Centre of expertise on child sexual abuse

Support matters

The landscape of child sexual abuse support services in England and Wales

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About the Centre of expertise on child sexual abuse

The CSA Centre's overall aim is to reduce the impact of child sexual abuse through improved prevention and better response, so that children can live free from the threat and harm of sexual abuse.

We are a multi-disciplinary team, funded by the Home Office and hosted by Barnardo's, working closely with key partners from academic institutions, local authorities, health, education, police and the voluntary sector. We aim to:

- increase the priority given to child sexual abuse, by improving understanding of its scale and nature
- improve identification of and response to all children and young people who have experienced sexual abuse
- enable more effective disruption and prevention of child sexual abuse, through better understanding of sexually abusive behaviour/perpetration.

We seek to bring about these changes by:

- producing and sharing information about the scale and nature of, and response to, child sexual abuse
- addressing gaps in knowledge through sharing research and evidence
- providing training and support for professionals and researchers working in the field
- engaging with and influencing policy.

For more information on our work, please visit our website:
www.csacentre.org.uk

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Foreword

By May Baxter-Thornton, Andy Jeffrey, Sabah Kaiser, Mike Peirce, Kelly Stacey, and others who prefer to remain anonymous

Experts by experience

This new report from the Centre of expertise on child sexual abuse makes it clear there is a desperate need to improve the availability of support services for victims and survivors across England and Wales. Victims and survivors of child sexual abuse, both children and adults, deserve appropriate support for their needs, at the time they need it most. For far too long, our voices have been disbelieved, discounted, or ignored. Now we have evidence-based research which highlights gaps in support and clearly makes the case for long-term, sustainable funding of support services.

We know of so many victims and survivors who are struggling to find the help that they need. The online landscape for them is so convoluted and confusing, particularly when it comes to finding free trauma therapy, support groups and fellow survivors to reach out to in a safe environment. Even though there is now far more awareness of child sexual abuse and its impact, the numbers of those seeking support have grown exponentially, meaning that waiting lists have grown as demand outstrips resources. Alongside this, the scale of child sexual abuse seems to be increasing, and this report shows the vast number of victims and survivors unable to get support due to the lack of services in their region.

Victims and survivors need support as soon as possible so they can process and deal with their sexual abuse, and go on and live a fulfilled life in terms of their education, relationships, work and family life. Appropriate support can give them back the power and control that was taken away, enriching their self-worth and confidence and allowing them to thrive in spite of what has happened to them. Here one of us describes the difference that receiving that support, even long after the abuse took place, can make – if it can be accessed:

"I attempted to end my life three times between the ages of 14 and 17. Despite this, there were no social workers involved, and my parents didn't have any support offered. Nobody asked anything. Somehow my friendship group found out that I had been in hospital, and when I returned to school they said they could no longer remain friends as they were angry with me because I was selfish. I was just viewed as a selfish, manipulative teenager. I don't blame my school friends or my parents as they didn't have any support or information and society had words for girls like me, the first abuse was before I became a teenager. As I had no services involved, and I was so ashamed and isolated, it heightened my vulnerabilities to further abuse and I was re-victimised…

"I still live daily with the impacts of trauma. Last year, I accessed 24 sessions of telephone counselling through a Rape Crisis centre. The counsellor was so professional, warm, understood attachment and, I think, got me. By the end of the 24 sessions, I had just started to build some trust and connect a little. Although the sessions have ended, I have been able to refer back to see the same counsellor; however, due to lack of funding and capacity there will probably be 18 months to wait. For people like me, intergenerational trauma and multiple episodes of childhood abuse have interfered with the development of the relate/regulate sections of the brain. Growing older doesn't rectify this. Mental health and relationships continue to be affected into adulthood and vulnerabilities remain high."

The lack of support for families and parents is also a huge concern. How can a parent know how to support their child if they don't have access to support themselves? To support a child after they've suffered sexual abuse takes a lot of understanding and patience at a time when the parent is dealing with a huge amount of trauma themselves. Support is also needed for siblings within the household who will witness the effects of the sexual abuse, such as aggressive outbursts, post-traumatic stress disorder, eating disorders, substance abuse and mental health issues. Support for parents and families is vital in the healing of the victim. This is not a problem that is just going to go away, and the key implications in this report highlight exactly what is needed moving forward to help victims of child sexual abuse become survivors.

The release of this report marks a significant milestone in the effort to better understand and improve the provision of support services for those affected by child sexual abuse in England and Wales. The research undertaken by the Centre of expertise on child sexual abuse is both timely and crucial, and this report serves as a call to action. It bears witness to victims' and survivors' resilience, service providers' dedication, and the pressing need for change. We must work together to ensure that no victim or survivor is left waiting for support and that all of them, regardless of their background, receive the care and attention they deserve. Let us move forward with empathy, compassion, and a commitment to making a lasting difference in the lives of victims, survivors and their families. As another of us concludes:

> "Helping a victim of child sexual abuse means delivering help when they are ready to reach out, not six or 12 months later as many services do today. I was able to access one-to-one counselling within five days of disclosure. It literally saved my life. Nothing more needs to be said."

> This report bears witness to service providers' dedication and the pressing need for change

Executive summary

This report presents the findings from a research study to better understand the provision and availability of support in England and Wales for people affected by child sexual abuse.

As well as illustrating the breadth and diversity of that support, and of the services providing it, the report reveals significant gaps in the support available to victims/survivors and their families.

By exploring the challenges that services face in relation to meeting demand, securing funding, and recruiting and retaining staff, the report highlights the precarious environment in which many of them operate – and recommends how policymakers, funders and commissioners of child sexual abuse support can address this.

Key findings

Our study identified a wide range of dedicated and committed services providing support to victims/survivors and their families through a diverse and often innovative delivery offer. Yet it is also clear that this falls a long way short of meeting the need for support, and that many services are on a precarious and uncertain financial footing.

A 'postcode lottery' is evident in terms of the likelihood that a victim/survivor can access support that meets their needs, although there is shortage everywhere.

- We identified 468 services supporting victims/survivors of child sexual abuse and their families in England and Wales. Four-fifths of them were in the not-for-profit sector.
- Services were scarce relative to demand and need, with huge geographical variation: in each region, we estimated that there were between 10,000 and 20,000 victims/survivors for every service providing support.
- Fewer than a quarter of services were operating across multiple regions, and most had limited capacity: almost half had supported fewer than 100 people in relation to child sexual abuse during 2021/22.
- There were slightly more services for children – mainly older children – than for adult victims/survivors, but an apparent lack of services supporting parents of sexually abused children. One in seven services was focused primarily on the needs of women/girls, with far fewer focused on boys/men or on minority ethnic groups.
- Half of services – and two-thirds of those in the not-for-profit sector – told us they could not keep up with demand. As a result, we calculated there were around 55,000 people on waiting lists to access support. More than half of these lists were over six months long, and one in nine was longer than a year. Services were also having to limit the amount of support that their users could access.
- Nine out of 10 services in the not-for-profit sector said they faced challenges around their funding, often because of the short-term nature of grants and contracts; only a third were fully confident that they could sustain their service at current levels into the next financial year. A lack of funding, along with demand pressures, was felt to hinder efforts to increase services' reach to a more diverse range of people.
- Many services described challenges in maintaining sufficient resources – particularly in terms of recruiting and retaining staff – to support victims/survivors and their families.

Implications of the research

For the response to victims/survivors of child sexual abuse (including the hundreds of thousands of children and adults not currently receiving any support) to be effective, the support available has to be **sufficient, appropriate** and **accessible** – but we found that these fundamental elements are not currently in place.

