more clearly what CSA is and be supported to develop the knowledge to equip them better.

7. CSA is the most uncomfortable subject for some professionals to deal with. **Adults can find the right language to speak to young children in words and ways that are developmentally appropriate and need to be less afraid of doing so**. Until we do, children will remain vulnerable and some will be sexually abused. This is not a problem that children can solve. It requires adult responsibility to develop effective solutions.

Animations

As part of this work we have developed a series of very short animations (approximately 60 seconds each) about different aspects of child sexual abuse. We invite you to look at them and share with colleagues, family and friends to help raise awareness.

Links to the animations:

https://vimeo.com/440954662

https://vimeo.com/440947224

https://vimeo.com/440948937

https://vimeo.com/440952691

https://vimeo.com/440951258

With the right responses, children can and do, thrive after sexual abuse

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1 Introduction

In 2018 Barnardo's embarked on a programme of change and influence. Core Priority Programme funding was provided to a small number of internal practising child sexual abuse (CSA) services to undertake research across four key themes:

1. **Understanding what works**
2. **Finding children who are hidden and supporting their voices to be heard**
3. **Developing new and effective approaches**
4. **Influencing widespread policy and system change**

The Safer Futures Sexual Abuse Therapeutic and Assessment Service (SATAS) has worked in the field of child sexual abuse for over 20 years, as part of a local authority contract for 15 years and subsequently providing interventions on a spot purchase basis across the North-West. Throughout this period we have written and delivered training to multi-agency professionals using strengths-based approaches across the ever widening spectrum of sexual abuse, tailoring courses to specific needs, alongside providing consultancy in complex cases. Additionally, we have a long-standing, highly experienced team, all of which provided a strong foundation for understanding some of the complexities and anomalies for children and families. Specifically, we brought a working understanding of the challenges for organisations and the needs of children and families. We have experienced first-hand the impacts of rising thresholds, reducing budgets over a protracted period and the disconnect between practice, legislation and research as new challenges come to light and research seeks to keep pace, and catch up where possible.

Based on our premise that issues for individual—and specifically younger children—are raised and considered in isolation, with little coherence or consistency, **children under ten who have been sexually abused and their families** are one of the most overlooked groups at this present time. As such, we feel it is important to examine whether that premise has any basis and value, and if it does what that may mean in terms of better understanding some of the current limitations.

We chose to start the process by mapping what we had learnt experientially across the period the Service had been running, in terms of what services had been delivered and what had not progressed beyond the enquiry stage (see Appendix 2). We considered what we had learnt about why and how decisions were made by referring authorities and how well systems understood and supported children under ten and their families at various stages from prevention to intervention. We focussed on the areas that were repeatedly raised over time. This brought out a wide range of issues that we then grouped broadly into eight themes to help make them more manageable to reflect on (as shown in Table 1). We did this across a number of team sessions and in doing so identified what we believed to be significant disconnect across all areas and a lack of interconnectedness and cohesion within strategic planning.

Theme	Indicative Questions to Explore under each Theme
Access to appropriate services	Do children under ten and their families have access to appropriate services when needed? What barriers prevent access? Is there a lack of assessment to identify if support is needed for parents who act protectively? Is there a greater emphasis on assessment of risk than on needs?
Disclosure	What type of responses do children under ten get from adults following disclosure? Is it effective? Are there any additional vulnerabilities and barriers for children under ten in disclosing? Are these responded to by professionals and reflected in systems and procedures?
Investigation	Are there effective systems in place for children under ten and how would this be clearly evidenced if statistics are not effectively and consistently collated? Are children and their family's needs effectively assessed post disclosure?
Court, evidence and legal process	Court, investigative and therapeutic processes can still exclude some young children. Why do statistics relating to sexual offences against children group together all children under 13? How does this impact on being able to understand more specifically, children's needs across this wide range of developmental levels, and what in particular does it mean for the youngest age groups?
Skills and knowledge	Are practitioners equipped to work effectively with CSA? Is there a lack of consistency in confidence, skills and knowledge levels of multi-agency practitioners? How are professionals supported and are there effective systems in place in multi-agency organisations?
Communication and additional needs	Is greater responsibility placed on all children, including those under ten, to disclose? Do systems have embedded processes to respond to children under ten who may not know that what is happening to them is not normal, who may not have the language to 'tell', who disclose through pictures but then can't verbalise or sequence events?
Trauma-based interventions	Do children and their families get an assessment of need? Do professionals understand trauma based impacts? Are potential interventions trauma informed based on accurately assessed needs or on what is available locally? What happens if a specific service isn't available locally?
How professionals respond to children under ten	Do professionals understand the specific dynamics within CSA? Do they have an understanding of how trauma can affect a child, of how children's behaviours are a form of communication, and of this being developmentally age appropriate as their emotional literacy is still developing. Do they understand within this context how to create meaningful communication with a child? Do organisations have systems and processes in place to support staff to do this effectively with children under ten?

Table 1: Themes identified from initial mapping exercise

Our main finding from this mapping exercise is that there appears to be a disconnect between theory, practice and strategic planning which we believe allows gaps to open up

for children, in terms of understanding needs more clearly and inconsistent access to services; a finding which itself is supported by the literature (Brown & Ward, 2012; Allnock & Miller, 2013; Parke & Karsna, 2019). The literature shows that there is a broad range of research underpinning practice, each focussing on its own specific area of child sexual abuse but which is also disconnected from the child's whole experience. This demonstrates that neither practice nor research recognises fully the significance of the connectors between these parts and there is a lack of strategic planning in place to respond to needs identified. This then leads to a failure to understand the child's whole experience or the interlinking nature of what is or is not known or available, across the spectrum of need for children under ten and their families. We believe this to be the case despite changes of governments, despite the development of multiple systems across agencies for understanding, assessing and responding to child sexual abuse, and despite the increase of specific legislation and research, which serves to foreground the significance of this disconnect as a systemic issue.

Whilst our practice-informed mapping was useful as an initial exploration into the areas that we felt were likely to be most significant, what we did not know was whether the same issues were relevant and replicated more widely, or whether they were specific to the areas we had delivered services in. This formed the starting point for our research and the focus of this report: to develop an overview from the perspective of professionals, of what is currently available for children and their families; what is not, and what this means for them: **Mapping the gaps for children under ten years who have been sexually abused and their families.**

The initial phase of the research focussed on testing out whether the fragmentation we believed exists is reflected across current multi-agency professionals, and at what levels. The aim was to get a snapshot of prevalence, needs and access to services for children under ten and their families, and also to consider practitioner knowledge, skills and confidence levels. This was done via:

- **A Survey Monkey questionnaire** circulated nationally to multi-agency professionals aimed at understanding how sexual abuse is being responded to and how confident professionals feel in understanding and responding to children under ten and their families

- A smaller sample of **13 semi-structured interviews** with multi-agency professionals who had worked with children who had been sexually abused

A team of researchers from the University of Bedfordshire were commissioned to conduct a **rapid evidence assessment** focused on understanding child sexual abuse disclosure among children under the age of ten; post-abuse support for children under ten and their families; and related gaps in services. In addition, as we learnt from the process we also

developed the **short animations** (links to which can be found in the Executive Summary section of this report) that will be used to raise awareness of some key issues facing children and families.

We understood that the research would be a challenge from the outset. The rapid evidence review undertaken by Warrington and Soares (2020) for Barnardo's fairly quickly became a scoping review given the limited empirical research specifically relating to young children under ten. This in itself indicates their needs are not considered or understood and identifies a need for more specific research to be developed for this group of underrepresented children and their families. This gap and the need for further specific work with younger children is noted in a number of the papers reviewed (see for example, Allnock and Miller, 2019; Horvath et al., 2014; Cossar et al., 2016; Warrington et al., 2017).

We sought to test out and bring into focus the level at which young children's needs are understood, and responded to; whether there is any coherence to the support or protection they can expect to receive across their journey, following an experience of being sexually abused by someone known, trusted and who they may have been dependant on. The remainder of this report outlines the methods, analysis and main findings from each of the elements of the research. Specifically, Section 2 provides an account of the Survey Monkey questionnaire and Section 3 provides an account of the semi-structured interviews with multi-agency professionals. In Section 4, we bring these sections together in order to triangulate findings and identify the most significant issues affecting children under ten who have been sexually abused and their families. We conclude in Section 5 by synthesising the findings, which indicate there is continued fragmentation across CSA in all areas in relation to children under ten. There is a lack of research specific to this age group so strategic planning cannot be evidenced linked to specific need. This in turn leads to ad-hoc decision making across prevention, protection and intervention, and a lack of availability and accessibility to services. All of which indicate that children under ten and their families are not well enough served or protected by those best placed and responsible for doing so. The findings from the rapid evidence assessment are integrated throughout to highlight where the findings of our own research are supported or refuted by the wider literature.

2 Online Questionnaire

A questionnaire administered through Survey Monkey was distributed to multi-agency professionals. The questionnaire consisted of fifteen questions asking about their experience in working with children under ten years who had been sexually abused and their families. The questions asked about gaps in services for children and families, professionals' own confidence within this area and their training needs. (See Appendix 1 - Questionnaire)

The questions were devised around the team's own practise-based experience in order to gather the breadth of gaps in services from other multi-agency professionals. Sections were also included to allow for free narrative and opportunity to identify additional areas for consideration.

A snowball sampling approach was used and the survey was sent out to key professionals in Children's services, education, health, safeguarding, and other Barnardo's and specialist services in various local authorities, who then disseminated it within their organisation.

A total number of 154 responses were received, with the main respondents being from education (61) and Children's services (51) as shown in Figure 1.

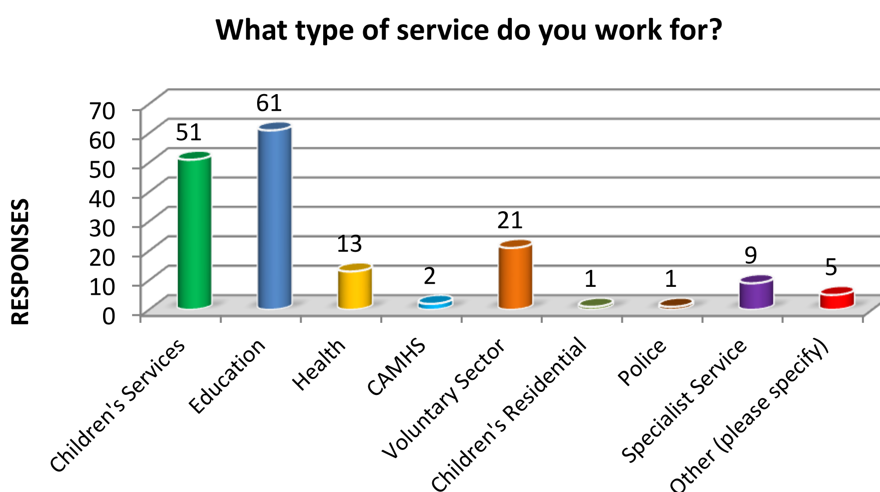

Figure 1: Services represented by respondents

As can be seen from Figure 1, a high number of Children's services and education professionals completed the survey, whereas only one respondent was a member of the police and CAMHS and children's residential professionals were equally poorly represented. Any findings reported must therefore be understood against this potential limitation, and the insights gained from the analysis therefore, cannot be understood to be broadly representative outside of Children's services and education.

2.1 Mapping the gaps and identifying emerging themes

From the team's practice-based experience, we identified significant service provision gaps that were consistently presented across a lengthy period of time, as identified in the introduction (Table 1). Where any responses to the survey were similar, they were grouped within these emerging themes. Any that were different or significantly broader, were collated separately.

Our analysis comprises the quantitative analysis of responses, coupled with a thematic analysis of free text responses in order to shed further light on issues raised. Speculative analysis revealed that many participants used the free text opportunity to raise issues that were covered in various other questions. As such, the analysis has focused on the number of times that a particular issue was raised across the survey responses as a proxy for understanding how significant the issues were to participants, rather than focussing on how many of the participants mentioned each particular issue.

When we grouped the free text responses into emerging themes (see Figure 2), the area most identified was around service availability, access and funding which was mentioned by respondents a total of 163 times. Ofsted (2018) reports that in social care most local authorities have had significant reductions across the public sector, although frontline statutory services have been protected from local authority cuts; however reductions in other areas such as preventative and wider Children's services means local authorities are less likely to intervene at the early stages. Professionals in the survey were identifying few or no local or specialist child sexual abuse (CSA) services for children, parents, carers and siblings along with long waiting lists/timeliness of interventions. This could be due to the lack of funding for services and it also might depend on what area/borough professionals are based as to what services are available to them. Soares and Warrington (2020) suggest there is a well-evidenced lack of service provision to meet need and younger children's needs are noted to be particularly poorly served.

> 'Lack of services/funding for those children who have been abused but are not always displaying any concerning behaviour yet. Interventions are reactive not proactive' (Children's services professional)

The second area most mentioned was gaps in skills and knowledge which was identified 58 times. Professionals identified not feeling confident about their current levels of knowledge and wanting in-depth specific training around CSA which is bespoke to their setting.

> 'I am able to identify if a child is at risk of or has been sexually abused but I have not had any training around the work I could do to support the child in school' (Education professional)

However some professionals also suggested they need more opportunity to attend training and that pressure around time constraints to undertake their work can often impact on this. This implies that managers and organisations are potentially not valuing CSA training, not prioritising staff to attend, or that the training provided is not meeting the skills need well enough.

