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Mapping Therapeutic Services to Children and Young People who have been Sexually Abused *Services in Scotland*

Anne Stafford, Natalie Morgan-Klein, Sue Kelly

The University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection (CLiCP)

Summary Report

February 2009



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1 INTRODUCTION

This is the summary of a report of findings from research mapping therapeutic services available to children and young people (0 – 18) in Scotland who have been sexually abused. Key findings from the study are listed below:

2 HEADLINE FINDINGS

- 134 services were identified in Scotland as able to provide a therapeutic service to children and young people who have been sexually abused
- Specialist services to children and young people who have been sexually abused account for a low proportion of the services identified. Across Scotland, seven services of this nature were identified
- Most of the services (82) available to children and young people who have been sexually abused are not specialist post-sexual abuse services, rather, they are services whose main focus is to address a range of emotional and mental health issues
- Children and young people are most frequently referred by social work, health, education or other agencies; self referrals are only common in the voluntary sector

- Services reported using more than 40 different therapies/approaches to work with children and young people who have been sexually abused; it is unclear whether different approaches are offered as part of a staged, integrated approach to meeting the needs of children and young people who have been sexually abused
- Most staff working in services for children and young people who have been sexually abused are professionally qualified; counselling, nursing and social work qualifications are most common
- Services exist for children and young people who have been sexually abused and have additional support needs. However, these are patchily provided. There is little evidence of a strategic approach to meeting the needs of children and young people who have been sexually abused who also have additional support needs
- Giving priority to those children and young people whose needs are judged to be the greatest is one of a range of strategies used to manage demand
- Two fifths of the sample (and two thirds of the voluntary sector services) reported that the need for services was not reflected in demand
- In some cases demand for service was managed by not promoting the service
- Despite in many cases, demand for services being actively managed, more than two thirds of services reported being unable to meet current levels of demand
- Funding for health based services is generally secure; funding for services provided by the voluntary sector is less secure.

3 AIMS OF THE STUDY

The specific aims of the study were to:

- Map the availability of therapeutic services for children and young people who have been sexually abused, raped or sexually exploited
- Evaluate the accessibility and approachability of services to children and young people
- Consider the provision of services in relation to the identifiable demand and need
- Consult with professionals working in therapeutic services about the accessibility of services, interagency working and how to deal with any areas of unmet need.

4 POLICY CONTEXT

Scotland has had a national strategy to address the needs of adult survivors of childhood sexual abuse since 2005. The Scottish Executive Strategy for Survivors of Childhood Sexual Abuse (Scottish Executive, 2005) aims to ‘consider the care needs of people who had survived childhood sexual abuse’ and to ‘redress some of the inadequacies within existing services, and to deliver improved help and support for survivors.’ The strategy recognised the contribution of the voluntary sector to work in this area, but noted that services were often provided by projects primarily established to deal with other areas e.g. rape and domestic abuse. It outlined the need for an integrated approach to meeting the needs of adult survivors of childhood sexual abuse.

The strategy for adult survivors of childhood sexual abuse does not explicitly and directly address the needs of children and young people where sexual abuse is current or has recently occurred who

have been sexually abused. This is in contrast to Scotland’s national strategic approach to addressing the problem of domestic abuse (Scottish Executive, 2000). This contains within it, a separate strategy to meet the needs of children and young people experiencing and affected by domestic abuse. The National Domestic Abuse Delivery Plan for Children and Young People was published in 2008.

5 METHODOLOGY

The research consisted of an initial phase of work to identify all relevant services; 134 services were identified, contacted and key data collected. Phase 1 telephone interviews were with service managers and practitioners in relation to 84 of the 134 services. Phase 2 comprised in-depth interviews with 9 service managers, practitioners and commissioners of services in different sectors.

This is summarised in Table 1 and discussed in more detail below.

Table 1: Summary research design

	Initial Phase Service identification and collection of core data	Phase 1: Interviews to collect quantitative data Service managers and practitioners	Phase 2 (a) Qualitative interviews Practitioners/Managers	Phase 2 (b) Qualitative interviews Service Commissioners
Vol Sect	63	49	2	0
Health	61	27	1	1
SW	7	5	2	2
Partnership	3	3	1	0
Totals	134	84	6	3

6 CHARACTERISTICS OF SERVICES

The mapping research examined the settings and services in Scotland where children and young people who have been sexually abused may be referred, or refer themselves, for therapeutic support. The table below sets out the sector in which services were based and type of services.