There is both a humane and an economic case for greater and more considered investment to sustain and support existing service provision, and to enable an expansion in provision for both child and adult victims/survivors and their families. We have identified six priorities for policymakers, funders and commissioners:

1. **Ensure sufficient funding for services to maintain their current provision and provide timely support.**
   This should include unrestricted, multi-year funding, enabling services to provide support which meets service users' needs at the time they need it; services should not have to be operating with lengthy waiting lists.
2. **Working closely with services, provide funding that enables them to expand and develop, so they can meet the diverse needs of their existing service users and new user groups.**
   This funding might be used by services to extend their reach; to design, develop and evaluate new support, with the involvement of their service users; and to explore different models of support, so they can adapt to service users' individual needs.
3. **Provide funding and support in relation to services' infrastructure.**
   This would enable services to improve their data collection systems and analysis; support and work in cooperation with other professionals, without reducing the support they provide to their own service users; develop and share quality and impact assessment frameworks and tools; and develop and share learning and practice around service user engagement and consultation.
4. **Provide funding to support the appropriate training and upskilling of professionals, whether they work in specialist support services or in the wider professional network.**
   Specialist professionals need training to keep up to date and develop their skills in areas such as different forms of child sexual abuse and ways to support children. Also, given the central role played by non-specialist professionals in statutory agencies when concerns about child sexual abuse arise, training for them is urgently required so there can be an effective, joined-up response to children and adults affected by that abuse.
5. **Commission research into specific groups' support needs and access to services.**
   This research would be particularly beneficial in relation to boys, physically disabled children, and children and adults from minority ethnic backgrounds.
6. **Enhance funders' and commissioners' own expertise in funding child sexual abuse support services effectively.**
   This could include access to information and guidance, training, and resources to support funders and commissioners in carrying out informed needs assessments.

Implications for services, and for all agencies and partnerships involved in the response to child sexual abuse, included the following:

- Statutory agencies in particular should not close cases before support from other services has commenced; this will avoid victims/survivors being left with no support. They should also consider providing funding for not-for-profit services to which they make referrals.
- Services should be included in local networks and partnerships, especially Local Safeguarding Children Partnerships/Boards, and have opportunities to come together regionally and nationally.

About the research

The research, carried out by the Centre of expertise on child sexual abuse (CSA Centre) between July 2022 and April 2023, began with a mapping exercise which identified **468 services in England and Wales** providing therapeutic or wellbeing-focused support to victims/survivors of child sexual abuse, and/or their families. We then contacted all these services, inviting each of them to participate in an online interview; a total of 166 services were interviewed.

The mapping encompassed all services supporting victims/survivors of child sexual abuse – both children and adults – and/or their family members, provided the support was offered free of charge and had a therapeutic or wellbeing focus.

In addition to services focused solely on responding to child sexual abuse, it covered services in the sexual violence sector whose remit included child sexual abuse (such as Rape Crisis centres), and services with a wider remit which included child sexual abuse – for example, services focused on trafficking, child criminal exploitation or domestic abuse, where support around sexual abuse could be provided where relevant.

What do support services look like?

Of the 468 services we identified:

- one-fifth were focused solely on supporting victims/survivors of child sexual abuse and/or their family members
- nearly a quarter operated in the sexual violence sector
- almost three-fifths had a wider remit.

Services in the **not-for-profit** sector – almost all of them charities – made up 81% of the total. They included Rape Crisis centres, rape and sexual abuse centres, Women's Centres, Women's Rights Centres, counselling services, victim support services and survivor-led services.

A further 5% were in the **private** sector, mainly based in universities or providing residential care.

The 14% of services in the **statutory** sector were part of the NHS, local authorities or the criminal justice system.

More than half of services were operating across fewer than 10 local authorities within **a single region**. In contrast, one-fifth were operating across **the whole of England and/or Wales**; almost all national services were in the not-for-profit sector.

Four-fifths of services provided support for **children**, and very slightly fewer supported **adults** (whether they were victims/survivors of child sexual abuse, parents of sexually abused children, and/or otherwise affected by sexual abuse).

Fewer than a quarter of services provided support mainly or exclusively to groups with particular characteristics – mostly to **girls/women** or people from **minority ethnic backgrounds**. One in six provided support specifically around **child sexual exploitation**, but few focused on other forms of child sexual abuse.

Two-thirds of the services we interviewed had been providing support in response to child sexual abuse for **more than 10 years**.

What support is available?

Services provided five main types of support, with two-thirds offering multiple types:

- Three-quarters of services were providing one-to-one **therapy, counselling or emotional support** to children, adults or family members affected by child sexual abuse.
- More than half offered one-to-one **advocacy, casework or support** from Independent Sexual Violence Advisors (ISVAs) or Child Independent Sexual Violence Advisors (ChISVAs).
- Nearly half offered **group-based** interventions.
- Nearly a third provided a **helpline or chat service**.
- A small proportion provided **residential care**.

Support was most commonly available to **adults and older children** aged 13+; there was much less direct support for under-10s. While most support was available to both sexes, a quarter of group-based interventions were solely for women or girls. Very few services were specifically for particular ethnic or faith groups.

While services said they tried to be flexible, one-to-one and group support was commonly offered only during **weekday office hours** – only one in nine one-to-one therapeutic interventions was available at weekends – and was often **time-limited**.

Who is supported?

Almost half of the services we interviewed told us that, in 2021/22, they had supported **fewer than 100 people** affected by child sexual abuse. A small minority, mainly in the not-for-profit sector, had supported thousands of children and adults during the year.

More than half of services supporting children, and two-thirds of those supporting adults, estimated that at least 75% of their service users in 2021/22 were **women and/or girls**.

Services were keen to improve their **response to under-represented groups**, and said they had supported an increasingly diverse range of people in recent years – but one in six estimated that people from **minority ethnic backgrounds** made up fewer than 5% of their service users. Physically disabled children were also particularly under-represented; in contrast; most services supporting children estimated that at least 10% of their child service users had **learning disabilities/difficulties**.

> Services told us they had supported an increasingly diverse range of people in recent years

Gaps in provision

Services were scarce across England and Wales. By comparing the number of services with the estimated number of child sexual abuse victims/survivors in each region, we found that thousands of people were likely to be living with the impacts of child sexual abuse for every service available to support them. In each region, there were **between 2,500 and 5,000 child victims/survivors** – and **between 10,000 and 23,000 adult victims/survivors** – for every service supporting those age groups.

The overall ratio of victims/survivors to services ranged from **10,000:1 in Wales to 20,000:1 in the West Midlands**.

Nearly two-thirds of services supporting children **did not appear to offer any support to their parents.**

There were also major gaps in provision for people affected by specific forms of child sexual abuse, particularly **intra-familial abuse** and **abuse in online contexts**, and for people with specific characteristics. Very few services outside London – and none in the South East or South West – were focused on supporting people from **minority ethnic backgrounds**, and services dedicated to **men/boys** affected by child sexual abuse were scarce in all regions. Services said they wanted to improve their reach to both groups.

Waiting lists

Only half of the services we interviewed – and barely a third of not-for-profit services and those focused on sexual violence – felt able to **meet the demand** for support. This was deterring some from promoting themselves.

Three-quarters of interviewed services in the not-for-profit sector, and almost half of statutory services, were operating a **waiting list** for people seeking support; each list contained 180 people on average, from which we estimate that around **55,000 people** in England and Wales were on waiting lists to access support in response to child sexual abuse.

The average time spent on a waiting list was **more than six months**; one in nine lists involved a wait of more than a year.

Many services said their **waiting lists had lengthened** in recent years. Most were providing some sort of interim support to people on their waiting list, from keeping in regular contact to providing access to peer support groups or resources.

Holding waiting lists was also affecting service provision – for example, by **reducing the number of support sessions** that could be offered to each service user. Services also highlighted the negative impact on the **mental health of victims/survivors**, and on children's social relationships and ability to engage with education.

> Three-quarters of services in the not-for-profit sector had a waiting list for people seeking support

Funding of services

Most interviewed services in the not-for-profit sector derived their income from multiple sources: almost three-quarters received **grant-funding**, two-thirds were **commissioned to deliver specific support**, and two-fifths received income through **individual donations**.

In contrast, the statutory services all received their income solely through commissioning.

Many services had also received **uplift funding** in 2021/2022, often related to the COVID-19 pandemic. While they welcomed this additional income, it presented challenges for some – partly because of the short timescales in which it had to be spent.

Some services felt that their funders/commissioners **lacked understanding** around the provision of child sexual abuse support, or **imposed criteria** which made it difficult to respond flexibly to need. Others said their funders/commissioners were **supportive** and took an **active interest** in their work.