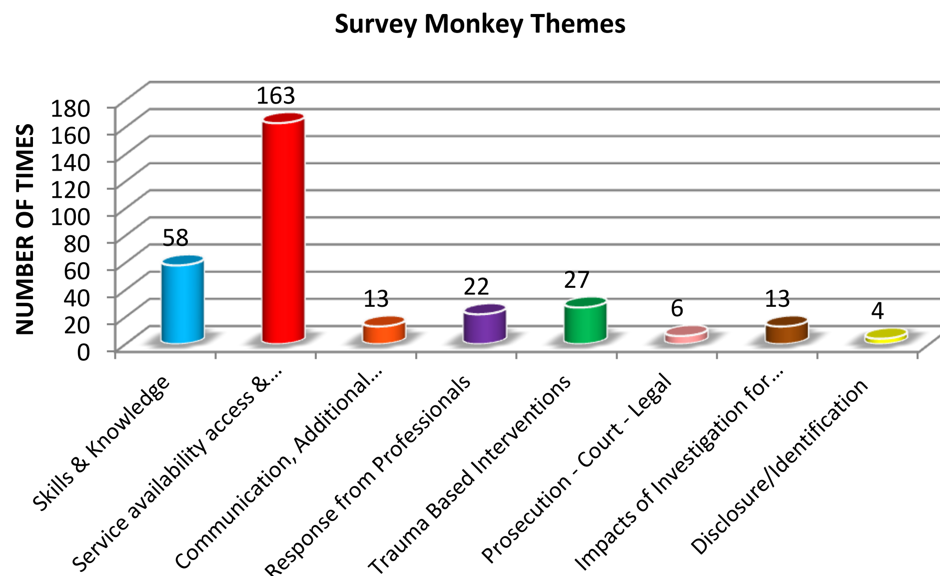

Figure 2: Number of times Survey Monkey themes were mentioned in questionnaire responses

Figure 2 shows that there are the fewest responses around disclosure, potentially because the professionals completing this survey might not have received the disclosure directly themselves. Research suggests that when children decide to disclose they most commonly turn to family or friends before reporting it to a professional, although when they do teachers are the professionals they are most likely to disclose to (Allnock & Miller, 2013). As such, when a child chooses to disclose to a professional first, they need to have the skills to be able to support that child.

Factors relating to courts, evidence and the legal process were also raised only six times by the respondents. This could be due to the fact that the respondents might have had minimal experience of children going to court. Possible reasons for this could be that children under ten and particularly the youngest age groups are less able to give a clear verbal disclosure and there is a greater likelihood of them not being seen as a credible witness. Research suggests that only around one quarter of CSA offences investigated by the police result in a charge or summons and that just three quarters of CSA offences prosecuted result in a conviction (Centre of Expertise on CSA, 2017). Reported statistics for child sexual abuse offence prosecutions in 2017/18 were 6,378 prosecutions and 4,878 convictions (Centre of Expertise on CSA, 2019). However, there is a gap within the official statistics themselves as, depending on how offences are classified, these figures did not identify specifically, how many of these children were under the age of ten years.

The additional issues identified by respondents which did not fit within the gaps mapping chart (see Table 1) were:

- A ‘One Stop Shop’ for children and families that offer a range of therapeutic services and other services such as: financial, legal & housing (mentioned by 23 participants)
- Long term follow up/Support for CSA (Children & parents into adulthood) (mentioned by 33 participants)
- The need for an ‘Evidence base’ for long term outcomes and follow-up (mentioned by 3 participants)
- Early intervention and prevention, learning about what behaviours are acceptable and unacceptable from a young age. Speakeasy/RSE/Sexual abuse awareness education for all adults/parents/carers (mentioned by 24 participants)
- Consistent national strategy/specialised response for families affected by CSA (mentioned by 6 participants)

The insights of professionals provided a wider overview to the gaps identified from our practice base with children and families. With the exception of the additional areas mentioned above all responses could be categorised into one of the themes identified from our practice-based experience (see Table 1). As such, we are confident that we have identified the broad range of issues that affect children and their families. It clearly suggests that gaps do occur at every stage of the process and as such reinforces our beliefs that young children are very much unseen and unheard across all areas, and across all systems and organisations that are meant to protect them. The additional areas, interestingly, all identified wider strategic responses being needed, the need to better understand how to engage parents, and more inclusive family interventions being available. The remainder of this section outlines the main findings from the questions asked in the survey.

2.2 Prevalence of sexual abuse in children under ten

The respondents were asked if they had worked with children and families where there had been an experience of sexual abuse. Out of all 154 responses 91% answered yes to this question (141 responses). Out of these just over 32% had worked with children under ten years whilst 41% had worked with children both under and over ten years. Although it is quite significant that such a large number had worked with children who had been sexually abused, this could be due to the fact we targeted professionals who worked with children, particularly education and Children’s services professionals, and were therefore more likely to report higher incidences of encountering sexual abuse. This demonstrates that we were successful in targeting the right professionals who could provide genuine insights within this area.

Just over half of the respondents (50.3%) had worked with a child who had a disability, was deaf or had other communication needs. Soares and Warrington (2020) suggest that current evidence informs that Deaf and disabled children experience a 'double vulnerability': more likely to experience CSA and less likely to have this recognised and responded to by adults. When we looked at the qualitative data respondents identified a lack of CSA services that are inclusive and able to support cultural, communication and additional needs (11 responses). Due to this we widened out the communication/additional needs theme and added inclusion as we did not feel this was a separate issue, but one which had not previously been so clearly identified. Professionals recognised that children/adults have limited access to resources to help them communicate effectively and services are currently unable to meet their needs. They identified that specific CSA support was needed within this area; specifically, better access to specialist services which facilitate communication was highlighted with services working together.

Further additional challenges that exist for children/families/professionals are:

- Parents with their own learning disabilities unable to access services
- Children with special educational needs and disabilities (SEND)/complex needs or who identify themselves as LGBTQIA+ not being able to access services
- Gaps in how services support children and families' cultural needs

> 'This is an area that is difficult to find support for children and young people with SEND. SEND can be used as an excuse' (Education professional)

> 'There is a lack of consistency and expertise in the national offer for children and parents/ carers which offer up to date, researched and evidenced based, trauma informed interventions. Support is lacking consistently around the whole family, schools and community with specific reference to additional needs including SEND, BAME (Black, Asian, Minority Ethnic) and LGBTQIA+'. (Children's services professional)

2.3 Confidence levels

Professionals were asked how confident they felt in working in CSA as shown in Figure 3. The total overall confidence levels peaked at 46% for 'somewhat confident', followed by 22% responding that they were 'very confident' but only 4.6% claiming to be 'extremely confident'. The greater majority of respondents had some degree of confidence, whilst 21% felt that they were not confident and 5% were not at all confident.

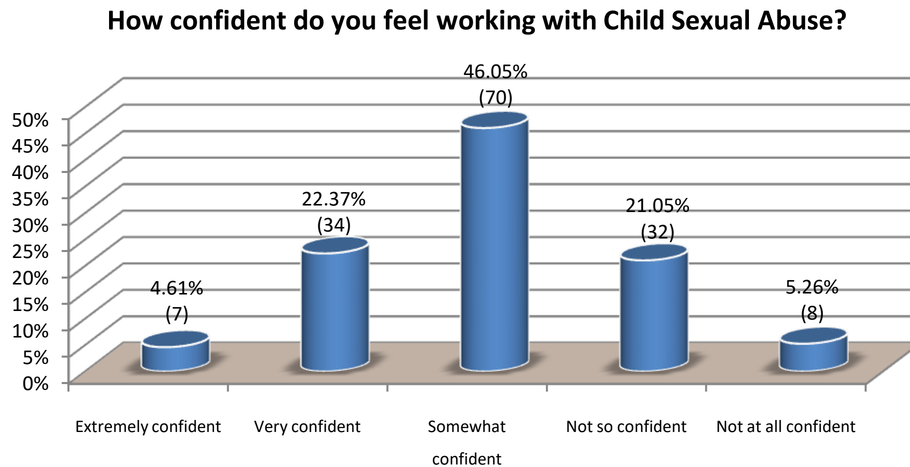

Figure 3: Professionals' Levels of Confidence in Working with Child Sexual Abuse.

Professionals were asked if their needs were met sufficiently to undertake their role working in CSA, and just over 51% of the total respondents said yes. However, when this was separated into the two main professional groups represented by these respondents, approximately 45% of Children's services professionals and 50.8% of education professionals said that their needs were not met. This could indicate that the professionals who are most commonly in the position of being the first responders to CSA may not feel sufficiently equipped or confident. This might suggest that for every two children wanting to talk about sexual abuse for the first time, one of them will be doing so with a professional who doesn't feel adequately skilled. This may have a profound effect on how effectively the conversation is managed, and perhaps most importantly, how supported the child feels as a result of disclosing to this professional. Although this group of professionals indicated they felt confident in working with sexual abuse, their responses previously, and in looking at gaps (below) identifies that they are also aware that additional intervention is needed for a number of children experiencing sexual abuse that falls outside of their remit and that there is an issue around accessing such services. Soares and Warrington (2020) highlight the critical role of caregivers and other close adults in enabling such opportunities, communicating their preparedness to hear a disclosure and recognising a child's cues.

> 'I do feel confident around supporting disclosure, listening, etc. but I would definitely seek further specific support due to lack of experience in the field' (Children's services professional)

> 'We have training in recognising the signs and working with other agencies, but knowing what to say and what not to say would be of benefit' (Education professional)

> 'I don't feel confident in delivering work in this area as I don't really feel as though I know enough' (Children's services professional)

When asked to expand on what would help, both Children's services and education professionals ranked the following three areas in the same way. The top answers were:

1. Training (31 participants)
2. Specific CSA services (12 participants)
3. CSA services able to accommodate SEND (3 participants)

2.4 Training

Respondents were specifically asked if they had accessed any training that was useful to their work in CSA. Over half of all education staff (55%) and one third (31%) of Children's services staff said they had not. The overall training needs were analysed to see what training professionals identified as most useful:

1. Specific CSA/CSE training (15 participants)
2. Trauma related training (14 participants)
3. Local Safeguarding Board training (12 participants)
4. Designated Safeguarding Lead training (8 participants)

Reflecting on the significance that around 50% of professionals feel unequipped to carry out their roles when working with CSA and that 55% of education staff and 31% of Children's services staff have not actually accessed any training that was useful to their role around CSA, raises questions about why professionals are not accessing training. There can be many potential reasons for this: lack of time or opportunity to attend; training not prioritised within the organisation; appropriate training not available. Soares and Warrington (2020) highlight the importance of skilled and confident staff and professionals' expertise in supporting children. Including their ability to feel comfortable talking about CSA; professionals not appearing to be overwhelmed by what children tell them and conveying to children their ability to hold and manage risk and anxiety.

> 'More up to date training informing practitioners on recent evidenced based practice and trauma informed support' (Children's services professional)
>
> 'No training has been offered' (Children's services professional)
>
> 'Lack of time due to statutory responsibilities' (Children's services professional)
>
> 'Specific training for school staff and the time allowed to access it' (Education professional)

2.5 Gaps in services for families

Just over 63% of professionals identified that they thought there are gaps in services for children under ten years who had been sexually abused.

The top ranked gaps identified for children were:

1. No specialist CSA services/resources (42 participants)
2. Long waiting lists/timeliness of interventions (10 participants)
3. Professionals not feeling confident in CSA (8 participants)
4. Barriers to services/Referral criteria e.g. age limit (7 participants)
5. No Family therapy/parent/child work available (7 participants)
6. No long-term support (6 participants)

Just over half of all professionals (55%) identified that they thought there were gaps in services for non-abusing parents/carers of children under ten years who had experienced sexual abuse.

The top ranked gaps identified for the non-abusing parent/carer were:

1. No specialist services (39 participants)
2. Professionals unaware of service or where to signpost (6 participants)
3. Professionals need support/training to help parents (6 participants)
4. Waiting list/timeliness (5 participants)
5. Family therapy/parent & child work (3 participants)

Just over half of professionals (55%) said they or another agency provided specific CSA parent/carer support. 30% said no support was provided and 13% said it was not applicable. The reasons why 30% did not provide parent/carer support were due to: it not being within the services' remit/persons' role (10 participants), professionals were not aware of services offered (7 participants), there were no resources/services available (6 participants) and lack of parental engagement (3 participants). Soares and Warrington (2020) identify that there is a strong consensus that the role of caregivers is significant to therapeutic interventions with children after CSA and should be a central consideration of service provision.

Around 43% suggested that joint parent and child work was offered to families (the questionnaire did not provide opportunity for clarification on this point). 31% did not get offered any support and 25% responded 'not applicable'. The main reasons identified for not receiving any joint work included: professionals not knowing why it was not offered (10 participants), it wasn't available (8 participants), the work was offered by a different service (5 participants), it wasn't the services' role or remit (3 participants) and parents did not engage (3 participants).

> 'At the time there was no service to support parents. Parents are generally unsupported or the support is very minimal due to the funding agreements with Local authorities. Despite the fact that practitioners are aware that support to parents and working holistically with the family dramatically improves the outcome for the child. Parents and carers are the key protective factors within

children's lives a practitioner may spend about an hour a week with a child, the parent is there 24/7 we need to educate and empower parents of children who have been sexually abused' (Children's services professional)

2.6 Were services helpful?

When asked whether services were helpful, responses varied depending on the individual service provider and the quality of service the child and family received (7 participants). Furthermore, waiting times/timeliness of services were highlighted as an issue (6 participants). Other issues raised include that there was no long term follow up (5 participants) and services/sessions were time limited (5 participants), which professionals found unhelpful to children and families who required longer term support. Families who had received a holistic approach where all the family members received support had a positive outcome (3 participants). With only three responses this would suggest that a holistic approach was not offered that widely, which confirms insights from our own practice-based experience.

Professionals suggested improvements around what they would like to see happen for children and families in an ideal world as seen in Figure 4.

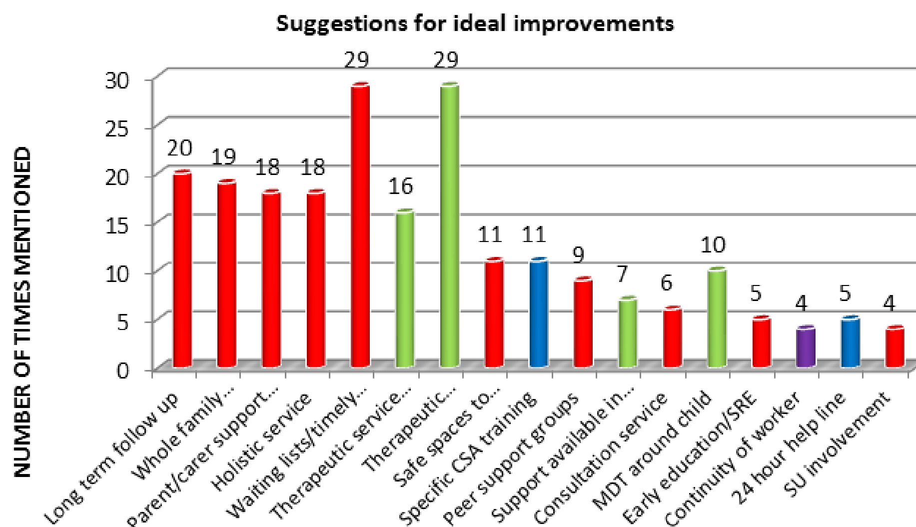

Figure 4: Professionals' suggestions for service improvements.