Table 2: Service type BY Sector

		Tot		Health		Vol Sector		SW		Prtnrshp	
		%	n	%	n	%	n	%	n	%	n
Service type	Total	100%	134	100%	61	100%	63	100%	7	100%	3
	Specialist post CSA	23%	31	2%	1	41%	26	43%	3	33%	1
	Specialist post Abuse/trauma	14%	19	3%	2	24%	15	14%	1	33%	1
	Gen Emotional/Mental health	61%	82	95%	58	32%	20	43%	3	33%	1
	Sexual exploitation	1%	2	0%	0	3%	2	0%	0	0%	0

Specialist services to children and young people who have been sexually abused account for a low proportion of the services identified. Most of the services (82) available to children and young

people who have been sexually abused are not specialist post-sexual abuse services, rather, they are services whose main focus is to address a range of emotional and mental health issues.

In all, 134 services were identified. 63 were provided by the voluntary sector. 61 were based in health (all but one of these was a Child and Adolescent Mental Health Service (CAMHS)). 7 were social work services and 3 were services working in partnership between different sectors. The type of service provided varied widely according to sector.

50 (of 134) specialist abuse services were identified. 31 were specialist post-sexual abuse services and 19 were specialist post-abuse/trauma services.

There were only seven (of 31) specialist post-sex abuse services specifically for children and young people. The rest (24 services) were adult focussed services who accepted children and young people as young adults: mainly in the 16- 18 age range; and sometimes children as young as 12. 15 of these services were women only services; 9 of these were rape crisis type services.

82 (of 134) were services addressing a range of emotional or mental health issues who, as part of their remit were able to provide support to children and young people who have been sexually abused. 58 were Child and Adolescent Mental Health Services (CAMHS), available to children and young people who have been sexually abused, and who also have a demonstrated mental health concern. 20 were general counselling services in the voluntary sector.

Relatively few services (3) were social work services providing specialist support directly to this group of children and young people. Local authorities tend to channel monies for such services via the voluntary sector.

Some form of therapeutic support was identified within all Health Board areas in Scotland; with numbers of services ranging from 2 in 3 Health Board areas, to 45 in Greater Glasgow and Clyde.

7 REFERRAL AND ASSESSMENT

Information was gathered about the assessment and referral pathways travelled by children and young people in order to access a service. As expected, referral sources for the Health/CAMHS services were from health and other professional sources. Voluntary sector referral sources were from a wider range of professionals. The majority of services able to accept self-referrals from children and young people were based in the voluntary sector. Information gathered about this demonstrated the key role played by social work in identifying and referring children and young people who have been sexually abused to specialist voluntary sector services.

Referral routes were complex. The adult focussed post-sex abuse or post-abuse/trauma services were mainly accessible on the basis of self-identified need. For the others, children were accepted for service following careful assessment of need; sometimes by both referring and accepting agencies. Others highlighted that because of the complexity of the issue of child sex abuse, referral and assessment decisions too were complex. Some argued for the need for careful assessment, with some flexibility built into the process

In some areas, respondents valued the availability of different kinds of services; providing the possibility of choice for children and young people and for referrers; with children and young people able to self refer to some services; while a social work or other professionals referral was required in others. Areas differed in the extent to which local services were linked and strategically organised.

8 THERAPIES AND APPROACHES TO WORK WITH CHILDREN AND YOUNG PEOPLE

In practice, service managers and practitioners named a wide and eclectic range of models of therapy and therapeutic approaches to work. In all, more than 40 different therapies and approaches were reported. This varied by sector. Practitioners in the voluntary sector tended to use ‘counselling’ and ‘person centred’ approaches; and to describe themselves as providing ‘emotional support’, ‘empowerment’ models. There was a high use of ‘creative therapies.’ Health reported more use of specialist therapies such as ‘Cognitive Behavioural Therapy’ (CBT), ‘Family Therapy’, ‘Psychodynamic approaches’ and approaches such as ‘EMDR’. The extent to which the array of available therapies and approaches are effective and strategically offered as part of a staged, integrated approach to meeting the needs of children and young people who have been sexually abused is unclear.

9 PROFESSIONS AND QUALIFICATIONS OF STAFF

The vast majority of staff across all sectors (183.3 of 208.6) held a professional qualification. Respondents mentioned more than 10 different qualifications; counselling, social work and nursing were most frequently named. Numbers of non-professionally qualified staff were low (9). There were 49.5 volunteers. Many of them were experienced and qualified, some using their volunteering to work towards a qualification.