Four-fifths of services – and particularly those in the not-for-profit sector – said they were experiencing challenges with their funding, often linked to its **short-term** nature. Nearly two-thirds did not feel fully confident that they could sustain their existing service provision into the next financial year. Issues identified by not-for-profit services included funding decisions made at short notice, **increased competition** for funding, and an overall **reduction in the funding available**.

Staffing and volunteers

More than half of the interviewed services had **between one and nine full-time equivalent staff** directly providing support around child sexual abuse. Most services with larger numbers of staff had a sexual violence remit.

Recruiting and **retaining staff** was a challenge for the vast majority of services, because of the skills required and the not-for-profit sector's difficulty in offering competitive salaries.

Very few services had no paid staff, but more than half were using **volunteers** to support their service delivery, in roles such as befriending, administrative or technical support, and service promotion. Others said they lacked the resources to manage volunteers or were struggling to recruit them, particularly as a result of the COVID-19 pandemic and the cost-of-living crisis.

Three-quarters of services said their staff and volunteers had **received specific training** around child sexual abuse, but a similar number said they would like more training in this area.

> Four-fifths of services were experiencing challenges with their funding, often linked to its short-term nature

Referrals and other external connections

Most services said they felt **well-connected** to other services and agencies, although it seemed that they were generally not referring to connections with other services providing child sexual abuse support.

Two-thirds of services supporting children were linked into their **Local Safeguarding Children Partnership/Board**; they felt that this helped them understand the risks and types of harm facing local children, feed into safeguarding strategies, and develop positive working relationships.

However, most services said that systems for **receiving incoming referrals** and **making onward referrals** were not always proving effective. Not-for-profit services spoke of statutory agencies closing cases after referring them on, without checking whether the receiving service could provide support within an appropriate timeframe; ineffective multi-agency working, sometimes resulting in inappropriate referrals, was another issue. Other agencies' restrictive referral criteria and high thresholds for accepting cases were identified as challenges for services making onward referrals.

Support for other professionals

Three-quarters of interviewed services were offering **training, advice/guidance, case consultations** and/or other support to other professionals – most commonly, to those in schools, the not-for-profit sector, the police and children's social care. Half of these services sometimes **charged** for this support, but very few *always* charged.

More than 70,000 professionals were estimated to have received support in 2021/22. Services said the number had risen in recent years, with some linking this to increased awareness of child sexual abuse among professionals.

While services felt that their support was beneficial in improving professionals' knowledge and confidence to identify and address child sexual abuse, they said it was a challenge to **manage the balance** between this work and directly supporting victims/survivors in the context of limited resources.

Assessment, evaluation and service development

Almost all the services we interviewed were assessing and evaluating the **quality and impact of their service provision** in some formal way, and more than a third had signed up to or were in the process of signing up to quality standards.

However, developing and implementing effective assessment and evaluation systems required resources, and many services told us they would appreciate support in this area.

Four-fifths of services formally **involved service users** in the design and delivery of service provision, often through consultation groups or panels. Again, many said they wanted support with this.

Two-thirds had **expanded their provision** in recent years, and four-fifths were considering ways to develop it further. Although the COVID-19 pandemic had increased levels of complex need and trauma among service users, and increased delays in the criminal justice system, it had also led to an injection – albeit short-term – of funding into the sector, allowing services to increase in size or scope.

Factors contributing to effective support

Services highlighted the importance of providing support that was **flexible** and **tailored to individual needs**, delivered by **highly skilled, compassionate and committed staff**.

Service **accessibility** was also highlighted; most services said they took steps to make themselves accessible, most commonly by addressing **language and cultural barriers**, and improving access for **physically disabled people**.

1. Introduction

In May 2022, the Centre of expertise on child sexual abuse (CSA Centre) launched its 'Strengthening Services for Victims and Survivors' programme. At its heart, this programme aims to enable children and adults who are victims/survivors of child sexual abuse and their families to access services that promote safety and encourage healing and recovery. The programme's key aims are to:

- increase the strength and resilience of services supporting victims/survivors of child sexual abuse and their families
- support national governments, funders and commissioners to commission services effectively on the basis of a better knowledge of need
- help service provision keep pace with the needs of victims/survivors of child sexual abuse and their families.

As part of this work, we set out to map the support available to victims/survivors of child sexual abuse and their families across England and Wales, in order to understand what support is being provided and by whom. This report presents the findings from that research. It describes the availability – and lack of availability – of support for victims/survivors and their families, revealing both the breadth and the diversity of existing support services as well as the gaps in provision and some of the challenges faced by those providing support.

1.1 Background to the research

The CSA Centre estimates that at least 15% of girls and 5% of boys are sexually abused before the age of 16 (Karsna and Kelly, 2021). Our most recent analysis of agency data found that there was a 15% increase between 2020/21 and 2021/22 in local authorities' recording of concerns of children being sexually abused, mirrored by a 15% rise in child sexual abuse offences recorded by the police (Karsna and Bromley, 2023). Despite these increases in agencies' identification of concerns of child sexual abuse, we know that a far greater number of children experiencing sexual abuse are never identified by or report their abuse to police or children's social care.

Being able to access support, as a child or an adult, is crucial to mitigating the adverse impacts of child sexual abuse (Truth Project, 2022). Being sexually abused as a child can have both immediate and longer-term impacts, particularly in terms of mental and physical health, relationships and educational attainment; it can adversely affect wellbeing, employment and income across the life course. Non-abusing parents, siblings and other family members may also be significantly affected by the abuse. Our ***Key Messages from Research on the Impacts of Child Sexual Abuse*** (Vera-Gray, 2023) provides more information, and highlights how support from services can reduce long-term adverse impacts for both children and adults.

However, previous work by the CSA Centre has shown that services providing specialist support to victims/survivors of child sexual abuse cannot keep pace with demand (Parkinson and Sullivan, 2019), and that provision varies widely depending on funding available in local areas (Scott, 2023). Additionally, some groups of victims/survivors, such as those who are younger, Black or Asian, disabled, or care-experienced, have needs which are also not sufficiently met in many areas (Ali et al, 2021; Franklin et al, 2019). Mapping studies have found a lack of sufficient support for children who have been sexually abused (Allnock et al, 2009 and 2015; Butterworth et al, 2020), and the All-Party Parliamentary Group for Adult Survivors of Childhood Sexual Abuse has noted the lack of support for adult victims/survivors (APPG, 2020).

It is difficult to know what support is available, for whom and where. Directories such as those provided by the **Survivors Trust**, **Rape Crisis England and Wales** or the **Male Survivors Partnership** list only the organisations that belong to their networks and depend on those organisations to keep them up to date, while others such as the **Survivor Pathway** and **Sexual Violence Support** websites cover only specific geographical regions. In its final report, the Independent Inquiry into Child Sexual Abuse (IICSA)[1] noted a number of problems encountered by victims/survivors and family members seeking support, particularly around:

- inconsistent signposting and referrals to support services by other professionals
- restrictive eligibility criteria
- variation in the availability of support services both nationally and locally
- the availability of support that is tailored to particular needs
- long waiting lists
- time limits on the amount of support provided.

IICSA's final report (Jay et al, 2022:40) also recognised that many problems experienced by victims/survivors when trying to access support result from "the fragmented and complex funding and commissioning of support services across England and Wales from the public, private and third sectors".

Meanwhile, the need to improve access to support for people affected by child sexual abuse is enshrined in the UK Government's Tackling Child Sexual Abuse Strategy:

> "We will help victims and survivors of recent and non-recent child sexual abuse to rebuild their lives by improving the support available and developing and embedding best practice."
> (Home Office, 2021:8)

The right to access support is a key element of the Victims' Code (Ministry of Justice, 2021) and the National Vulnerability Action Plan, which requires police forces to "*ensure all staff know where and how to access service provision for all strands of vulnerability, especially at the local neighbourhood level*" (National Police Chiefs' Council, 2023:12).

In its final report, IICSA highlighted the gaps in provision of support services for victims, and recommended that UK and Welsh Governments should ensure sufficient provision of specialist therapeutic support for child victims of sexual abuse (Jay et al, 2022).

> Being able to access support, as a child or an adult, is crucial to mitigating the impacts of child sexual abuse

1 IICSA was a statutory inquiry for England and Wales, established in 2015 under the Inquiries Act 2005 and led by Professor Alexis Jay, to investigate how institutions handled their duty of care to protect children from sexual abuse. It published 19 reports on 15 investigations covering a wide range of institutions, with its final report published in October 2022 making a series of recommendations to better protect children from sexual abuse.