As seen in Figure 4, respondents were asked what they thought would be most helpful to children and their families who have been sexually abused in an ideal world.

The category of:

- long-term follow-up includes support available from childhood to adulthood
- parent/carer support means support available to non-abusing parent/carer
- waiting list/timely interventions means shorter timescales to access services

- therapeutic interventions includes play therapy (14), art therapy (7) and specialist counselling (8)
- specific CSA training relates to professionals and their job role
- consultation service relates specifically for professionals for advice and support
- MDT is the multidisciplinary team around the child
- SU involvement means service user involvement in developing CSA services.

The six highest ranked on the professionals' 'wish list' were:

1. Shorter waiting list and interventions that were timely to the child and family (29 participants)
2. Therapeutic interventions, including a range of interventions available for children such as play therapy, art therapy and specialist counselling (29 participants)
3. Long term follow-up for children and families offering support from childhood into adulthood (20 participants)
4. A service that could provide a whole family approach, working with child, parent/carers and siblings. A service that could provide both individual and/or family therapy (19 participants)
5. Non abusing parent/carer support to be available (18 participants)
6. Holistic CSA service, a one-stop shop offering all support under one service from therapeutic services, financial support, legal advice, housing, medical etc. (18 participants). A current example of this in the UK is the lighthouse project in Camden town, which is based on the Icelandic Barnahus model (NSPCC inform, 2018)

The suggestions made by professionals are not necessarily ground-breaking ideas/models/interventions that are not already being delivered in CSA services. However, there seems to be an inequality of access to services and questions need to therefore be asked about why all professionals do not get equal access to services that already exist for the children and families under their care. This could be due to geographical location and the operation of a 'post code lottery' since it is widely reported that over the years Local Authorities have had to make cuts to funding these crucial services.

2.7 Summary of online questionnaire

The aim of the survey was to understand how sexual abuse is being responded to and how confident professionals feel in understanding and responding to children under ten and their families. It also aimed to identify further gaps for children and families that we may not have considered from our own practice based experience.

The survey gave us a snapshot of professionals' views. However the limitation of the data is that the snowball sampling approach utilised in the survey meant that we were unable to recruit respondents from other key professions such as the police. If it had we might have had more responses relating to disclosure and the criminal justice system; this might have given us a wider view on areas identified outside our own practise based experience. The insights gained from the analysis cannot be understood to be broadly representative outside of Children's services and education, due to the disproportionate number of respondents from these professions. Nonetheless, out of the professionals who completed the survey, 91% had worked with a child who had experienced CSA, which means this group of professionals had genuine insight into the area.

Through this survey, professionals' insights added a wider overview to the gaps in services for children under ten who had been sexually abused and their families. All free-text responses could be categorised into one of the emerging themes identified from our practice-based experience, with the exception of the additional areas mentioned in (Section 2.1). The additional areas identified primarily expanded on some of the issues already highlighted, such as a need for interventions to be more holistic, offering support to whole families, needing an evidence base for long term follow-up and outcomes, and there being more emphasis on prevention/awareness-raising and the need for a public strategy. This insight reinforced our belief that young children are very much 'unseen and unheard' across all areas and have been for a sustained period of time.

The survey did assist in identifying what issues/gaps are most prevalent for this group of professionals. The largest theme identified within the survey was 'service availability, access and funding', with the second being 'skills and knowledge'. Professionals identified the lack of specialist CSA services as the main gap for children and families and indicated that families who are fortunate enough to get a referral to a service are met with long waiting lists. Finally, when a CSA service is provided it is not always at the right time for the child and their family, with families left to deal with the unfolding crisis and not receiving any support until months or years later. This could be due to the lack of funding for services and it also might depend on which area/borough professionals are based as to what services are available to them. This reflects what has been identified within other research; that after abuse has been identified many victims of child sexual abuse are waiting months or years before accessing appropriate therapeutic support. The type and availability of support varies significantly across the country (Warrington et al., 2017; Allnock, 2015). It highlights that the need for timely, specialised therapeutic support is vital in helping children and families to heal and recover, which sadly is not available to all and a wider strategic response is needed for these families.

> 'When support is received it is often long after the disclosure, families need support as soon as possible, not once the LA no longer knows what to do with the family and the risks have heightened' (Children's services professional)

The second largest theme identified was 'skills and knowledge', although of course, this is to be expected since the survey did ask specific questions around training and confidence. Professionals identified low levels of confidence and suggested the need for more specific CSA training in order that they feel more equipped to undertake their role when dealing with CSA. It suggests that alongside a focus on awareness-raising training which many organisations do provide, there needs to be more specific training made available on how to apply this to practice due to the wide range of roles professionals have and the many points at which children may need support or intervention. Multi-agency professionals have a role in taking account of individual circumstances and needs identified, from early intervention through to complex child protection and beyond. The skills and knowledge needed will vary from role to role and situation to situation. Having identified this gap, it would be beneficial for there to be more focused work with professional groups to better understand how training and support needs could be provided more effectively.

Professionals identified the need for CSA services that offer a 'holistic approach'. This would include whole family interventions, including support to children, parent/carers, siblings and their family members; in other words, a service that offers a range of therapeutic interventions as well as other advice and support services e.g. financial, legal, and medical.

Professionals also want CSA services that can cater for children who have special education needs and disabilities (SEND). In the survey 91% (141 responses) of the professionals said they had worked with a child who had been sexually abused and 50% (75) said the child had additional needs such as SEND, deaf or additional communication needs. Research suggests that children with a disability are three times more likely to be sexually abused, than children without a disability (Soares and Warrington, 2020). Professionals have already identified a lack of CSA services and availability, so it is vital that all CSA support is inclusive to all aspects of SEND.

More early intervention and prevention was identified as being needed. This might include offering support to families at a point that is timely and when they need, so they are not left with unresolved trauma which may then become entrenched over time. A suggestion of post disclosure support could be pre-trial therapy with the child and support to parents in order that they can support their child. Prevention work could include working more closely with education professionals around talking generally to children about growing up, bodies and boundaries, and how schools are introducing the new relationships and sex education (RSE) curriculum. This might further include supporting parents with general information and advice about talking to children about this area, so they feel more confident in protecting their children. However the survey already identified that that there are significant issues for professionals with service availability, access and funding, so identifying local CSA services which can offer support around early intervention and prevention appears unlikely at present.

The survey confirmed many of the gaps identified from the service mapping exercise, suggesting that nothing has significantly improved at a practice level. It did however bring into focus the range of areas that professionals continue to grapple with when it comes to supporting children under ten who have been sexually abused, and extended the areas to include more public awareness and more holistic, joined up interventions needed for children and their families.

3 Interviews with Multi-agency Professionals

Semi-structured interviews were undertaken with 13 experienced professionals from a range of backgrounds and with a range of prior professional experiences. Barnardo's SATAS has developed research partnerships with local authorities. Individuals from Children's services were invited to take part in the interviews by the local authorities themselves. A more diverse range of services were also contacted by Barnardo's SATAS directly and asked if they had anyone who might be interested in being interviewed as a part of the research.

Interviewees consisted of ten women and three men. Their length of professional experience ranged from approximately four or five years to over 25 years. No student or newly qualified workers were interviewed in order to increase the likelihood that they would have relevant experience of working with child sexual abuse (CSA). They were currently employed in: social care, health, education, disability, family support and trafficking services. These services were targeted because it could be expected from statistics related to child sexual abuse that they would be working with populations that include at least a moderate proportion of children who have experienced sexual abuse.

The interviews typically lasted up to an hour and were conducted by three different members of the SATAS team at the interviewees' workplace. The interviews consisted of questions asking about their experience in working with children under ten years who had been sexually abused and their families. This included questions about services that were offered to children and their families, gaps in services for children and families, gaps for professionals working with this group, consideration of issues for marginalised groups of children and their families and also what they would like to see in an ideal world in relation to the sexual abuse of children under ten. (See Appendix 3)

On a number of occasions, when Barnardo's requested an interview with professionals, respondents felt that they would have little to contribute to an interview. This was because they had limited or no experience of working with children under ten who had been sexually abused. It is noteworthy that, amongst those professionals who did agree to be interviewed, there was a general lack of experience reported in working with sexually abused children in this age group. This included professionals from services where it is known that children using their services statistically have a higher likelihood of experiencing sexual abuse e.g. where a child has a disability or is exposed to domestic abuse (Miller & Brown, 2014; Jones et al. 2012; Bidarra et al. 2016). This serves to highlight the significance of this research and foregrounds that children under ten who have been sexually abused are a largely invisible group.

It was clear during the interviews that professionals were not always confining their answers to their experiences of working with children *under the age of ten*, despite this

being the subject of the questions. Although they were not always doing this, they were attempting to think about younger children in their answers.

In order to better understand those issues which were most prevalent in the interviews, we made the methodological decision to give focus here to those issues which were raised by at least half of the people interviewed. This is in many ways an arbitrary threshold and is certainly not indicative of the fact that anything mentioned by less than 50% of participants is insignificant (as indicated in the 'limitations' section of this report). For this reason, despite focussing the majority of our discussion on reporting those issues raised by over 50% of participants, we felt the need to at least acknowledge these lesser mentioned issues, which are outlined in Section 3.9.

3.1 Services offered to children who have experienced sexual abuse

Professionals were asked what services were offered to children under ten who had experienced sexual abuse and their family members. Table 2 below shows the different types of services children and families were offered and the number of professionals who reported this was the case.

Service Offered	**Number of respondents**
Children's services	13
Primary mental health service	10
Parent/carer support	10
Therapeutic intervention	9
Services that were not specialised in sexual abuse	9
Preventative education	7
Police/CPS	6
Specialist sexual assault support service	4
Voluntary sector short term intervention	4
Sibling support	3
Consultation to professional	2
Information advice and guidance	2
Fostering agency	1
GP	1
CAFCASS/legal	1
Therapeutic foster placement	1

Table 2 Services offered to children under ten and their families

All 13 professionals identified that Children's services were involved with children and their families where there was an experience of sexual abuse. This reflects statutory safeguarding procedures and may suggest that safeguarding is the focus of most responses to the sexual abuse of children under ten.

Nine out of 13 professionals identified that a therapeutic service had been offered and within this there was a wide variety of different types of services including art therapy, EMDR and psychotherapy. Only five professionals reported that it had been their experience that a dedicated child sexual abuse (CSA) therapeutic service had been offered. This may reflect comments made across a number of different interviews about the lack of provision, funding and awareness of such services in some areas of the country. It may also reflect a tendency to prioritise safeguarding over recovery.

Ten professionals identified that parent/carer support was offered, which might suggest that this is readily available and quite consistently offered to families. However, it became apparent that this is not necessarily the case. For instance where parent/carer support was available, a distinction was apparent between general Children's services support and support focussed specifically on the sexual abuse. Where support in relation to the sexual abuse was reported, the quality of the support was not consistent. Additionally access to support varied hugely depending on a number of factors which will be outlined further in Section 3.4.

Ten professionals identified that children and their families who have experienced sexual abuse were referred to mental health services which appears to be disproportionately high given that the experience of sexual abuse is not a mental health problem in itself. Referral to mental health services is not always felt to be the most appropriate referral for children who have been sexually abused. These services are designed to meet the needs of people who have a diagnosable mental health condition and are not designed to work specifically with issues such as sexual abuse, bereavement or bullying. However there is a body of research (see below for an example) which identifies that if not responded to appropriately, having to find coping mechanisms to manage the impacts of their experiences can for many, contribute to the development of a mental health condition over time.

The fact that ten professionals identified that mental health services were offered raises questions as to whether children who have experienced sexual abuse are referred there because professionals misunderstand sexual abuse to be a diagnosable mental health condition or do not understand that there are services designed specifically to address the impact of sexual abuse. [1] It also raises the question of whether it is because there simply are not sexual abuse specific services available in particular areas and/or whether funding is not available for the provision of such services. This was reflected in a number of interviews:

[1] See The Impact of CSA: a rapid evidence assessment', Fisher et al. (2017) for an examination of the prevalence of diagnosable mental health issues arising following an experience of CSA. The study also details the prevalence of other psychological impact that does not meet the diagnostic threshold but does have a 'significant detrimental impact on victims and survivors' quality of life'. (p.54)

> ‘CAMHS are more likely to say they haven’t got the resources to offer this service’,
>
> ‘They can get pulled into [Local CAMHS] where it’s not necessarily appropriate…’,
>
> ‘Sometimes though with CAMHS… they have to have such a high-level threshold to get through, it wouldn’t just be… sexual abuse or sexualised behaviours… it would be about diagnosis of ADHD or autism’.

Seven out of 13 professionals identified that preventative education was offered where children and their families had experienced sexual abuse. However this was often offered as a tertiary form of prevention, i.e. that it would be aimed at preventing re-victimisation.

Whilst not raised by over 50% of participants, it nevertheless appeared significant in our analysis that <u>only</u> four professionals reported the provision of a specialist sexual assault support service and <u>only</u> six professionals reported the involvement of the police and criminal justice system. This may be a feature of the limitations of this research, but it may also be evidence of the existence of age related barriers to children under ten accessing these types of services. It also raises a question that is not within the scope of this research, whether–in professionals’ experience–children over ten appear to have similarly low rates of access to these services or whether those under ten have less parity of access to such services. The experience outlined here may fit with our practice experience that both systems and professionals across welfare and criminal agencies appear to automatically default to a position that largely disregards children under five as potential witnesses. It is also our experience that children between five and ten years of age are much less likely to be considered credible witnesses. And that cases across the under ten age group often only proceed to court if there is some tangible or physical evidence not reliant on the child’s account.