10 CAPACITY TO MEET ADDITIONAL SUPPORT NEEDS

Some services exist for children and young people who have been sexually abused and who also have additional support needs. However, provision is patchy; and respondents’ views were mixed about the capacity of services to provide support to children and young people who have been sexually abused and who have other specific needs.

Table 3: Main client group BY Service type

Main client group	Service type									
	Tot		Spec P-CSA		Spec PA/Trauma		Gen Emot/MH		Sex exploitn	
	%	N	%	n	%	n	%	n	%	n
Total	100%	131	100%	30	100%	19	100%	80	100%	2
Non-specific CG	43%	56	80%	24	74%	14	23%	18	0%	0
Mental Health (MH)	37%	48	3%	1	5%	1	58%	46	0%	0
LAAC and MH	4%	5	0%	0	0%	0	6%	5	0%	0
Learning Difficulties and MH	2%	3	0%	0	0%	0	4%	3	0%	0

Vulnerable and MH	1%	1	0%	0	0%	0	1%	1	0%	0
SW involve/CP concerns	4%	5	7%	2	16%	3	0%	0	0%	0
LAAC/At risk of LAAC	1%	1	0%	0	0%	0	1%	1	0%	0
Risk sex exploitation	2%	3	0%	0	0%	0	1%	1	100%	2
BME	2%	3	0%	0	0%	0	4%	3	0%	0
Housing	2%	3	10%	3	0%	0	0%	0	0%	0
Asylum seek/refugee and MH	1%	1	0%	0	5%	1	0%	0	0%	0
Gay and bisexual	1%	1	0%	0	0%	0	1%	1	0%	0
Care leavers	1%	1	0%	0	0%	0	1%	1	0%	0

Some felt their services were well equipped to meet other categories of need. Others described initiatives at the level of individual practice. Some seemed equipped to meet some needs, (for example, disability), but not others (for example, children from BME backgrounds). Some were candid about gaps; recognising services were not well equipped to meet additional needs.

It was recognised that while specialist post-sex abuse services were able to address child sexual abuse, they may be less well equipped to meet the needs of a young person who also had additional needs; and specialist services for children with specific needs may be less able to adequately address child sexual abuse.

There was little evidence of an integrated, strategic approach to how best to meet the needs of children who had been sexually abused who had additional support needs.

11 CAPACITY TO MEET DEMAND

The picture of capacity of services to meet demand is mixed. Around two thirds of reporting services said they felt unable to meet current demand.

With regard to waiting lists and waiting time, this varied widely. Children and young people faced widely differing lengths of waiting times for services. This varied with sector and type of service received. Waiting times of 2 to 4 weeks and 6 to 12 months were reported. While some practitioners seemed relatively unburdened by waiting lists and waiting times, others reported a constant ‘juggling’ and prioritising of cases. Health services in the sample reported longer waiting times than voluntary sector services.

The issue of capacity to meet demand is complex. Respondents were clear that meeting demand does not necessarily mean ‘meeting need’. Many made a clear distinction between demand for services and potential or ‘latent’ demand. While current waiting lists and waiting times may seem manageable, various methods were in use to manage and sometimes limit demand.

Some services reported managing demand on the basis of acute need. Priority was given to those whose needs were judged to be greatest or who seemed to have the most significant difficulties. Sometimes children and young people who were perceived to have other sources of support were given a lower priority. The behaviour of a child or the severity of the abuse was sometimes taken

into account. There was some information to suggest that in the context of longer waiting lists of 6 to 12 months, some professionals were informally not referring to some services.

In the other direction, prioritising those judged to be in the greatest need could conflict with other pressures on the service, with some evidence that while children and young people would normally be prioritised according to need, sometimes those judged to be in less acute need, whose cases could be concluded more quickly, would be prioritised in order to increase turnover and reduce waiting lists. In some services, waiting lists were closed when certain thresholds were reached.

A contrasting approach was also reported. Here children and young people were seen on a 'first come first served' basis; ensuring that even when a child's level of need was not overt ('the quiet ones') they were not given lower priority status.

Respondents were aware of the difficulties for children and young people of long waiting times for service. This was mainly expressed with regard to concerns about safety and the wellbeing of children and young people in the intervening period.

Some services reported managing demand by intentionally not promoting awareness of their service; maintaining an artificially low demand for service. They believed that a greater awareness of the service may generate an increase in demand that could not be met. Despite this however, a large majority reported being unable to meet current demand.