1.2 This report

After an explanation of what the research involved, including the strengths and limitations of the approach taken, this report presents the research findings:

- **What services are supporting people affected by child sexual abuse?** – the characteristics of support services and who is providing them.
- **What kinds of support do services provide?** –the range of support that services provide for victims/survivors of child sexual abuse and their family members.
- **Who are services supporting?** – the numbers and characteristics of people being supported by the services we interviewed, and changes in the diversity of service users.
- **Is support widely available?** –gaps in the provision of support for people affected by child sexual abuse, and the groups which services find particularly hard to reach.
- **How quickly can people receive support?** – services' ability to meet the demand for their support, and the consequences (e.g. waiting lists) when they cannot.
- **How are services funded?** – the types and sources of services' funding, and the funding-related challenges that services face.
- **How are services staffed?** – services' staffing levels and use of volunteers, and challenges around recruitment and retention.
- **How well-connected are services?** – services' referral pathways and connections with other agencies, and how well these are working.
- **How do services support other professionals?** – the types and recipients of support provided by services to other professionals, and the demands of providing this support.
- **How do services assess, evaluate and develop the support they provide?** – services' activities to strengthen their support provision by assessing service quality/impact and involving their service users, and how this provision has developed in recent years.
- **What enables services to provide effective support?** – services' own view of the key strengths and qualities of the support they provide.

Each of these chapters begins with a short summary of the findings that follow, along with reflections and implications of the findings.

A final chapter draws together the overall research findings and presents **conclusions** emerging from these.

Quotations

The research findings are illustrated with quotations from our interviews with services, which are identified as follows:

- 'NFP' indicates a service in the not-for-profit sector
- 'stat.' indicates a service in the statutory sector
- 'CSA focus' indicates a service solely focused on supporting people affected by child sexual abuse
- 'SV remit' indicates a service with sexual violence remit which included supporting people affected by child sexual abuse
- 'wider remit' indicates a service supporting people affected by child sexual abuse within a wider remit of service provision.

Definitions and terminology

We use the term **'child sexual abuse'** to refer to all forms of abuse, as set out in the UK Government's definition of child sexual abuse:[2]

> "…forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing, and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children."
> (Department for Education, 2023:162)

Child sexual exploitation has been defined as a form of child sexual abuse where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for the financial advantage or increased status of the perpetrator or facilitator (Department for Education, 2023:154).[3]

For the sake of simplicity, and in line with the above definition, we use the term **'child'** to refer to anyone under the age of 18; it is important, however, to remember that adolescents as well as young children can be sexually abused. An exception comes where we are discussing sexual orientation and gender identity, where we refer to 'young people'.

When we refer to a **'service'**, we mean an intervention or group of interventions provided by an organisation for people affected by child sexual abuse. For example, the various helplines provided by the NSPCC have been categorised as individual services, rather than the NSPCC as a whole being categorised as a service.

By **'support'**, we mean a response which focuses on the needs of victims/survivors and non-abusing family members arising from the sexual abuse of children. Services were *not* considered to be providing support around child sexual abuse if they would refer someone disclosing such abuse to another service for support with the impact of this. As explained in more detail in Chapter 2, the support services that we have sought to map and understand are those providing some kind of therapeutic or wellbeing support to victims/survivors and family members affected by child sexual abuse.

In referring to people who were sexually abused as children, we use the term **'victims/survivors'**, in recognition that each individual may regard themselves as a victim, a survivor or a combination of both.

Finally, we use the term **'parent'** to encompass any parent or carer in a parental or principal care-giving role to a child; this may be, for example, the child's biological parent, step-parent, adoptive parent, foster parent or other relative in that role.

> The services that we have sought to map are those providing some kind of therapeutic or wellbeing support

2 In Wales, the national action plan on child sexual abuse (Welsh Government, 2019) has a similar but shorter definition.

3 Again, a different definition is used in Wales (Welsh Government, 2019), but the element of exchange is central.

2. What did the research involve?

This research set out to map the support available to victims/survivors of child sexual abuse and their families across England and Wales, in order to understand what support is being provided, by whom and where, and to explore current practice. Specifically, it aimed to address the following questions:

- What support services currently exist in England and Wales for victims/survivors of child sexual abuse and their families?
- What are services' strengths, and what challenges are faced by these services?
- How has provision changed in recent times?
- Where are the gaps in service provision across England and Wales, and how does this compare with the need for support?

2.1 Which services were included?

We wanted to include *all* services in England and Wales providing therapeutic or wellbeing support to victims/survivors of child sexual abuse and their families. This included services for:

- children who have been sexually abused
- adults who were sexually abused in childhood
- non-abusing parents and other family members of children who have been sexually abused
- family members of adults who have sexually abused children.

Services could be supporting children only, adults only, or both children and adults. Support to parents and other family members could be provided alongside support to children or separately.

The support provided could relate to any or all forms of child sexual abuse, including both intra- and extra-familial abuse, abuse in online contexts, and abuse in the context of modern slavery and trafficking.

> We were interested in services for children *and* those for adults who were sexually abused in childhood

Provided it had a therapeutic or wellbeing focus, the support could involve a range of activities and approaches including:

- therapy and counselling
- psychoeducative/educative work
- advocacy support, such as from an Independent Sexual Violence Adviser (ISVA) or Child Independent Sexual Violence Adviser (ChISVA)[4]
- peer support
- helplines and chat services
- residential care for victims/survivors of child sexual abuse
- family work/interventions
- support during legal processes.

Support could be provided in person, online or by telephone; could be delivered one-to-one or as a group-based intervention; and could be short-term or long-term.

We wanted to know about all services doing this work, whether they were based in the not-for-profit, statutory or private sectors, or delivered as part of consortia or multi-agency initiatives;[5] this also included survivor-led ("by and for") services. They could be of any size and geographical remit, provided their support was available free of charge to people living in England or Wales.

In addition to services that focused specifically on responding to child sexual abuse, we wanted to include:

- services working in the sexual violence sector whose remit included child sexual abuse (e.g. Rape Crisis centres)
- services with a more generic remit which included child sexual abuse (e.g. services supporting children who have been exploited or trafficked, where support around sexual abuse was provided alongside other exploitation-related support).

We also wanted to know about services providing support for children who have engaged in harmful sexual behaviour, and their families; many of these children may themselves be victims/survivors of child sexual abuse.

We did *not* want to include statutory safeguarding services, or services which:

- focused on the *prevention* of child sexual abuse (e.g. education/awareness-raising programmes, outreach programmes, campaigns or disruption-focused services)
- were for *adults who had sexually harmed children* or feared they might sexually harm children
- *charged* service users for the support provided
- provided *only a medical assessment* without any additional therapeutic/ wellbeing support
- focused specifically on *other forms of abuse* such as female genital mutilation or child criminal exploitation.

We also excluded more generalist services providing support for children or adults with issues affecting their wellbeing or safety, where support related to sexual abuse was not specifically provided as part of this. For example, organisations like MIND or the Samaritans were excluded because their support does not specifically relate to child sexual abuse but responds to a wide range of needs.

> We excluded statutory safeguarding services, and services which focused on *preventing* child sexual abuse

4 Also known as a Child and Young Person's Sexual Violence Adviser (CYPSVA).

5 We use the term 'not-for-profit' to refer to charities, voluntary/community organisations and social enterprises.

2.2 Numbers of services identified and taking part

Full details of our research methodology can be found in Appendix 1.

We used desk research to map service provision across England and Wales, and then contacted all the services we had identified, asking them to take part in an online interview. Interviews were conducted with every service that consented and was available within the timeframe available for this phase of the research. (Some interviews covered multiple services provided by the same organisation from different locations.) Services that were unable or unwilling to be interviewed, or that did not respond to our invitation, were asked by email to check the information we had gathered on them through our desk research, in terms of their geographical remit, service user group, and main types of service provision.

The desk research initially identified 923 potentially relevant services, but 394 of these were subsequently excluded because they did not provide relevant support (n=324), had closed down (n=27) and/or were duplicate entries (n=97).