Following on from identifying the services that were offered to children and their families after an experience of sexual abuse, interviewees were then asked about the specific gaps they could identify from their experience of working with children under ten who had experienced sexual abuse and their families.

3.2 Gaps in provision for children under ten who have been sexually abused and their families

Each interviewee was asked what they thought was missing for children under ten who have been sexually abused and their families.

As with the previous question asked, professionals interviewed did not typically confine their answers to younger children. Where specific reference was not made to children under ten, it was therefore taken that responses related to children more generally, and ‘families’ included parent/carers and siblings.

Whilst a wide range of factors were highlighted by our participants as being missing for children and/or their families, five themes in particular were discussed by at least half of the people interviewed: (i) support for adults in a parent/caring role; (ii) access to services; (iii) availability of a dedicated/specialist child sexual abuse service; (iv) adequate systems; and (v) specific issues facing children and families who are marginalised. Given their prominence within our interviews, these five areas warrant further discussion.

3.3 Support for adults in a parent/caring role

The first area to consider is the support that is offered to adults in a parent/caring role. Children need the support of their parent/carers. Research indicates that parental support after disclosure may be a key factor in reducing the impact of sexual abuse and Post Traumatic Stress Disorder symptoms in a child (Bernard-Bonnin et al., 2008; Everson et al., 1989 in Yamamoto, 2015).

A consideration of caregivers is noted to have particular significance in therapeutic support for younger children who are likely to have greater levels of dependency on parents or carers than older children (adolescents) and social networks which are often limited to immediate family as cited in Soares and Warrington (2020: 46).

Safe caregivers are described as being likely to develop their own significant support needs as a result of the identification of their young child's sexual abuse (Jessiman et al., 2016; Van Dain et al., 2018 cited in Soares and Warrington 2020: 48). These in turn are noted to have the potential to impact on parents or carers' ability to support their child (Santa-Sosa et al., 2013 in ibid, p48). Support to parent/carers should involve support both in their own right as well as to enable them to better support their child. It can include exploring the impact of the sexual abuse, both on themselves and their child(ren) as well as support to understand what has happened, what work may be undertaken with their child going forward, and how their child may respond to that work alongside how they could best respond to their child(ren).

Over half of the interviewees identified significant gaps in service provision when it came to supporting non-abusing parent/carers. Caregivers' understanding of the purpose and goal of a therapeutic intervention is noted to be key (Jessiman et al., 2016) and as one interviewee commented:

> 'Parent/carers have sometimes not been kept in the loop as to what's going on and don't have an understanding as to what, if say therapeutic work is being done with a child… how it might affect their behaviour whilst they're undergoing it; what they can do to support the child, to make them feel safe whilst work is being undertaken'.

The amount of time that young children spend with safe parent/carers, compared to the amount of time they spend in a therapeutic intervention is noted to justify support

dedicated to enable parental wellbeing – promoting a positive familial context to maximise children's wellbeing and recovery (Whitson et al., 2015; Kilroy et al., 2014 cited in Soares and Warrington, 2020: 51). Another interviewee told us:

> 'Unless they reach a certain threshold, I think work with parent/carers is very limited… Unless you work with parents about how they can support their child, they often do not know how best to respond and need help to understand the child's emotions… It can be tricky if parents aren't ready to look at themselves and how they are responding to things, [if support isn't provided to parent/carers] then the practitioner is left working with the young person alone without influencing change within the environment, which is needed'.

These illustrative quotations acknowledge the significance of parent/carers and also serve to highlight areas where support may be lacking. Any work with the child could be in danger of being undermined, if the child and the work are not supported by the adult in a parent/caring role. Where support is not provided, the child loses a direct source of support in helping them deal with the trauma; the emotional and psychological impacts.

The sensitivity of very young children, aged six years or younger, to the direct impact the CSA has on their caregivers has been evidenced in empirical studies by Jensen et al. (2005) and Warrington et al. (2017). Provision of support to parent/carers can reduce this burden and any misplaced responsibility for the impact the sexual abuse has on their family (Soares and Warrington, 2020: 51-52).

The significance of supporting parent/carers was recognised, even from those professionals interviewed who were not directly responsible for providing this type of support. For instance, one interviewee from the voluntary sector pointed out that it was not within her role to undertake work with parents, yet she still engaged in some of this work because she had learnt through her experience that supporting the adult who had a parent/caring role in the long run, was of benefit to the child:

> 'I might informally pick up some of this work along the way… If a parent needs to talk or cry about what's happened… feeling guilty. They need and deserve what the child is getting, but there is nowhere for them to go'.

Whilst it is clearly testament to the dedication and compassion of this professional to provide this support, it does raise the question about the quality and consistency of the support being provided and whether informal support like this is best meeting the needs of the parent/carers and ultimately the child. It also illustrates why some parent/carers feel better supported than others, and why some professionals may feel more over-burdened and/or less adequately qualified to offer support than others. As one interviewee highlighted:

> 'We've got an awful lot of newly qualified social workers, so you have to think about the skills of the worker; that they could give that support and actually

> could be more dangerous to send somebody out there who doesn't know what they're doing'.

The issue of stigma surrounding sexual abuse was mentioned by a number of professionals interviewed, particularly when the abuser is a family member, and that this appears to be a barrier to support for some adults in a parent/caring role. One interviewee commented that:

> '[Non-abusing parent/carers] tend to feel like they're the only ones in that situation… I remember one mum saying "If my partner had beaten me up I'd be able to talk about that and people would be able to understand and respond to me, but the fact that my children have been abused by my ex-partner, people want to know what I did wrong, why I didn't protect them"…'

For this reason, group/peer-support can be helpful as it is based on the belief that people who have faced, endured and overcome adversity can offer useful support, encouragement, and perhaps mentorship to others facing similar situations (Davidson, Chinman, Sells & Rowe, 2006). With regards to this, one interviewee acknowledged the absence of group support where there has been an experience of sexual abuse:

> 'We know that in other situations like domestic abuse, peer to peer support can really help, but again because of some of the stigma around sexual abuse, there isn't the same sort of support there. There's a lot of victim-blaming goes on; not just of children, but also parents or of people in that immediate network'.

Interviewees further acknowledged the isolation many parent/carers feel as a result; one highlighted emotional and other impacts and a lack of support to help deal with these:

> 'Being able to have services that are about the parent are missing; how they feel as a parent and how they feel as a person… and how the whole family dynamic changes'.

By tackling the stigma of child sexual abuse, parent/carers are likely to feel less vilified and better able to seek the support they require both individually and as a family and which they need to support their child who has experienced sexual abuse. Parental (or carers') ability to support young children after an experience of child sexual abuse is described by some authors as a 'buffering factor'; minimising the negative impact of CSA on children (Corcoran, 2004 cited in Kilroy et al., 2014 by Soares and Warrington, 2020). When work is undertaken with the child alone, in isolation from their support network, there is a danger of the child being perceived as the 'problem' and ultimately being responsible for their own recovery from sexual abuse. When the importance and necessity of providing support to adults in a parent/caring role fails to be recognised, this goes some way to perpetuating this idea.

The second theme for discussion relates to access to services and the obstacles that impede access for children who have been sexually abused and their families.

3.4 Access to services

According to the interviewees, the main barrier to accessing services was due to the child and/or other family members not meeting service criteria/thresholds. Various explanations were identified: whether due to the level of risk/safeguarding; whether or not a disclosure had been made; seriousness of impacts; services not being appropriate to meet specific needs, including those for children and families who have been marginalised; and/or age limitations:

> 'At the moment with the massive cuts there are very few services. And even if you can refer, the thresholds are really high to get any kind of support'.

In the *Making Noise: Children's voices for positive change after sexual abuse* research, referrals for therapeutic support appeared to be dependent on recognition and severity of emotional needs as opposed to being automatically considered:

> 'With a small minority of interviewees describing getting to a 'breaking point', including serious self-harm and suicide attempts, before referrals were made, regardless of professionals' prior knowledge of their experiences of abuse' (Warrington et al., 2017: 93).

Of course one of the thresholds that will have to be met relates to safeguarding and the level of risk for the child. It may be the case that in order to gain access to services, a child needs to be an open case to a local authority social worker. As reflected in the Survey Monkey findings however, interviewees similarly highlighted that where safeguarding/risk issues had been addressed and the child's non-abusing parent/carer was seen to be acting protectively following disclosure for example, cases were closed. Interviewees commented:

> 'If the person perpetrating the abuse isn't in the picture or is in prison, the risk has been removed and so services are not offered to the family'

> 'Where children are not open to Social Care, if they don't meet the threshold, I think there's a real gap in them being able to access support'.

> 'When [the child] initially alleged the abuse, we assessed it, Section 47, and closed it because Mum had acted protectively… nothing else was done. Mum was quite upset about it… There was actually an incident where [the child] asked his sister to do something sexual towards him and Mum feels that's as a result of no work being done with him basically…'

Without meeting particular service criteria and thresholds, children and families do not necessarily have access to a service despite being impacted by the sexual abuse.

Interviewees commented on access to sexual abuse recovery not being offered, even when they recognised it would be beneficial, and it not being until later in the individual's life when unresolved problems surface in a variety of ways, that support was eventually made available.

Acknowledgement was made of the potential impact on the child, of not having access to a service at the time it was needed. Where needs remained unresolved and/or were not addressed early enough, this resulted in more significant and entrenched problems later on in the child/young person's life, which ultimately required access to more services (see Section 3.6).

Specific references to problems accessing services for 'very young children' were made by a small number of interviewees, who identified that this was at least in part as a result of services not being available due to the child's age. Some struggled to name any services that would take referrals for young children (under six years of age in particular) and did not know where to signpost them on to.

The above section highlighted the problem with access to services in general. A common theme additionally raised by at least half of the interviewees, was that availability of specialist child sexual abuse services was missing for children and their families, which will now be discussed.

3.5 Availability of dedicated/specialist child sexual abuse services

Reference was made by some, to specialist services having previously being accessible in the area in which they work, but no longer being available due to withdrawal of contracts/service level agreements. One interviewee recalled having referred children of **all** ages to one such service in the past:

> 'It was able to respond… it was child-focused… It was holistic around that child and their whole family'.

One of the key findings of The *Making Noise* research (Warrington et al., 2017) was that interviewees gave a clear message that there were specific advantages to specialist provision:

> 'Specialist CSA services are particularly helpful in countering stigma and isolation and understanding the complexities of CSA in the family environment' (p 90).

It was highlighted by some of our interviewees that in their experience, instead of specialist workers, social workers were expected to undertake work with children who had experienced sexual abuse. One interviewee said:

> '…but it's hard for them to commit and they haven't necessarily got the skills and such a high staff turnover; it's not consistent for people. Boxes get ticked for work having been completed, but it often isn't in a meaningful way'.

Interviewees again mentioned that largely as a result of dedicated child sexual abuse services being unavailable, 'children now get pulled into services that aren't appropriate to meet their specific needs.' This could be seen when professionals were asked about what services children, in their experience, were actually referred to. The majority of interviewees identified mental health services being offered to children who had been sexually abused (see Section 3.1)

> 'The specialist element of sexual abuse recovery work is often not recognised and instead, children are subsumed in other services'.

Mention was also made of the parents of such children having to negotiate these 'convoluted routes' to find appropriate support services and in so doing, needing to repeat/recount details to a new professional each time they try to seek help. This in itself can be traumatising and cause additional/unnecessary stress and harm. According to research involving a survey of 400 adult survivors of CSA, led by Professor Noel Smith from University Campus Suffolk, in conjunction with the charity Survivors in Transition – more than 80% had to proactively disclose what had happened to them as children – an experience many found as traumatic as the abuse itself (Halliday, 2015). If adults find it so difficult to disclose and recount historical experiences of sexual abuse, then clearly the burden to disclose and recount experiences will be far greater on children.

Cost being a barrier was again highlighted by interviewees. In this instance, in relation to funding only being secured for access to specialist services when the needs of the child were so great/desperate and could not be met elsewhere. But more serious and perhaps shocking however, was the comment made by one professional interviewed:

> 'There is avoidance; an unwillingness to recognise and admit a child's needs because there's a cost attached to supporting them; what's needed is ignored because of the cost… Dreadful, but that is the state of affairs!'

This quote highlights the stark reality of the type of climate workers are operating in – or at least their perception of the climate they are operating in – where professional assessments are potentially skewed and influenced by predicted outcomes. As a result, the true needs of children and their families can be denied.

The process of securing funding for specialist services can take time and can therefore cause delay in children and families accessing appropriate services in a timely manner, a matter which will be further explored in the next section.

3.6 Adequate systems

Almost three quarters of people interviewed identified 'adequate systems' as missing for children. Specific problems within this theme related to delays for various reasons and a lack of consistency, both of which will now be discussed.

A key issue raised was that of delays and the negative impact on children and families:

> 'There can be massive delays and I don't think that does children any good. Initially everything starts to happen really quickly… then weeks can go by without [the ABE interview] actually happening. Families are just left and get frustrated…'

Children were described by several interviewees as being 'passed from pillar to post' and 'pin-balling' between services.

'Long waiting lists' were also highlighted as a barrier to accessing specialist sexual abuse centres and other services when they were needed, particularly in relation to therapeutic intervention. References were made to waiting lists between six and 12 months plus. Immediate access to services at the point of need is necessary in order to address issues arising at the earliest opportunity to produce the best outcomes:

> 'The therapeutic intervention needs to come then [when it's needed], not three or four years down the line when behaviours present that show the trauma manifested as something huge'.

One person interviewed, who highlighted the problem with services not being provided in a timely fashion told us:

> 'If somebody is willing and wanting to engage, you want them to be able to start before they suddenly decide they don't want to engage. But usually that's not the case because there's a lot of waiting around; and sometimes by the time they've been stuck on some waiting list for six weeks or whatever minimum, young people might just decide to disengage… If they'd had the chance to go straight into a service when they needed it or were asking for it, then outcomes would likely be better because sometimes, young people will then not engage at all and might just decide that's it and they won't get the support they actually need, which we all know can lead to quite negative outcomes later in life.'