This strategy was based on the perceived negative consequences of unmanageable demand and maintained an artificially low level of demand. However, the consequence of this is that children and young people do not receive a needed service; in practice children and young people and families who lack the knowledge and confidence to seek services out are more likely to be excluded by this approach. While some of the most vulnerable families may be in contact with professionals who are in a position to make a referral, it cannot be assumed that all relevant professionals are aware of available services.

Asked about the opening hours and opening times of services to gauge whether these were at times which maximised opportunities for children and young people to attend, most services appreciated the complexities of organising sessions at times that suited children, and their parents who may need to accompany them. Sometimes these demands were competing. There were pros and cons of children attending for appointment during the school day in terms of missing schooling and perhaps feeling stigmatised. On the other hand children may be too tired to engage if appointments were at the end of the school day.

Practitioners identified the challenge of providing effective services to children and young people in rural areas.

Some information exists to suggest that the availability of service was limited or modified for children and young people where there was an impending legal case. Almost a quarter of those interviewed said a legal case might affect the content and/or the timing of therapy. In some cases, therapy would not be provided at all; in others, emotional difficulties would be addressed but details

of abuse avoided. In other cases, practitioners were clear that children’s need for therapy would take precedence over a court case. This is an area where more guidance may be appreciated.

12 FUNDING

Funding for Health/CAMHS services was relatively secure. Voluntary sector funding for these services came from multiple sources including, social work, central government, grant giving bodies, and general fundraising. Voluntary sector respondents raised serious concerns about the insecurity and ad hoc nature of funding for these services.

Table 4: Security of funding

Time funding secure	Health	Vol Sect	SW	Partnership	Total
< 1 year	1	34	0	2	37
1 year	3	2	0	0	5
2 years	0	3	0	0	3
3 years	1	7	0	1	9
Indefinite	12	4	5	0	21

The majority of voluntary sector services reported at least one funding source that was secure for less than the current financial year. For many, the task of securing on-going funds was onerous and time consuming. The short term nature of funding brought attendant difficulties of recruiting and retaining staff; and for future planning. There were inevitable knock-on effects on clients; funding uncertainty made committing to long term therapeutic relationships with clients problematic.

Concern was expressed that the new concordat between central and local government in Scotland and reduction in special ring-fenced funds may make already insecure funding arrangements, more uncertain.

Many felt that while the case for the need for specialist services to support children and young people who had been sexually abused had been generally accepted; funding to make it possible was lacking.

While Scotland does now have a national strategic approach to addressing the needs of adult survivors of child sexual abuse; it does not yet have a parallel, national approach to addressing the needs of children and young people where sexual abuse is current or has recently occurred. Respondents in this study highlighted the importance of early intervention and of providing a therapeutic service at the earliest possible stage. Consideration could be given to the development of a national strategy for children and young people who have been sexually abused.

APPENDIX 1: SOURCES AND DIRECTORIES

The appendix below lists sources used to identify services offering therapeutic support to children and young people who have been sexually abused:

- Women’s Support Project, which produced a Scotland-wide ‘Register of Services on Violence and Abuse’ in 2004
- Glasgow Violence against Women Partnership, which publishes comprehensive online information on relevant services in Glasgow, including a list of counselling services, psychological therapies and other support available to asylum seeker women and young children
- Roshni – an organisation raising awareness of child abuse within the black and ethnic minority communities and promoting access to support services for children, young people and adult survivors of abuse – which produced an online service directory for Scotland (Roshni, 2008)
- The National Association for People Abused in Childhood, which provides an online directory of support services/organisations in Scotland (NACAP, 2008); and
- Survivor Scotland, a Scottish Government website for adult survivors of childhood sexual abuse, which also lists support services throughout Scotland.

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For further information about the research contact:

CLiCP - The University of Edinburgh/NSPCC Centre
for UK-wide Learning in Child Protection
Paterson's Land
The Moray House School of Education
University of Edinburgh
Holyrood Rd
Edinburgh EH8 8AQ
Tel 0131 651 6378
Email A.Stafford@ed.ac.uk



The University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection (CLiCP)
The University of Edinburgh, Moray House School of Education, Paterson's Land, Holyrood Road, Edinburgh, EH8 8AQ
Tel: 0131 651 6551 Fax: 0131 651 6088 Website: www.clcp.ed.ac.uk