This left 529 services identified as providing support to people affected by child sexual abuse:

- 468 services providing support to victims/survivors and family members affected by child sexual abuse
- a further 61 services supporting young people who had engaged in harmful sexual behaviour, and their families.

This report focuses primarily on the 468 services supporting victims/survivors and their family members. We were able to make contact with over half of these, and carried out interviews with a third:

- 166 services (35%) took part in an interview.
- 89 services (19%) were not interviewed but responded to our 'check' emails.
- 213 services (46%) were identified through desk research but did not take any active part.

Appendix 2 provides an overview of these 468 services, and compares the profile of those we interviewed or made contact with ('checked') with those that did not participate in the research. Overall, we found that that the profile of the interviewed services was closely representative of the wider sample of services. The exceptions to this were that the interviewed services:

- contained a smaller proportion of services supporting only children
- were more likely to be focused solely on child sexual abuse and less likely to have a wide remit.

The 61 services offering harmful sexual behaviour support services were not the main focus of this report, but findings from analysis of their data are presented in Appendix 3. The participation rate among these services was lower:

- 12 services (20%) took part in an interview.
- 12 services (20%) were not interviewed but responded to our 'check' emails.
- 37 services (61%) were identified through desk research but did not take any active part.

Data from the interviews was collected using SurveyMonkey, and was then downloaded with the other data collected from all 529 services into Excel for analysis. Some of the qualitative data was subsequently exported into a qualitative data analysis software system (NVivo 10, QSR International) for coding and thematic analysis (Braun and Clarke, 2006). The quantitative and qualitative analysis were then brought together to draw out the findings, organised under key themes.

To assess the availability of support across England and Wales for victims/survivors and family members affected by child sexual abuse, we also compared the number of services that we had mapped with the estimated number of victims/survivors of child sexual abuse in each region. These estimates were based on the CSA Centre's assessment that at least 10% of children are sexually abused in England and Wales (Karsna and Kelly, 2021), and that the prevalence of child sexual abuse does not differ significantly between regions (Karsna and Bromley, 2023). This data was then exported into Microsoft Power BI, enabling us to produce maps.

2.3 Limitations of the research

We recognise that there are a number of limitations to our approach, particularly around the extent to which we can generalise our findings:

- The findings are based solely on what services told us, or on the information on their websites. There may have been times when we misunderstood what services said or what information was available, or where participants might have sought to represent their service in a particular light. In addition, service provision can change rapidly – services may make changes in who they support or how they provide their support, for example. This means that we cannot guarantee the accuracy of the information we have collected.
- Although we spent several months identifying and making contact with as many relevant services as possible, it is highly likely that we have not mapped every service that exists. And some of the services we mapped did not respond to our efforts to contact them, so we had to rely on the information available on their websites.
- As well as providing a rich source of information, the immense amount of data we collected also presented a challenge for analysis. Having completed interviews with 178 services, often over an hour long, we had a great volume of both quantitative and qualitative data to analyse. We have, therefore, focused primarily on the quantitative data, using thematic analysis of the qualitative data to fill out understanding whenever possible.
- A further challenge we encountered when analysing service provision was the difficulty of separating out data relating specifically to children and to adults. This is because many services provided support to both groups; while we asked questions specific to each group in some sections of the interviews, other sections asked about service provision generally (in order to not to overburden interviewees), making it impossible to disaggregate the data fully.

While recognising these limitations, we consider that this report provides a unique insight into current service provision for child and adult victims/survivors of child sexual abuse, and their families.

> Our research findings are based solely on what services told us, or on the information on their websites

3. What services are supporting people affected by child sexual abuse?

Our mapping exercise sought to identify services in England and Wales providing support to victims/survivors of child sexual abuse and their families. This chapter describes these services.

Services focused on supporting children who have engaged in harmful sexual behaviour are covered separately in Appendix 3.

Key findings and reflections

1. Support for victims/survivors of child sexual abuse and their families in England and Wales was mainly delivered by not-for-profit services, most of which were long-standing and local/regional in their coverage.
2. Only a fifth of services had child sexual abuse as their sole focus; nearly a quarter provided child sexual abuse support as part of their remit of responding to sexual violence; and more than half had a wider remit such as domestic abuse or child exploitation.
3. While services focused on child sexual abuse are generally believed to be most able to support victims/survivors, generalist services have already been identified as playing a large role in meeting the need for this support (Allnock et al, 2015). Given the current shortage of service provision, these services are important in helping to meet demand, but it is vital that their staff have specific training to support people affected by child sexual abuse.

Implications

The reliance on the not-for-profit sector to provide most support services for victims/survivors and their family members means that funders and commissioners should also look to support the sector as a whole, offering long-term, sustainable funding that does not put not-for-profit services in competition with each other or with statutory-sector services. More funding, including ringfenced funding for child sexual abuse support, would allow services to support more service users and improve their reach across all groups.

In addition, the provision of support around child sexual abuse requires specialist knowledge and skills, and staff in all services should undertake specialist training before providing this support (see also Chapter 9). Funders, commissioners and policymakers should therefore consider how they can support the appropriate training and upskilling of professionals across all sectors to provide effective, joined-up responses to children and adults affected by child sexual abuse.

3.1 Services' remit

Through our mapping exercise (see Chapter 2), we identified a total of 468 services providing support for people affected by child sexual abuse. Figure 1 shows how support around child sexual abuse fitted into these services' activities.

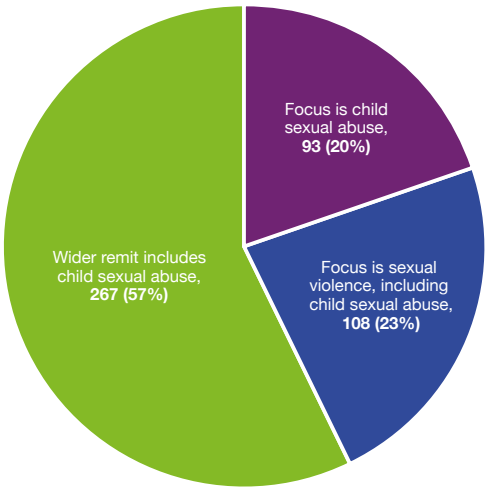
One-fifth of services **focused specifically on supporting victims/survivors of child sexual abuse.** Of these:

- The vast majority (n=76, 82%) were in the not-for-profit sector, but there were also 14 statutory services, two in the private sector and one delivered by a not-for-profit/ statutory partnership.
- A quarter (n=23, 26%) provided specific support for children who had been sexually exploited or were at risk of sexual exploitation, and a quarter (n=23, 25%) supported adult victims/survivors.

Nearly a quarter worked in the **sexual violence** sector, with a remit that included child sexual abuse. This second group included services provided by Rape Crisis centres in the not-for-profit sector and Sexual Assault Referral Centres (SARCs) in the statutory sector, although the latter were included only if they provided therapeutic support alongside medical assessments/examinations.

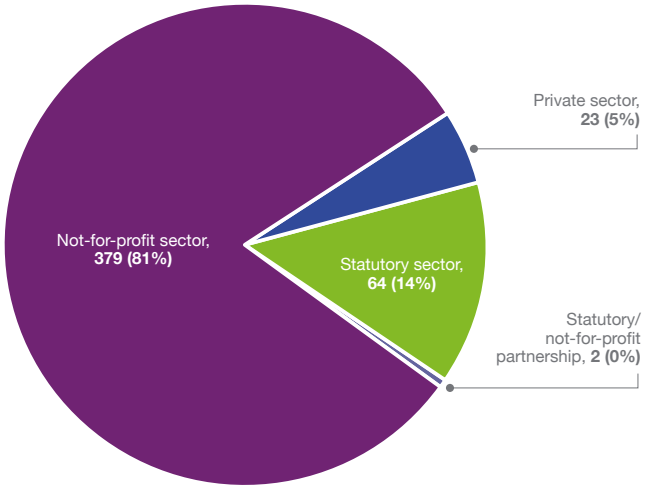
The remaining three-fifths had a **wider remit**, which included but was not focused on support around child sexual abuse. This group included services providing support to children who were being or had been exploited or trafficked; support relating to sexual abuse was one aspect of the support provided, alongside support for other forms of exploitation. It also included services providing support with domestic abuse, where support around child sexual abuse would also be provided where relevant.