In relation to adequate systems, consistency of service provision was also seen to be missing in respect of what was available. The services offered to children and their families were often cited as being dependent on the individual worker involved:

> 'I just think for the child, it very much depends who's involved with them and the experience and expertise of that worker; there's very little out there, it's a great shame'.

Another interviewee commented on this lack of consistency, in addition to workers within services being inexperienced:

> 'Everybody's on a temporary contract, there is no continuity; children are going through three, four, five social workers in a year. Therapy is going the same way…'

A high staff turnover has also been identified as impeding relationship building with the child and their family as identified in *Retaining Experienced Social Workers in Children's Services: The Challenge Facing Local Authorities in England*:

> 'When experienced social workers leave child protection practice, key skills that would benefit children and families are lost, as are the relationships they have built up with service users, colleagues and other agencies' (Baginsky, 2013: 6).

Not only does service provision appear to be linked to the individual experience and expertise of the social worker allocated to the child, a high staff turnover means that even if access to support is provided by one professional, it may not be maintained by the next.

This leads us to the next section where we consider from the perspective of professionals working in this field of work, what is missing for them.

3.7 Gaps in provision for professionals working with children under ten who have been sexually abused and their families

When asked what they considered to be missing for professionals in relation to working with children under ten who have been sexually abused and their families, three quarters of interviewees mentioned specific (in-depth) child sexual abuse training. Over half of interviewees also identified having adequate systems in place as missing. Both themes will now be discussed in turn.

3.7.1 Specific (in-depth) sexual abuse training

Professionals referred to sexual abuse being a complex area of work that strikes fear in many individuals whatever their role. One interviewee commented:

> 'There is something about sexual abuse and what this means; it's high end and workers can worry about saying the wrong thing or not knowing how to approach it… There is something about this area of work that causes a level of fear'

Interviewees talked about training being needed for a range of professionals including teaching staff, counsellors and foster carers, though reference was made to in depth training for social workers in the main. The reason for this was highly likely to be due to the particular roles held by the professionals interviewed; there being only one professional from education and the majority being social workers.

One interviewee commented:

> 'I had a very, very settled experienced team and I actually felt confident that they could, under direction and consultation, do some of that work with young people and children. Now I've got three newly qualified social workers and four agency workers, so I don't feel confident that they could do that…They need training and

> they definitely need targeted training…It's specialist training that we want; that we need'.

Another interviewee remarked:

> 'I think wider agencies would really benefit from training which challenges some of those perceptions around sexual abuse, particularly how children disclose and things like that – I think that's where there's a big gap'.

For findings from our on-line questionnaire supporting the view about there being significant gaps in access to specific and in-depth CSA training, its provision and quality, refer to Section 2.4 of this report.

Basic training was generally identified as being provided, but interviewees generally felt that this was insufficient and did not make them feel confident working with the level of complexity involved in the cases they were dealing with.

Interviewees acknowledged the importance of learning about the 'signs and symptoms' of sexual abuse and felt that this was typically done well in training that had been attended. However, several interviewees criticised training for having too much focus on 'signs and symptoms' and not more in-depth issues, such as how best to actually communicate and work with individuals impacted, including younger children and their parents. Professionals highlighted there being 'minimal, if any training delivered in relation to working therapeutically with a child who has been sexually abused'. One interviewee specifically referred to:

> 'A good child, a quiet child is not necessarily a sign that everything is going fine… Professionals tend to focus on the children that are really dysregulated and distressed at school and so we miss well-behaved, silent, compliant, invisible children where that is their survival strategy… Professionals need a lot of understanding and therefore training around that and other complex issues'.

Interviewees also raised an issue with training in relation to gaining a fuller understanding and developing skills in communicating with children and their families who are potentially going through the court process. Fear was expressed about contaminating potential evidence - not wanting to interfere with the police investigation: 'Training is missing that is about having discussions with children and parents as well, alongside how to support parents to help their child'.

Interviewees highlighted that workers often have no choice but to prioritise certain aspects of their work and therefore do not have the time or opportunity even to attend training when it was available – neither do workers have time and opportunity to reflect and put some of the skills learnt on training courses into practice:

> 'If you're working with sexual abuse you need the space to be able to attend training… I'm worried about some of the statutory agency workers that just have to move from one case to the next, without having time to process.'

Without training and skills development being prioritised for workers therefore, simply offering opportunities to learn will not be meaningful or useful in enhancing professional practice and confidence in the field.

3.7.2 Adequate systems

The other theme raised by over half of the interviewees was that of adequate systems being missing for professionals working with children under ten who have been sexually abused and their families. This included comments relating again to limitations on professionals' time and also to the nature of sexual abuse potentially taking its toll on the emotional health and well-being of workers. These issues will now be considered.

Emotional support for professionals working with children who have experienced sexual abuse was highlighted as missing for many. As one interviewee pointed out:

> 'In terms of burnout and secondary trauma for professionals working in child sex abuse, it's really important that they have this kind of support as it's so important to look after workers, and I think this is a massive gap we have at the moment'.

Mention was made of managers not always recognising or being accepting of vicarious trauma and of some not being sufficiently trained or confident to provide the level of emotional support required to their staff. As one person interviewed commented:

> 'Us as professionals need to have support about working with sexual abuse: naming it; how it makes us feel; is it triggering for us? And that's not always provided'.

Another interviewee posed the question:

> 'If your own employer doesn't even feel they are containing you, how can you [as a worker] contain the families in order for the families to be able to contain the children?'

A lack of time for support to be offered and provided was also spoken about, in addition to a lack of time for processing and reflecting on practice as was highlighted in the previous section:

> 'In safeguarding agencies there just isn't enough time for reflection and so you have a standard approach to every case, yet we know sexual abuse impacts families and individuals within them in different ways… '

Particular issues relating to what is missing for children under ten and their families who are marginalised was raised in various inter-related forms by all interviewees and will now be explored.

3.8 Specific issues facing children and families who are marginalised

Throughout the interviews reference was made to various marginalised groups having additional needs including:

- younger children
- disabled children including those with learning/developmental disabilities
- trafficked children
- Black, Asian and Minority Ethnic children, and
- children and families where there are additional communication and language needs.

Participants via our online questionnaire supported the finding that there is, 'a lack of child sexual abuse (CSA) services that are inclusive and able to support cultural, communication and additional needs (refer back to Section 2.2).The fact that children and families who are marginalised was raised as a key concern across the questionnaire and throughout our interviews signals its importance as an issue deserving of wider consideration. Specifically, in already marginalised communities facing prejudice and discrimination, where the stigma and shame of CSA can contribute to a compounded culture of silence around abuse, it can be even more difficult for people to access services. Consequently children and their families can be denied specialist support. As a result of stigma and attitudes towards CSA involving denial and feelings of shame, isolation, dependency and disability, amongst other things, children within these groups can potentially be even more vulnerable.

Interviewees commented:

> 'There is a lack of awareness around children with any sort of additional need; why they might be more vulnerable and might be targeted for any form of abuse.'

> 'There is even less support that's specialist for children with additional needs who have been sexually abused and it's a huge gap. They are additionally vulnerable to sexual abuse throughout life, not just as younger children and unless that gets addressed at an earlier point, it filters through life'.

It was mentioned that for children with additional needs, the focus for intervention specific to sexual abuse can be lost or even ignored:

> 'These children with complex needs and disabilities are actually the most vulnerable and yet there wasn't a great deal of emphasis placed on the

> safeguarding when it should be a lot more, because it was all focused on their disability.'

> 'Sexual abuse is often not recognised and so there is a misidentification of the needs and what the focus should be. The sexual abuse isn't the focus of the intervention and gets missed'.

Development of this theme is mirrored in the *Making Noise* research, where it is suggested that difficulties of recognising and responding to potential signs of sexual abuse can be compounded by a child's disability and its associated behaviours:

> There is the potential for adults to misinterpret signs of abuse or related distress in a child or young person with a disability (sometimes referred to as 'diagnostic overshadowing') (Franklin et al., 2015 cited in Warrington et al. 2017: 61).

Supporting this view, one of our interviewees commented:

> 'If a child is displaying sexualised behaviour, it will often be linked to their disability. It won't be linked to actually they're displaying that behaviour because potentially they've been sexually abused'.

Similarly a dearth of therapeutic provision was also highlighted for children with disabilities: 'Instead the focus tends to be on the child's behaviour and management of it'.

Interviewees reported access to CSA services being limited for some, due to professionals lacking the specialist skills required to address communication barriers. In particular, some of the challenges of using interpreters were raised, which included: limited availability, consistency and quality of service; confidentiality issues within communities; and certain words and concepts relating to sexual abuse not translating in certain languages.

Interviewees highlighted that services can often adopt a 'one size fits all approach' that means the particular needs of marginalised groups remain unmet, even if services are made available. Interviewees identified that services need to be able to adapt and respond more effectively to whatever the particular need is for a child and their family.

> 'There are services for children with disabilities, but they may not have the experience of delivering services for the sexual abuse component. And we might not have the skills needed or experience of Deaf children who use sign language; or a building is not even ale to accommodate a child using a wheelchair'.

Comment was made about professionals lacking the skills and confidence required for working with children with severe complex physical and/or learning and developmental needs in relation to sexual abuse. One interviewee reflected:

> 'There is an expectation that you would just modify practice to be able to accommodate a child with additional needs or any specific communication needs, but in reality I don't believe that's being done successfully, and most definitely not for non-verbal children… A specialist worker who knows how to adapt their practice sufficiently to really meet the needs of that child is quite rare. A huge gap there!'

The issue of more time being needed if the child and/or parents/carers have additional needs was raised as a requirement:

> '…in order for the work to be planned and adapted and for an individual's understanding to be checked out, more time has to be factored in, which sadly isn't available; very rarely anyway'.

Interviewees commented on the inconsistencies in educating children generally about sexual abuse and highlighted particular issues in relation to educating children who already have additional needs, particularly when those needs relate to speech, language and communication.

In circumstances where such children are known to be more vulnerable, interviewees identified the need for wider education with parent/carers and the general public. Interviewees commented:

> 'As professionals we need to talk about sexual abuse and open up the dialogue, otherwise we are contributing to the secrecy sexual abuse is perpetrated in'.

> 'It's my understanding that disabled children are four-five times more likely to be sexually abused than their non-disabled peers. For many of them, some others in marginalised groups and including young children, they don't even have the language to communicate about it'.

This point was confirmed and supported by those interviewees who felt able to comment; that in their experience children with additional needs, including younger children, were typically not provided with the words or language, signs or symbols to communicate about sexual abuse. This prevents a child's ability to understand, recognise and react to abuse and renders them unable to disclose.

This increases the imperative to take the responsibility for prevention and disclosure away from children and instead, for adults to get better at noticing children's non-verbal/indirect and natural communication. Indeed noticing changes in behaviour and demeanour and recognising signs of potential sexual abuse, was an issue raised by some interviewees, particularly in respect of children with additional needs. One professional suggested a possible reason for a hesitant response to this:

> 'I think children disclose all the time but we rarely hear what it is they are saying. What can stop us from being able to see or question behaviours, is in case we are

> wrong or in case it opens a can of worms because we can't and/or don't want to believe what we see'.

With the above in mind, the theme and need for 'recognition of abuse by others' is particularly important for marginalised groups and is explored in the *Making Noise* research, where comment is further made about children's vulnerability, where responsibility for sexual abuse and its discovery lies in what professionals need to get better at doing:

> Recognised forms of adversity may overshadow signs of sexual abuse in a professional's mind [there is a] need for professionals to ask open questions and/or voice concern in response to these signs of vulnerability, while clearly communicating messages that a child is never to blame for abuse (Warrington et al., 2017: 66).

Although not introduced by over half of the professionals interviewed and therefore not included as part of the five key themes above, a number of other factors seen to be missing in the area of CSA were raised by at least a third of interviewees. These seemed worthy of mention, as highlighted in the following section.

3.9 Additional points of discussion relating to what interviewees raised and/or felt is missing:

- Access to specialist CSA professionals for non-specialist workers – particularly for consultation, advice and guidance

- Knowing what services are out there for children under ten who have been sexually abused and their families – where to signpost to.

- Support for parent/carers to address their own unresolved sexual abuse history – in order for them to be able to provide the level of support their child requires for their recovery.

- Criminal-Justice-System training – work needed to be undertaken with juries, judges and the Crown Prosecution Service about CSA.

- Longer-term interventions – limited in what can be achieved in short-term work, including the building of the therapeutic alliance and inability to progress at the child's pace.

- Children potentially being more vulnerable due to stigma/attitudes towards CSA, involving denial and shame.

- Access to CSA services being limited due to lack of specialist skills of workers; communication barriers; lack of practical support.

So far, this report has focussed on children under ten who have been sexually abused and their families, and the services that were available to them, the gaps in provision, and also the gaps in provision for the professionals who work with these children and their families. The final part of the interview aimed to establish what professionals thought might improve the experiences of children under ten and their families. Specifically, interviewees were asked to think both aspirationally and realistically about what improvements they would like to see in an ideal world. This question included improvements interviewees would like to see for children under ten and their families, but also for the professionals involved in implementing the support to them.

3.10 Respondents' visions for improved services

In responding to this question, as might be expected, a number of professionals began their answer by saying that they would like for there to be no sexual abuse in the first place. However, all respondents were able to focus on more achievable responses to the issue as illustrated in Table 3 below.