Figure 1. Where does child sexual abuse support fit within services' remit?



n=468.

Figure 2. Child sexual abuse support services by sector



n=468.

3.2 Private, statutory or not-for-profit sector?

As Figure 2 shows, four-fifths of services supporting victims/survivors and family members were in the not-for profit sector, while only one in seven was in the statutory sector. A small number of services were delivered by private providers (although free for service users to access), and two were delivered through statutory/not-for-profit partnerships.

3.2.1 Not-for-profit services

Almost all of the 379 not-for-profit services were charities, but this category also included 12 community interest companies and social enterprises.

- Many not-for-profit services were Rape Crisis centres, rape and sexual abuse centres or other kinds of sexual violence support service.[6] Not-for-profit services also included Women's Centres, Women's Rights Centres, counselling services, victim support services and survivor-led services.
- Services provided by Barnardo's represented 10% (n=37) of not-for-profit services. Many were Independent Child Trafficking Guardianship Services, but there were also Barnardo's services responding to children who had experienced or were at risk of sexual exploitation, had been sexually abused in online contexts, or had experienced other forms of child sexual abuse.
- A further 10 services (3%) were provided by the NSPCC.

Reflecting the overall make-up of services (see section 3.1), a fifth of the not-for-profit services (n=76, 20%) focused solely on supporting people affected by child sexual abuse; slightly more (n=84, 22%) were in the sexual violence sector; and three-fifths (n=219, 58%) had a wider remit which included child sexual abuse.

Three-fifths of not-for-profit services (n=234, 62%) supported children *and* adults affected by child sexual abuse. The other two-fifths were split almost equally between those supporting only adults (n=75) or only children (n=70).

A quarter (n=101, 27%) focused their support on specific groups; these included female-only or male-only services, and services with a focus based on ethnicity, disability or sexual orientation/gender identity.

3.2.2 Statutory-sector services

There were 64 services located in the statutory sector.

- Two-thirds (n=42, 66%) were part of the NHS (e.g. SARCs and specialist child and adolescent mental health services (CAMHS)).
- Almost a third (n=19, 30%) were local authority services (e.g. complex safeguarding teams, exploitation teams, and a victim support service).
- The remaining three were criminal justice services providing support to victims of crime.

Compared with those in the not-for-profit sector (see above), services in the statutory sector were slightly more likely to focus solely on child sexual abuse or to have a sexual violence remit; these categories accounted for 22% (n=14) and 30% (n=19) respectively of statutory services, while just under half (n=31, 48%) had a wider remit.

Statutory services were also much less likely than those in the not-for-profit sector to focus their child sexual abuse support solely on adults. Only one-tenth (n=7, 11%) of them did so, with the remainder split equally between those supporting both children and adults (n=29, 45%) and those supporting children only (n=28, 44%).

6 Rape Crisis centres provide free, specialist support and services to women and girls who have experienced rape, child sexual abuse, sexual assault, sexual harassment or any other form of sexual violence. Many also provide support to men and boys.

3.2.3 Private sector services

Only 23 services were delivered by private providers.

- Three-fifths (n=14, 61%) were sexual violence support services based at universities, with sexual harassment and violence advisors or sexual violence liaison officers providing support to students.
- A quarter (n=6, 26%) were residential care services. Four of these provided support nationally across England, one covered England and Wales, and one served a single local authority area. One therapeutic residential care home provided support to girls and young women only. Three private residential services focused on children who had experienced sexual exploitation, another focused on all forms of child sexual abuse, and one had a wider remit that included child sexual abuse; the remaining service had multiple homes providing support to children who had engaged in harmful sexual behaviour, had experienced sexual exploitation, and/or had complex needs due to experience of trauma.
- Of the three other private-sector services:
  - one provided counselling across England and Wales to parents and other adults affected by the sexual abuse of children within cults
  - one provided national support to adult victims/survivors of child sexual abuse in online contexts
  - one, with a remit that included child sexual abuse, provided therapeutic support across multiple regions.

3.3 Geographical coverage

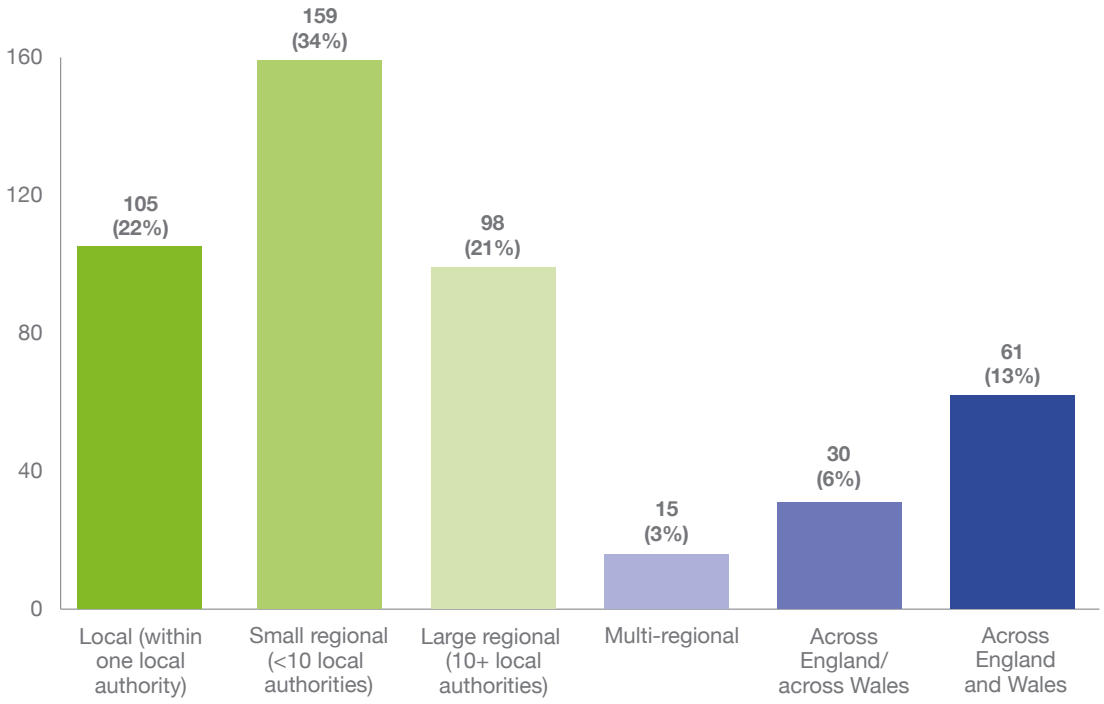
As Figure 3 shows, more than half of services were operating in a single local authority area or across fewer than 10 local authorities within a single region. Another fifth of services were operating across 10 or more local authorities in one region, while a small number had bases in more than one region. One fifth were operating across England and/or Wales.

Of the 61 services operating across both England *and* Wales:

- Nine-tenths (n=54, 89%) were delivered by not-for-profit organisations, alongside four statutory services and three in the private sector.
- Very few were in the sexual violence sector; more than a quarter (n=17, 28%) focused solely on child sexual abuse, and more than three-fifths (n=38, 62%) had a wider remit that included child sexual abuse.
- Fourteen were dedicated to specific forms of child sexual abuse: abuse in institutional contexts (n=7), intra-familial abuse (n=4), abuse in online contexts (n=3) and/or child sexual exploitation (n=3).
- Nearly half (n=27, 44%) provided support to both children and adults, while almost two-fifths (n=23, 38%) supported only adults and fewer than a fifth (n=11, 18%) supported only children.
- Half of the national services (n=30, 49%) were providing therapy/counselling or emotional support, which was generally delivered virtually (e.g. in an online forum). More than a quarter (n=17, 28%) ran a helpline, and almost as many (n=15, 25%) provided advocacy support.