Suggestions for improvements	Number of interviewees who suggested the response
Education for children, parents and professionals (including about normative sexual development/behaviour)	9
Training (specialist)	7
Specific CSA service	7
'Go to' person for children (including better communication with children with disabilities)	5
Needs led services	5
Time for direct work with families (more/sufficient)	5
Long term follow up services	4
Public awareness campaign	3
Advice/support for professionals	3
Perpetrator work	3
Joined-up services	2
Funding	2
Better understanding about how children disclose	2
Timeliness of intervention	2
Support for parents	1
Moderated self-help groups	1
More males in the field	1

Table 3 ideal world question responses

A total of nine interviewees said they would like to see more **education and awareness-raising about CSA**. In these answers, professionals adopted a wide and comprehensive definition of education and included education for children, parents and professionals. This is distinct from training or specialist training on CSA as it includes basic awareness raising and education to dispel common myths that still exist around CSA. Some answers

stressed particularly the importance of education for children, specifying very young children, around understanding basic concepts such as the names for private body parts and children's rights to control over their own bodies (the beginnings of consent). This is in line with the aspirations for the new national curriculum on relationships and sex education. However a number were very clear to caveat their response with an acknowledgement that children sometimes can be made to feel responsible for their own safety via this type of education however that in reality no child can never be responsible for their own safety and must never be made to feel responsible for it.

It was acknowledged in some responses that there are misunderstandings and a lack of general awareness in adults, both parents and professionals alike, about different aspects of CSA that are unhelpful to children and the adults who are trying to support them. One interviewee stated, 'Prevention I suppose is all about education… it's more about the education of the adults and the general population'. Another made the point in relation to general understanding and awareness of trauma in CSA:

> 'There is still a lack of understanding about developmental and complex trauma in society and services… I'm talking about increased understanding of the impact of sexual abuse…'.

Many of the comments made about education were closely related to the comments made by three interviewees about the need for some sort of public awareness campaign around CSA. The rationale for needing a campaign was because sex is a taboo subject in the UK which in turn results in negative consequences for the protection of children from sexual abuse and for responses to them following sexual abuse. It was proposed that a public awareness campaign that de-stigmatises sex would make it much easier to prevent child sexual abuse and respond more effectively to it when it occurs. One interviewee commented:

> 'I'd like to see more nuanced understandings in society more generally…most people know about a healthy diet and I'd like to see something similar with emotional and mental health responses to sexual abuse so that it's not something that's "out there"'.

Seven interviewees made separate mention of the need for training for professionals. Some identified that better understanding of the signs and symptoms of CSA was needed. Others identified that specialist CSA training that goes further than helping professionals to identify the signs and symptoms of CSA is required. This may appear to be somewhat contradictory and appears to reflect different training needs amongst these interviewees, with some requiring better training on CSA and others requiring training that extends beyond initial identification. The distinction is, however, perhaps more nuanced. For example, those that spoke of the need for better understanding of the signs and symptoms appeared to be linking this to the difficulties that exist with identifying CSA in children under ten specifically rather than requiring more training in CSA more generally.

One interviewee stated: ‘Teachers, professionals, everyone needs to be trained in terms of spotting the signs and indicators’, and another commented:

> ‘I would like to see more focus around people understanding how children disclose sexual abuse and us not putting it on the child to disclose, actually it should be us as professionals looking at what are the signs’.

Again, the comments made about specialist CSA training concentrating on signs and symptoms aligned very closely to the comments made by two interviewees about wanting to see better professional understanding of how children disclose sexual abuse.

Those that identified the need for training that went further than signs and symptoms were concerned with the need to develop more adequate responses to CSA and the resulting complexity of trauma that can follow. Also refer back to Section 3.7.1:

> ‘Sexual abuse is about real difficulties emotionally and grief for what has been lost and shame, I would like to see an understanding in services and professionals more generally of pain based behaviour… understanding that compassionately and there is some sort of understanding but still a disconnect’.

Seven interviewees spoke about **wanting to see specialist CSA services for children under ten and their families**, over and above that which other agencies can be trained to deliver. Taken all together, the description of what was meant by ‘specialist CSA services’ was complex and included work with whole families, work with the whole child (as opposed to only addressing issues pertinent to CSA), work that is responsive to individual need and at the pace of the child, work to address prevention, risk, complex trauma (including grief and shame), attachment, services that are able to support families through court processes, restorative justice, family reunification and undertaking assessments related to risk in families where known or suspected perpetrators are a factor. As one interviewee summed it up: ‘my question then is, in your research, have you come across any agencies that can do all of that?’ Considering this wide variety of need and whether any one service can and does offer all of this, the finding in the report of the Centre of Expertise on Child Sexual Abuse, *Effectiveness of services for sexually abused children and young people: research programme briefing* (2019), seems relevant and perhaps unsurprising: that, ‘services responding to CSA are diverse’. (p6)

It is striking to note that where more than half of the interviewees suggested an improvement they would like to see, the majority of their responses focussed on raising the awareness, understanding and the skill level of the whole of society, including the children’s workforce and children themselves. CSA can be regarded as a taboo subject and as such can be a difficult issue to engage with, especially when thinking about raising awareness amongst children and families. In addition, both during interviews and when Barnardo’s approached services for interviews, a lack of relevant experience of CSA amongst the children’s workforce was clearly identified. It may be the case that

interviewees felt that education and general awareness raising about child sexual abuse was the key factor that may lead to improvements in other areas of our responses to child sexual abuse. As CSA usually happens in secret and much of the harm done cannot easily be seen, it may also be the case that it is an issue that feels particularly unfathomable, even for professionals; in the words of one interviewee, 'an alien thing'.

3.11 Summary of interviews with multi-agency professionals

Following on from mapping the issues that arose from practice experience and the development of the original gaps chart (Appendix 2) we anticipated that all of the issues originally identified by the service may be reflected in the interviews. Whilst not always identified by over 50% of interviewees, and therefore not prioritised for analysis in this report, every issue identified from practice was raised by interviewees at some point. There were, however, a small number of issues that we identified through our practice experience, which did not appear to be supported through the interviews due to the fact that they were raised only rarely. These included: skills and knowledge of professionals working with children with sexualised behaviours; skills and knowledge in undertaking direct work with children under ten who have experienced sexual abuse; and consideration of the needs of fathers, each of which will now be discussed.

The significance of the gap in the **skills and knowledge of professionals working with children under ten with sexualised behaviours**, not being picked up to any great extent by interviewees perhaps should be no surprise. There are a myriad of possible explanations including but not limited to the fact that (1) working with sexualised behaviours is a relatively specialist area whether with children under or over ten, (2) it is easier to dismiss sexualised behaviours in children under ten as exploration, (3) children under ten are not of the age of criminal responsibility, therefore engender less perceived risk, and (4) many adults would prefer not to face up to the sexualised behaviours of young children because it creates uncomfortable feelings for them. Again this poses the question, not in the remit of this research, of whether children under ten face a specific age related barrier to accessing sexual abuse services of this nature.

It is perhaps significant that interviewees on the whole did not concentrate on the gaps in professionals' **skills and knowledge in direct work with children under ten who have experienced sexual abuse.** As captured in this section of the report, and despite current statistics on the proportion of children in the UK who experience sexual abuse, many professionals reflected that identified instances of sexual abuse are not, in their experience, common (even amongst vulnerable populations). Without better identification of the children who have this experience, the needs of these children will continue to go unmet. Where these skills were considered by interviewees, it was identified that it can be difficult to gain experience of direct work in the field of sexual abuse when it appears to be so hidden.

When asked about the gaps in provision for family members, very few interviewees considered **the needs of fathers.** This may be for many reasons, including that it is statistically more likely that the non-abusing parent(s) in a family will be the mother and is less likely to include the father. Furthermore, mothers still tend to assume more of the caring responsibilities for children, meaning that there is a likely bias towards foregrounding the needs of mothers over fathers.

The fact that all other issues identified from our professional practice were highlighted by the small number of professionals we interviewed lends support to the validity of our experiences, but also underlines the importance of bringing all of the issues and gaps for children under ten who have experienced sexual abuse, their families and the professionals working with them, together in one place. The unique experiences of children under ten are rarely studied and little is known that is specific to this age group.

An issue which arose that was not wholly anticipated was that of participants describing **awareness raising** in a manner that began to sound like a **wide public awareness campaign** (see Section 3.10 of this report). Sexual abuse of children and the associated issues remains a taboo subject which together with its secretive nature, facilitates the sexual abuse of children under ten (and indeed all sexual abuse) remaining hidden from view. Interviewees were clear that a wide spread and sustained public awareness campaign would contribute to furthering the prevention efforts in this arena. Anecdotally, from our practice, adults seem quite well informed about the nature of child sexual exploitation (CSE) due to media coverage, but appear much less well informed about the dynamics of CSA and therefore potentially less prepared for proactive safeguarding.

Finally an issue that arose during the interviews which the team found encouraging, was that there was a significant recognition of the need to shift the balance away from children under ten having to disclose sexual abuse in order to get their needs met, towards an acceptance that adults have a duty to be more curious and more proactive in their helping behaviours. Whilst this is a welcome change in perception, many of the comments made by interviewees suggest that a change in institutional structures, systems and processes to support an effective shift in practice are still needed.

4 Summary and Discussion

This section will return to the initial questions raised from our practice-based experience regarding the perceived continuing fragmentation of services for children under ten who have been sexually abused and their families through disconnect between research, practice and strategic planning. It will consider whether this has any validity across the broader platform accessed, through the interviews undertaken with multi-agency professionals and the widely circulated online questionnaire. It will consider what this means for children and their families; whether children under ten who have been sexually abused and their families have access to appropriate services when needed, alongside whether there is effective strategic planning, to support interventions being available across the spectrum of CSA when needed. Whilst this will still only represent a snapshot of views, it will provide some insights into common themes arising from practitioners across a range of disciplines.

4.1 Did the online and individual interviews find any similarities with practice-based perceptions of fragmentation between research, practice and strategic planning?

The initial gaps mapping undertaken by the Safer Futures team considered what we had learnt about why and how decisions were made about services to children and families; how referrals were made and needs understood, the timing and drivers for referrals being made, impacts of changing thresholds, funding cuts and of emerging research on day-to-day practice, at various stages from prevention to intervention. We mapped areas of need that had been repeatedly raised over time. This brought out a wide range of issues that we then grouped broadly into eight themes to help make them more manageable to reflect on:

1. Availability and access to services
2. Disclosure
3. Investigation
4. Court, evidence and legal process
5. Skills and knowledge
6. Communication and additional needs
7. Trauma-based interventions
8. How professionals respond to children under ten

Individual semi-structured interviews were undertaken with 13 experienced practitioners from a range of professional backgrounds. An online survey was circulated nationally to professionals, with 154 responses received. Although covering a wide range of professionals, the main groups of respondents to the survey were from social care and

education. From these two sets of information we were able to analyse whether there was any correlation with the practice-based mapping.

During the individual interviews, issues from all eight areas were identified by all professionals, although not all raised the same issues within the same questions. Similarly, issues correlating with all eight areas were identified by multi-agency professionals in the online survey. This identifies that there is a level of commonality across agencies regarding the gaps identified, with a higher likelihood that these are being experienced by multi-agency professionals nationally and that there is a broad range of unmet need for children under ten who have been sexually abused and their families across the spectrum of potential practice intervention with little evidence of strategic direction. This strengthens the view that strategy and services are fragmented, inconsistent and not meeting the majority of children's needs effectively. Professionals also raised additional issues from a broader perspective, relating to prevention and interventions, which were added into the mapping process and which will be discussed further.

4.2 Groups who are marginalised

Particular issues were raised from both processes, in terms of children and families who were less able or likely to access services, even where they exist. These were raised in various inter-related forms by all interviewees with reference made to various groups who are marginalised having additional needs including:

- younger children
- disabled children including those with learning/developmental disabilities
- trafficked children
- Black, Asian and Minority Ethnic children, and
- children and families where there are additional communication and language needs

Some of the examples provided were parents with their own learning disabilities unable to access services, a lack of services that can meet the needs of children with special educational needs and/or complex needs, or who identify as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/allied plus (LGBTQIA+). The question was raised about how accessible services are for some cultural or faith communities and to what extent services are designed to be inclusive and community based.

4.3 Wider perspectives on need as identified through interviews and online survey

Semi-structured interviews allowed flexibility for professionals to express views more freely in parts, and the online questionnaire included free text boxes to provide respondents with the opportunity to add additional comments. Although collating these

was challenging, some interesting additional themes represented across both processes were able to be extrapolated. These were broadly grouped together into the following areas as a separate category to the gaps already identified:

Respondents identified the need for:

1. A more defined prevention strategy for children
2. A wider public awareness raising campaign
3. A national strategy for CSA
4. Holistic and inclusive, whole family interventions
5. Support to be available as needed, across a child's lifetime

Points 1-3 all interlink in terms of what practitioners felt is needed to better protect children and help adults keep them safer. There was recognition: that CSA occurs in secrecy; of the dependence and vulnerability of children in our society; of marginalised children particularly those under ten; of those with additional needs; also that some adults play a key role in children's recovery and may need supporting themselves and that they can also be part of communities who may feel disenfranchised. Additionally, that as a society we are complicit with secrecy given CSA is still seen as a 'taboo' topic. This is the case despite statistics on prevalence[2] which indicate there is a high likelihood of it occurring to a significant number of children across the span of their childhood, and that most child sexual abuse occurs within, or close to, the family home[3].

Across both interviews and survey, practitioners expressed a view that the public need to be better informed through development of an awareness raising campaign, if they are to be able to increase understanding and offer greater protection to children. An awareness raising campaign was felt to be a mechanism to help break down the barriers of secrecy, to support CSA to become something that is better understood, to refute some of the commonly held myths that enable many to believe it happens 'out there' and not within our homes, families, communities by people we know and who sometimes we live with. Children and families where there are additional needs were also considered, in terms of ensuring reach and making information accessible and inclusive. Such a campaign was identified as linking to a more defined prevention strategy for all children and sitting within an overarching national CSA strategy, in an area that is viewed as fragmented and not meeting children's needs well enough, currently.

Further to this, points 4 and 5 above identify some specific areas that professionals believe need further focus in terms of effective interventions such as:

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[2] Current estimates show that 12-20% of girls and 5-8 % of boys are sexually abused' (Kelly & Karsna 2017)

[3] Up to two thirds of all sexual abuse takes place in and around the family' (Children's Commissioner's report into sexual abuse within the family 2015)

- Giving explicit recognition to other members of a child's family also needing to be able to access support;
- Children being able to access services at different points throughout their childhood for example when circumstances or developmental changes occur which could trigger a child back into having trauma reactions. Suggestions were made such as a 'One Stop Shop' or services that allow children to return for a 'top up' which would avoid long waiting lists and having to re-tell and re-start each time;
- The need to make services inclusive and accessible to all communities.