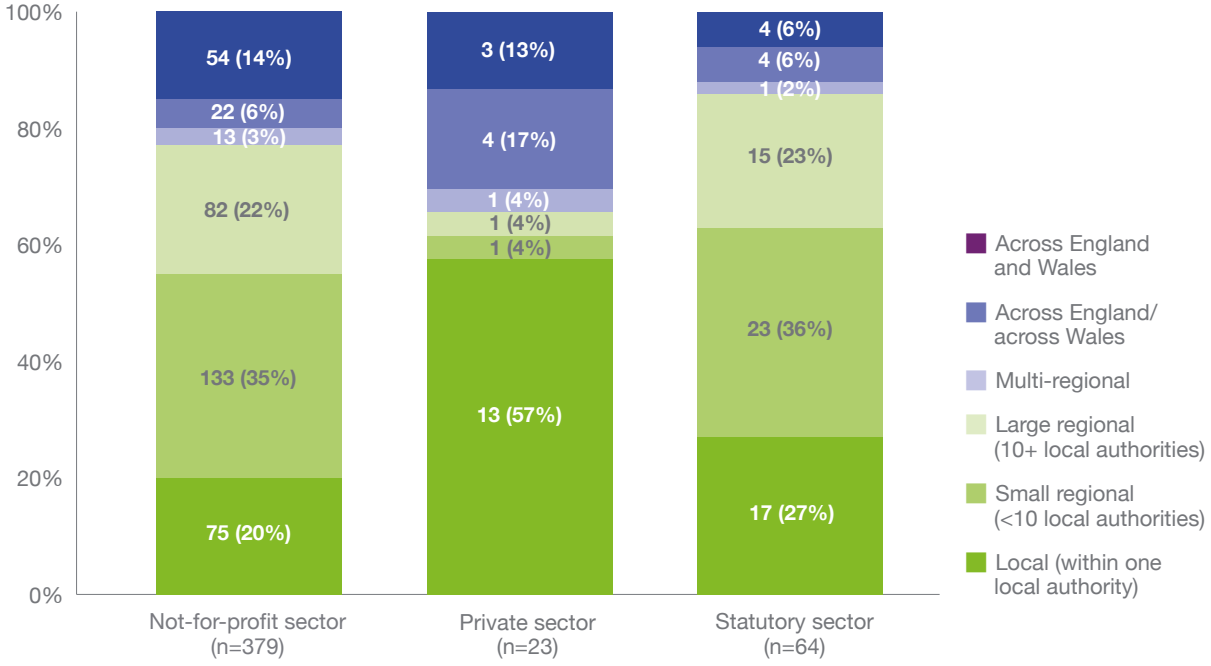
As Figure 4 shows, not-for-profit and statutory services were mostly local or single-region; compared with statutory services, those in the not-for-profit sector were less likely to be operating in a single local authority and more likely to be working across England and/or Wales; most national-level statutory services were in the NHS. The 23 private-sector services were polarised in their geographical coverage: almost three-fifths were operating at a very local level, but nearly a third were national services.

Figure 3. Services' geographical coverage



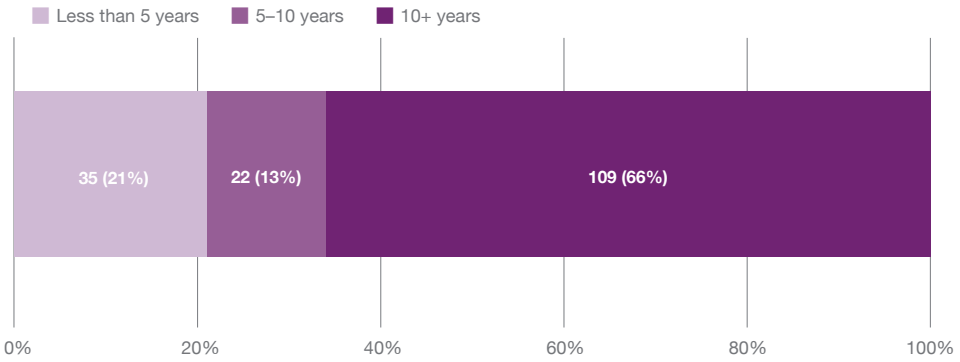
n=468.

Figure 4. Services' geographical coverage, by sector



n=466. The other two services were delivered through statutory/not-for-profit partnerships; each covered fewer than 10 local authorities within a single region.

Figure 5. Length of time that services had been offering support in relation to child sexual abuse



n=166.

3.4 How long had services been operating?

In our interviews with 166 services, we asked them how long they had been providing support around child sexual abuse. Two-thirds said they had been providing this support for more than 10 years (see Figure 5).

Among the 136 interviewed services in the not-for-profit sector, two-thirds (n=91, 67%) had been providing support around child sexual abuse for over 10 years. The same was true of two out of the three private-sector services, but only half (n=13, 52%) of the statutory services we interviewed.

Some services described the advantages of having been in existence for a long time:

> "We have good community links, having operated in [the area] for over 20 years, meaning we have established and trusted pathways." [ID219, NFP; wider remit]

Five-sixths (n=32, 84%) of the 38 services focused on sexual violence had been providing support in relation to child sexual abuse for over 10 years, as had three-fifths (n=46, 61%) of the 76 services with a wider remit. In contrast, almost half (n=24, 46%) of the 52 services focused solely on child sexual abuse had existed for less than 10 years.

3.5 Provision for specific groups

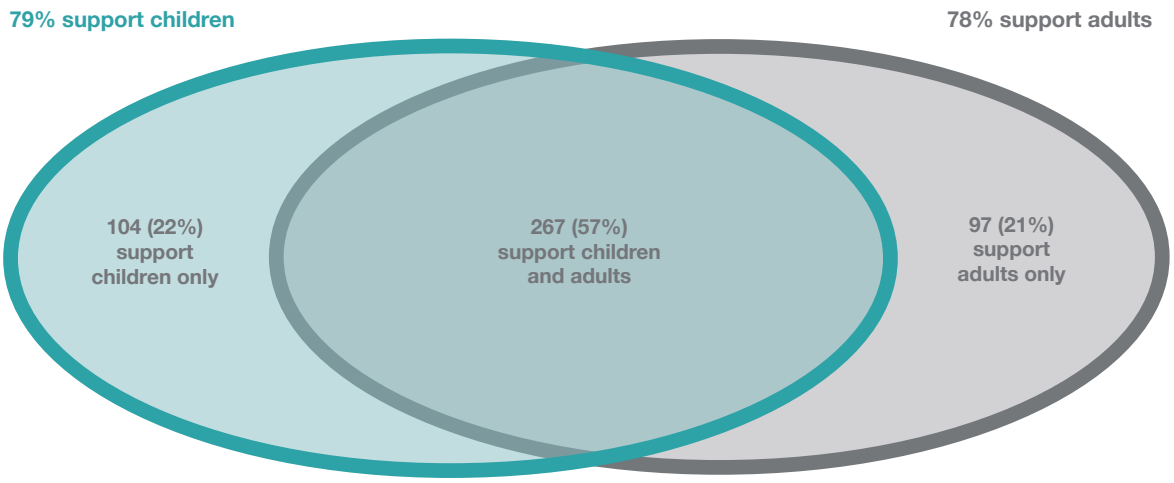
3.5.1 Adults and children

As Figure 6 shows, more than half of services were providing support to both children and adults (either as victims/survivors of sexual abuse or as non-abusing parents or other adults affected by child sexual abuse). Just one in five services focused their support solely on children, and a similar proportion supported adults only. This means that, in all, children were supported by over three-quarters of services, as were adults affected by child sexual abuse.

Services working at national level were more likely than local/regional services to be working with children only, and less likely to be working with both children and adults (see section 3.3 above).