This suggests that current measures in place that should address this are perhaps not working as effectively as they might, and there is practice based evidence to indicate, that decision making and information sharing between adult risk management and children's safeguarding services are still often disjointed, leaving children vulnerable.

The literature review completed by Soares and Warrington (2020) as part of this research project, makes clear that children need support with a number of different aspects of their lives in the aftermath of sexual abuse and this will vary for each individual. For example, this may include support to manage changed family dynamics and relationships, or housing arrangements. The provision of holistic or 'integrative' support is advocated in a number of studies (Beetham et al. 2019; Warrington et al. 2017; Jessiman et al. 2016; Kilroy et al. 2014). Jessiman et al. (2016) critique services whose focus is too narrow, noting that provision too often focuses specifically on the effects of the sexual abuse. Jessiman's study and others, including that by Beetham et al. (2019) promotes the idea that recovery needs to be viewed relationally and contextually.

The eight sections as defined in the mapping process, along with the findings from interviews and survey contain issues that are inexorably interlinked. The overarching issues from across all eight themes relate to the key areas of availability, accessibility, and sitting beneath those are issues relating to skills and knowledge of practitioners, assessment of need, understanding CSA, and statistics. These will each be considered further.

4.4 Availability

Availability of services that provide child sexual abuse interventions was highly significant as previously discussed in the body of this report, in both interviews and online survey. It has also been an area identified within our practice-based experience over a significant period of time.

During interviews, experienced professionals made reference to problems identifying services for very young children. In some cases, it was noted that this was at least in part as a result of services not being available, or in existence, due to the child's age, with

practitioners struggling to identify services for children under six years of age and not knowing where to signpost them on to.

There was a general view from respondents that there are significant gaps in terms of availability of child sexual abuse services for children of all ages, which seems to be replicated across the country, and which seems to become more acute the younger the child. Services that do exist will have specific referral criteria, which in itself can create barriers that exclude some children.

There is no clear pathway identified as being available for children that would ensure they were supported appropriately following being sexually abused.

> 'We are currently making decisions in a fog, using poor quality and old data. Due to inconsistent definitions and research methods of previous surveys, it is currently very difficult to make comparisons and track trends over time. In order to make better decisions, target responses effectively and best protect children, we need better data about both the prevalence and contexts of CSA nationally.'
> (Measuring prevalence, Centre of Expertise on CSA, website 2020 for further discussion on the challenges of collating accurate information and gaps) https://www.csacentre.org.uk/documents/briefing-english/

It would seem that an underpinning issue linked to availability could be the lack of understanding about what services a child who has experienced sexual abuse needs. Is it counselling, CAMHS, CSA specialist services, family support? Whilst it highlights that practitioners recognised the need for timely, specialised therapeutic support, it also identified some differences of understanding about what this may be, which in turn could impact on how families are responded to or signposted.

4.5 Accessibility

Accessibility is not possible without availability, however availability can only be effectively achieved if accessibility and children's needs are fully understood at a strategic level, and then acted on within a coherent strategy.

In 2015 it was stated in the Children's Commissioners report, *Protecting Children from Harm*, that '**child sexual abuse that happens within families has been largely absent from the national conversation'**. Within the same report it states that '**up to two thirds of all sexual abuse happens in and around the family**'. These children are not hidden, but they are currently invisible within strategic planning and for many, in terms of having the protection and support, that should be their right.

We are aware that some work has begun towards the development of a national strategy led by the Home Office to which Barnardo's is contributing. In order to be effective not only do the areas known about need to be given focus, but more importantly, the links between what is known; getting accurate data across all systems so prevalence and need

can be more clearly understood. Within that, for there to a differentiation across the 0-10 age range, so the needs of the youngest in our society can be more clearly understood, actively making these children visible. It would also make strategic planning across the whole spectrum in a way that can be most effective, possible.

Barriers to accessibility currently are wide and varied. According to the interviewees, the main barrier to accessing services was due to the child and/or other family members not meeting service criteria or thresholds, whether due to the level of risk or safeguarding, seriousness of impacts, services not being appropriate/available, and/or age limitations.

Children can experience **barriers in terms of age restrictions** which can be defined by contracts and funding arrangements, and are variable in terms of which children are included or excluded. It is difficult to get exact statistics, but it was noted in interviews that some of the experienced professionals found it difficult to name any services in their areas for children under six years of age, and yet by the very nature of their age, they will be more dependent, have less access to external agencies or networks and are less likely to know that what is happening is not normal. There are barriers for **groups who are marginalised including children who have additional needs**. Children cannot and should not ever be responsible for protecting themselves. The onus is on adults ensuring their needs are considered and included at all levels. These children are not invisible if we look for them, but can appear (and feel) so if we do not. Services need to represent and feel accessible to all of our communities. **Not meeting specific referral criteria;** referral criteria needs to include and not exclude, for example, a young child who has been sexually abused will have been groomed within a close relationship that distorts attachments and through which the child may have learnt some unhealthy and/or sexualised ways of acting towards others. Some services will identify this as problematic sexual behaviour, which not only labels a child (which may travel with them throughout their childhood), but may also exclude them from receiving a victim recovery service as they are seen as somehow responsible for the behaviour they learnt whilst being victimised when they were too young to know the difference, thereby being doubly victimised by a service that is meant to help. **Needs not being accurately assessed:** none of the professionals identified a clear framework from which to understand what support a child who had been sexually abused, or their family, may need. A few professionals indicated parents were assessed within their agency, but this was primarily based on perceived risk, and if none existed, then a case would be closed due to thresholds, leaving needs unassessed often at a time when greatly needed.

There was some indication that professionals looked for services in their area that may have tentatively been able to offer something, as opposed to nothing. Whilst well-meaning, this can contribute to the experience of some children feeling they are passed around from service to service and often does not meet their trauma recovery needs.

> 'Children were described by several interviewees as being 'passed from pillar to post' and 'pin-balling' between services. (Interviewee)

This lack of clarity is reflected repeatedly in our practice-based experience. Conversations with multi-agency professionals around interventions indicated there is a mixture of there being a fundamental uncertainty about what interventions are most appropriate for children who have experienced CSA and their families, a lack of structure and process regarding assessment of need, with the greater focus being on likelihood of risk to the child. Both are equally important but one should not negate the other. This links to organisational **thresholds for intervention** as raised by practitioners and which has been present throughout our experience**.** Assessment of immediate and on-going risk to a child is crucial, but so is the potential for longer term emotional and psychological harm taking root, if effective intervention is not accessible when needed.

There was acknowledgment within the interviews of the long-term impacts for some children of not receiving services when first identified, where interviewees commented on **long waiting lists** as a barrier to accessing specialist sexual abuse centres and other services when they were needed which links back to availability.

4.6 Understanding CSA intervention

Sexual abuse does not automatically lead to a diagnosable mental illness, which is a threshold for access to most mental health services. Intra-familial child sexual abuse happens within a relationship which is distorted and controlled by the abuser to meet their own needs. For young children who develop their understanding of how relationships work from adults close to them and who they (and others) trust, this can over time create a discord between brain and body. They are more likely to easily trigger into trauma responses in situations where they do not understand what to do, or know what is expected of them and may find it difficult to regulate behaviours and emotions with others. Alternatively some children disengage completely – the quiet silent ones that are less problematic to others but equally as concerning. If trauma remains unprocessed, children can grow into teenagers and adults who may still struggle to manage close relationships. It can over time become a mental health issue that for some lasts through childhood and into adulthood.

So what interventions work? There is a lack of cohesion and clarity in terms of interventions generally so it is no surprise there is uncertainty from professionals. Impacts of sexual abuse affect children (and their families) differently dependant on a range of factors about them, their families, the specific circumstances, including social and cultural contexts. From our practice-based experience we have learnt that interventions work best when they are flexible enough to meet each individual child's needs and includes work with their safe carer, to support understanding of how to respond most effectively to their child, to strengthen communication and build

confidence. This helps the child develop a healthier template for re-building and taking forward, positive attachments. Inclusion of parents in part of the process is a model developed over many years with service users and which we believe to be an integral part of the child's recovery process. More evidence is emerging about the importance of working with the safe carer/s alongside a child that suggests this type of approach has merit.

Soares and Warrington (2020) in a linked Scoping Report for this research, distilled the content of therapeutic interventions into seven areas, where there was evidence from the literature to suggest young children need support to:

- Make sense of the experience of the sexual abuse
- Address feelings of guilt and self-blame
- Express their feelings and communicate
- Be empowered and build on their strengths
- Manage symptoms of psychological distress
- Address their wider holistic needs
- Address sexualised behaviours

They also identified that the literature reviewed provides a strong consensus that the role of the non-abusing caregiver is significant to therapeutic interventions with children after CSA and should be a central consideration of service provision. Parents were noted to have a significant role in supporting young children's ability to access and trust therapeutic professionals; motivate attendance and engagement and enable a therapeutic alliance to develop.

There is no single framework that works for every child. As human beings we are unique and each person's circumstances vary. Interventions need to reflect this and should inform the way children are responded to. Trauma focussed approaches can include a combination of psychotherapeutic techniques, and particularly but not exclusive to younger children, elements of play, creative and expressive arts techniques, alongside cognitive strategies dependent on the individual. The Neuro Sequential Model (NSM) for trauma identifies the need to reflect the child's brain developmental stages by offering 'bottom up' response for family and child, incorporating **regulation** of body and nervous system, then **relating**, through attachment, relationship and emotions work, before **reflection** and learning, where the child and family can integrate and move on. The skill is for the worker to create a safe space for a child to work through their experiences in whichever way fits with their development, learning style and need. The skill for organisations and individual services is to create enough understanding, flexibility of approach and provide enough role-targeted skills-building in order for this to take place.

> 'The impact of poor service experiences is more than the absence of effective help at a point-in-time. Instead poor service experience is associated with a

> delay in survivors accessing future services over a longer duration'.4 (Smith et al., 2015)

4.7 Skills, knowledge and confidence of practitioners

For many years we have worked with professionals from all backgrounds. One commonality is the discomfort that most feel at least initially, when thinking about sexual abuse. A comment made during interviews captured this, where a professional referred to sexual abuse being 'a complex area of work that strikes fear in many individuals whatever their role'.

The definition of sexual abuse has become more complex over the years as we learn more and new challenges emerge. There are a range of needs in all scenarios and at various stages throughout a child and their family's experience. Developing the skill and knowledge to respond to all areas requires more than awareness raising training. Expectations on professionals to respond, to know what to do and to get it right across any given situations, are enormous.

Gaps in skills and knowledge were the second most mentioned areas in the broader based online survey, with professionals indicating they did not feel confident about their current levels of knowledge: some social care respondents indicated they had not attended any training that had been relevant to their role or provided the basis for practice delivery.

Some interviewees felt there was an over reliance on courses focussing on 'signs and symptoms' of CSA and not enough consideration of other areas, such as understanding more about how to respond to children and families in different situations.

It was interesting that given the levels of experience and training accessed by interviewees, it was they who identified low numbers of child sexual abuse cases reaching their services. Survey respondents contained a significant number of professionals from the education field which research tells us are a significant group in terms of young children and disclosure, who did not always feel equipped to know how to respond appropriately to children they had concerns about or who disclosed, indicating a gap in what could be an effective first response to children who are in need of an adult to help them.

> 'I am able to identify if a child is at risk of or has been sexually abused but I have not had any training around the work I could do to support the child in school'
> (Education professional)

[4] Hear Me, Believe Me, Respect Me: A survey of adult survivors of childhood sexual abuse and their experiences of support services. Smith N, Dogaru C, Ellis F. 2015

Skills based training that provides practitioners with the opportunity to explore how theory relates to practice and consequently builds confidence is rare, but from experience of developing and delivering skills and integration based training from short workshops to in- depth courses, they are very effective when they happen. How much practitioners integrate focussed learning into their work determines how effective they are in; supporting and communicating with children and families; promoting understanding; responding from a knowledge base of trauma and impacts; and in being able to analyse risk. Training needs to be focussed and related to direct practice to have greatest impact. Practitioners also need access to good quality reflective supervision due to the high potential for vicarious trauma in terms of professionals themselves, but also to be able to identify where this may be an issue for a parent/carer. The structure to support integration of learning into practice and support on-going reflection seems to be an area that is significantly under-resourced.

4.8 Statistics and legal frameworks

> ‘In the year ending March 2019, the police in England and Wales recorded **73,260 sexual offences** where there are data to identify the **victim was a child**
>
> A snapshot taken at March 2019, identified **2,230 children in England were the subject of a child protection plan** (CPP) and **120 children in Wales were on the child protection register** (CPR) **for experience of sexual abuse.**
>
> It is reported that sexual abuse has become the most common type of abuse counselled by Childline in recent years; it was also the most commonly reported type of abuse by adults calling the National Association for People Abused in Childhood (NAPAC’s) helpline in the year ending March 2019.
>
> In 2019 the Crime Survey for England and Wales (CSEW) estimated that **approximately 3.1 million adults aged 18 to 74 years experienced sexual abuse before the age of 16 years.’**
>
> (All data from the Office for National Statistics July 2020)

There are no current surveys measuring children’s experiences of sexual abuse because of the challenges in asking this age group about such a sensitive topic. We therefore do not know how many children are currently experiencing, or have experienced sexual abuse.

As there are no specific statistics for children under ten who have been sexually abused, there is no robust understanding of their specific needs within research or provision for those needs within strategic planning and yet we know from research that nearly two thirds of all sexual abuse happens in and around the home. We also know that children under ten including children who are marginalised or with additional needs, are some of the most vulnerable in society due to the very nature of their dependency, lack of knowledge and experience and lack of access to external support. Research tells us how

hard it is for children to tell about sexual abuse, yet there are no clear prevalence, prevention or intervention strategies in place nationally to help safeguard them.

Sensitivity of the subject area is a reason identified for not asking children about sexual abuse. An awareness raising campaign with adults was raised as a need within interviews and survey, one practitioner also raised the notion that it was a scary type of case to get. CSA is the area that raises the most feeling-led reactions and responses. It divides; it creates anxiety and often the desire to 'protect children' from talking about something perceived as 'too sensitive', meaning it can be intolerable for adults. Horvath et al. (2014) noted that 'the voice of child victims of intra-familial child sexual abuse (IFCSA) is largely absent from research and prevalence is difficult to estimate. If it is uncomfortable for adults, we need to ask what it must be like for the children living with being sexually abused when adults generally aren't able to 'tolerate or hear'.

If the word sex is taken out of the discussion then perhaps it becomes easier to talk about. Children have told us that they want us to be curious and to ask (Allnock. and Miller, 2013), and as adults we have the responsibility to listen to what they tell us and find a way to manage the uncomfortable feelings that CSA engenders. It is possible to speak to children in age appropriate and sensitive ways to gain some understanding of how they are, to develop conversations that send a message they are seen and heard and that they have a value, without once mentioning sexual abuse. What would be required are clear and safe processes, systems, boundaries alongside skills building for staff around communicating with children and effective and supervision for the professionals so they are not left feeling vulnerable themselves. Allnock et al. (2015) clearly tell us children can and want us to communicate and that it is adults who need to respond better.

It is clear that children under ten who have been sexually abused and their families are not well enough considered in terms of understanding their needs and without this, prevention strategies and safeguarding are not well enough thought out or effectively provided. It is also evident that there is no consistency or coherence regarding availability and accessibility of appropriate support and services when needed, which is likely to lead to significant issues for many across their lifespan.

4.9 Limitations

Several main findings have been raised in this report. However, it is important to understand the limitations behind this research as a way to contextualise their significance. The semi-structured interview process and free text option within the online survey allowed flexibility of approach but gives less rigorous and transferrable findings. What it did allow was an opportunity to get a snapshot of perceptions across a wide span of professionals on how the needs of children under ten who have been sexually abused and their families are actually considered and if they are viewed as being effectively provided for.

Circulating the online questionnaire nationally across various agencies and organisations, meant we had no control over distribution or of who accessed and responded. Of the 154 responses received there was a strong bias from education and social care professionals that had to be factored into the analysis.

In addition as survey responses were anonymous, to support professionals being able to answer more freely, we were not able to be sure that all key organisations and agencies were represented. A low level of respondents from services within police, residential homes and CAMHS specifically, means that we did not receive views from professionals from significant parts of the systems that would be involved with children who have been sexually abused, which would have been valuable to have had as part of the wider picture.

It also meant that voices that would likely hold more in-depth knowledge, such as from specialist services were not as well represented and the issues they raised may not have reached the 50% threshold used to identify the most common themes raised for further consideration. Therefore, as this was an exercise to gain a snapshot in time of perceptions and experiences, we felt there was validity in presenting some of these issues separately to ensure all voices were heard.

There is some emphasis on practice-based evidence across a period of over 20 years of experience. Although this may be open to some challenge from a research perspective given that our experiences may differ from those of others professionals and other services, it has much to offer in terms of learning from research informed practice, and in relation to strengths-based training and support in the areas of CSA for professionals. It allows for first-hand experience of interfacing with the gaps for children, which in turn can help in-part to inform where some of the barriers lie. This cannot be assumed to be representative other than within the area we have practiced and our specific experience, but could, with others, collectively contribute to understanding some of the wider systemic barriers and perhaps help to go some way to more clearly identify the connectors between research and practice to contribute to strategic thinking.

5 Conclusions

This work has synthesized a number of issues from practitioner views and understanding and our practice-based experience.

Research into childhood sexual abuse helps to understand many areas, although research with children under ten is significantly underrepresented, despite it being a significant age in terms of vulnerability and greater dependency, which is coupled with less likelihood of services being available: a situation that worsens the younger the child.

Statistics in terms of sexual offences against children identify large gaps and inconsistencies in the research base for children generally, but children under ten specifically. Without more accurate information, the likelihood of more targeted interventions are reduced, incrementally disadvantaging the youngest and most vulnerable children.

There is no clear strategy regarding availability and accessibility of therapeutic services to support children and their families with the impacts of trauma, which means many children do not get any services when needed, or get signposted to services that do not meet their needs, sometimes compounding the issues and sense of being 'un-helpable and/or responsible'.

A child and their family's needs are not well enough assessed and social care systems place greater emphasis on thresholds around perceived risk.

The fact that groups who are marginalised were raised as a key concern across the questionnaire and throughout interviews, signals its importance as an issue deserving of wider consideration. Specifically, in communities who are already marginalised, where the stigma, shame and lack of effective understanding of how to support and safeguard them can contribute to a compounded culture of silence, it can be even more difficult for people to trust in services enough to access them.

Access to training for professionals regarding child sexual abuse was inconsistent across the range of disciplines: some reported training to be useful, others less so. More specifically, access to courses with a focus on specific roles and equipping professionals with skills, appeared to be less available but could actually make a significant difference in terms of understanding and building confidence to apply the learning. It raised the possibility of too much reliance on the broader based understanding of sexual abuse, or signs and symptoms and less on some of the role specific needs to enable practitioners to feel confident about how they communicate with children safely and confidently, who may or may not, have been sexually abused.

A disconnect between research, strategy and practice is clearly evident. There are many pieces of this 'CSA jigsaw' available. These are issues that are known and the children

affected by them are not ‘unknown’, however there is a sustained lack of action to support coherent change needed for children and families to get the support they require. The gaps mapping exercise is a reminder that this continues to be a fragmented area for professionals to work in, with little real strategic coherence or planning. It is also a reminder that on a daily basis children under ten who have been sexually abused and their families are being let down. They are ‘known’ but are still in many ways ‘invisible’ across prevention, protection and recovery systems.

There was a greater recognition from both sets of participants of the value of holistic, whole family interventions which would be a positive step forward from considering children in isolation as often happens at present. Alongside this, there was a call for there to be consideration nationally around awareness raising, robust strategic planning to provide consistency around availability and accessibility of services to children (and families) with an emphasis on avoiding children having to ‘start again’ in a new service, each time they need a therapeutic ‘top up’.

There is so much known about aspects of CSA and so much that is not. Systems across the whole spectrum operate in isolation; there is no coherence about how statistics are gathered, so no real understanding about the true prevalence of sexual abuse, or even of offences committed against children under ten. What we do know is that figures on prevalence data available and sexual offences committed as a whole, are significantly high.

There are areas where research offers strong foundations for knowledge and practice which needs to continue, but we believe there is also a gap in learning from how practice influences research that needs to be addressed otherwise it risks remaining fragmented. Formal research, quite rightly uses a screening process that ensures information is clearly focussed, but this process can also exclude valuable learning from practice based knowledge and experience.

Some of the pieces of the ‘CSA jigsaw’ exist for us to build on in order to provide prevention, protection and support to children under ten, but to date these are not being connected to make one whole coherent pathway. Those connection points are the gaps that currently exist. It is not possible to identify exactly what the cost is for the failures to provide timely interventions and is beyond the remit of this work. However given the high numbers of children and families involved, indications about longer term support seeking across agencies, social care interventions, therapeutic services, and over time into mental health services, the financial and personal implications must be huge. Without change in the immediate, many children will continue to fall through the gaps, remain invisible and not well supported, with the illusion of cost saving; however the longer term indicates a different story with costs both to the individual and to the wider society. We believe more needs to be done but that it is possible to join the pieces of the ‘CSA jigsaw’

together and fill in the gaps in order to offer and deliver something better to children under ten who have been sexually abused and their families.

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Appendix 1- Survey Monkey questions

Barnardo's Safer Futures research on services for children under ten years who have been sexually abused and their families.

1. **What type of service do you work for?**
   - Children's Services
   - Education
   - Health
   - CAMHS
   - Voluntary Sector
   - Children's Residential
   - Police
   - Specialist Service
   - Other (please specify)

2. **Have you worked with children, young people and/or their families, where there has been an experience of sexual abuse?**
   - Yes
   - No

3. **If yes, were any of the children (please tick one box only)**
   - Under ten years
   - Over ten years
   - Worked with both age groups
   - Not applicable

4. **Did any of the children have additional needs such as, SEN (Special Educational Needs), disability, Deaf, additional communication needs?**
   - Yes
   - No
   - Not sure

5. **Did you or any other agency provide specific Child Sexual Abuse (CSA) support to the non-abusing parents/carers?**
   - Yes
   - No
   - Not applicable
   - ***If 'No', what was the reason?***

6. **Was any joint work offered with both the child and their non-abusing parents/carers?**
   - Yes
   - No
   - Not applicable
   - ***If 'No', what was the reason?***

7. **How confident do you feel working with Child Sexual Abuse (CSA)?**
   - Extremely confident
   - Very confident
   - Somewhat confident
   - Not so confident

- Not at all confident
- Not applicable

8. Have you accessed any training that is useful to your work with Child Sexual Abuse?

- Yes
- No
- ***If 'Yes', what training did you find most useful?***

9. Are your needs sufficiently met to undertake your role working in CSA?

- Yes
- No
- Not applicable
- ***If 'No', please expand on what would help?***

10. What specific CSA service(s) would your agency refer a child under ten years of age to, for support/recovery work? (tick all that apply)

- NSPCC Service
- Barnardo's Service
- CAMHS
- Counselling Service
- Sexual Assault Referral Centre
- Children's Services
- Nothing available in my area
- It's not my agency's role to make a referral
- Other (please specify)

11. Thinking about children (with or without a wide range of additional needs), do you think there are gaps in services for children under ten years who have been sexually abused?

- Yes
- No
- Don't know
- ***If 'Yes', what do you think the gaps are?***

12. Thinking about adults (with or without a range of additional needs), do you think there are gaps in services for non-abusing parents/carers of children under ten years who have been sexually abused?

- Yes
- No
- Don't know
- ***If 'Yes', what do you think the gaps are?***

13. Do children and families, where there has been an experience of CSA, get services at the time they need them?

- Never
- Sometimes
- More often than not
- Don't know

14. In your experience have the services provided to the children and families, where there has been an experience of CSA been helpful?

- Yes
- In a few
- Mostly
- Never
- Don’t know
- ***Can you tell us more?***

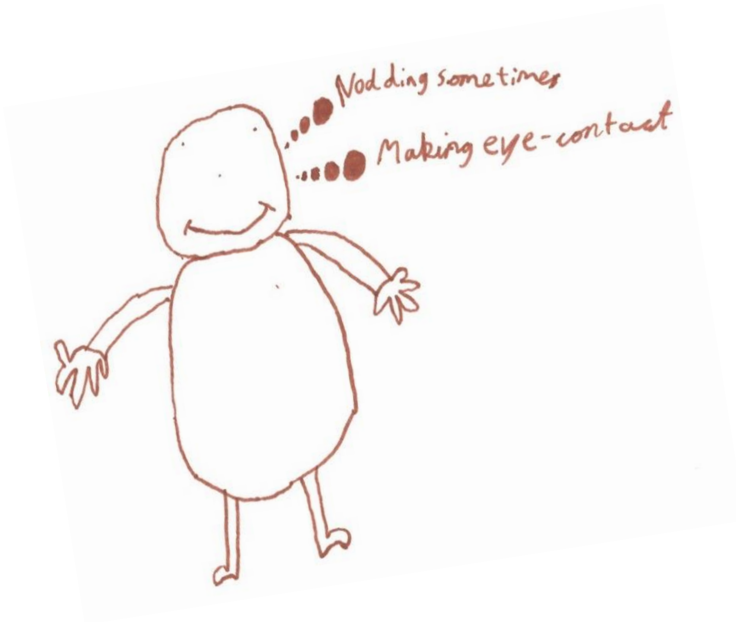
15. In an ideal world, what do you think would be most helpful to children under ten years who have been sexually abused and their families?
Please be as imaginative and creative as you like in your response.

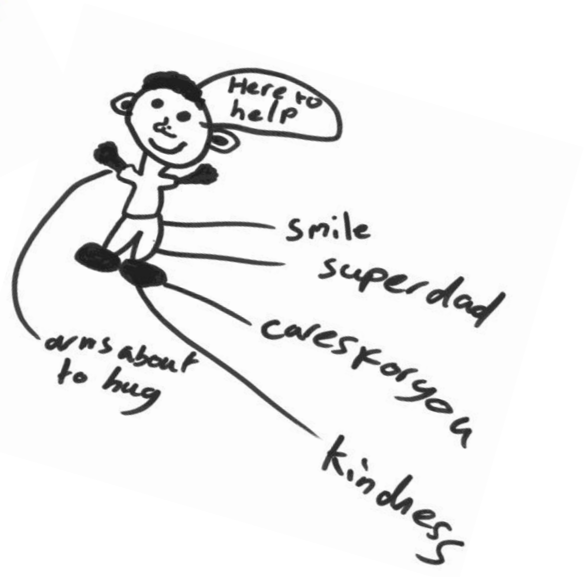
Appendix 2 - Gaps Chart

Appendix 3 – Semi-structured interview questions

1. What's your experience of working with children under ten who have been sexually abused and their families?
2. What services were offered to the child? Other family members?
3. What worked well / not so well?
4. Are you aware of families who didn't get a service and would have benefitted from one?
5. What do you think were the reasons for them not getting a service?
6. Is CSA an area you feel confident in? What would additionally help?
7. Do you think there are outstanding needs for professionals working in CSA?
8. What useful training have you had in relation to CSA?
9. What do you think is missing/ what are the gaps in services for children under ten who have been sexually abused?
10. Is there anything additional to add in relation to gaps in terms of services available to individuals with additional needs?
11. Are you aware whether children have the words, signs and/or symbols to communicate about abuse?
12. What do you think is missing/ what are the gaps in services for the child's family… Parent/Carers? Siblings?
13. Is there anything additional to add in relation to gaps in terms of services available to individuals with additional needs?
14. In relation to CSA, what would you like to see in an ideal world? In terms of prevention of CSA? following a child's experience of SA?

A huge **THANK YOU** to **all** the children who contributed their fabulous art work; here's a glorious sample to share with you…





FINDING THE SILENCED
look
listen
notice
respond...
sexual abuse...under 10's

Believe in children
Barnardo's