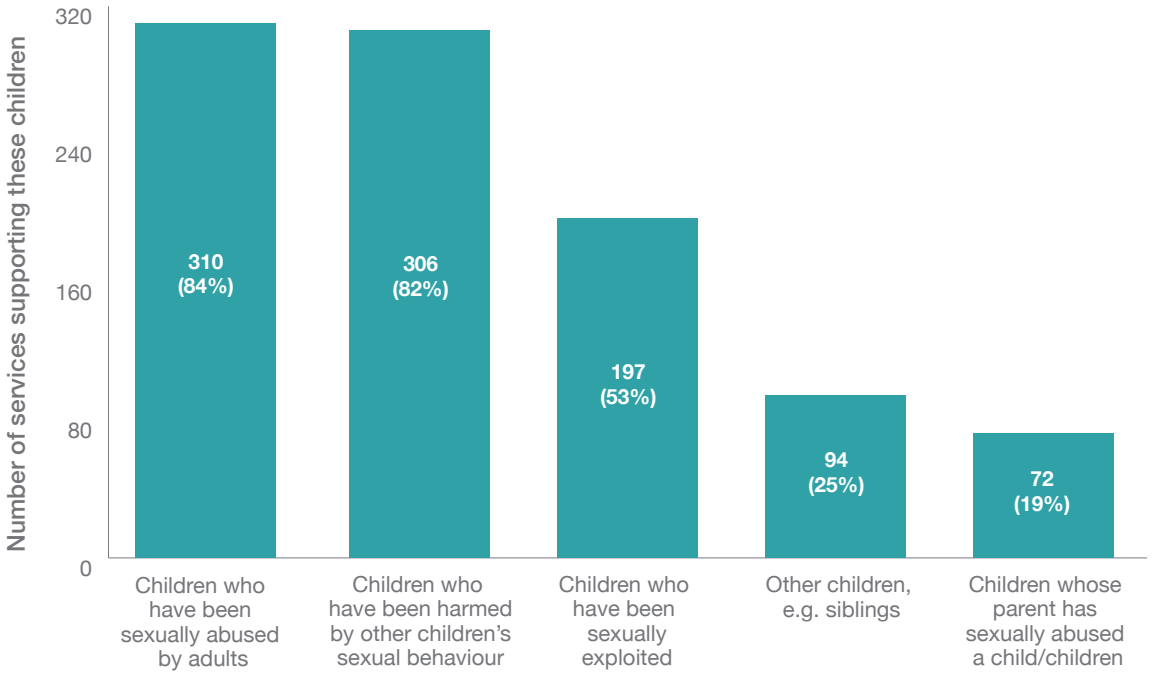
Most of the 371 services supporting **children** did not focus on a specific form of sexual abuse, although – as Figure 7 shows – half did provide specific support around child sexual exploitation. Only a quarter provided support for *other* children affected by child sexual abuse, such as non-abused siblings. Support for children with a parent known to have sexually abused another child or children was provided by fewer than a fifth of services.

Figure 6. Services supporting people of different ages



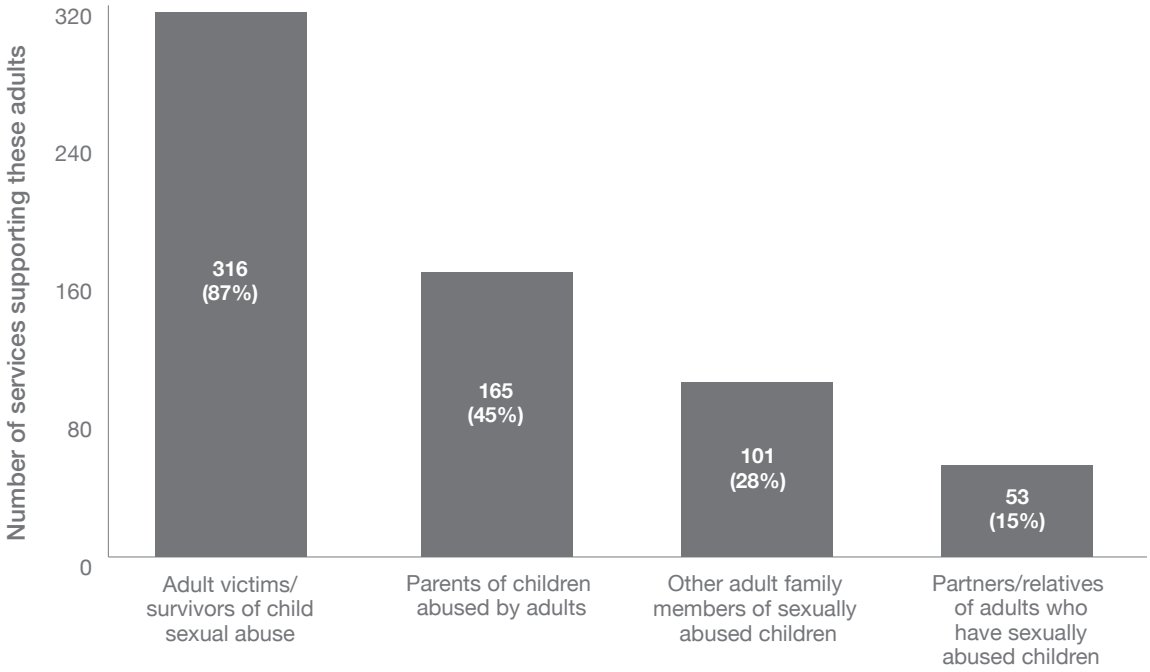
n=468.

Figure 7. Services' support for children



n=371.

Figure 8. Services' support for adults



n=364.

As Figure 8 shows, the 364 services supporting **adults** were most commonly working with adult victims/survivors of child sexual abuse. Nearly half provided support for parents of children who had been sexually abused, often alongside support given to the children. Far fewer services provided support for the partners/ relatives of adults who had sexually abused a child or children.

3.5.2 Groups with particular characteristics

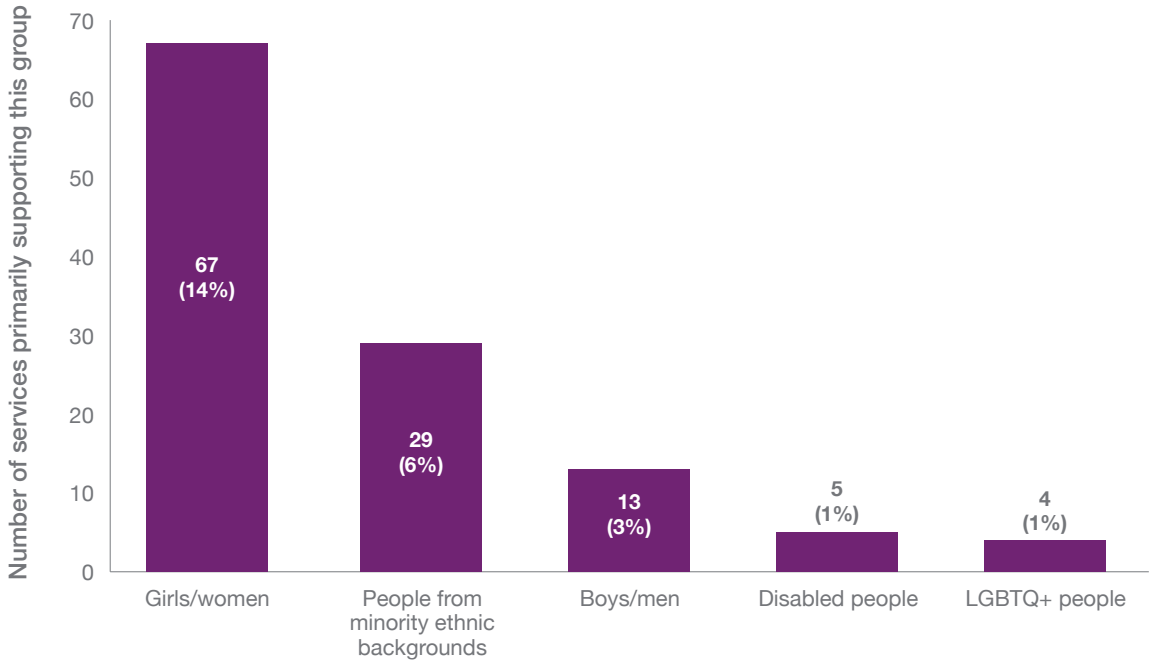
Fewer than a quarter (n=103, 22%) of the 468 services provided support exclusively or mainly to groups with particular characteristics. As Figure 9 shows, these services most commonly supported girls/women, followed by people from minority ethnic backgrounds and boys/men.

Nearly three-quarters (n=74, 72%) of these 103 services were operating within a single region, with a quarter (24, 24%) working across England and/or Wales. Compared with all 468 services we mapped (see Figure 3 above), those with a focus on a particular group – and especially those focused on boys/men or people from minority ethnic backgrounds – were slightly more likely to be operating across England and/or Wales.

3.5.3 People affected by specific forms of child sexual abuse

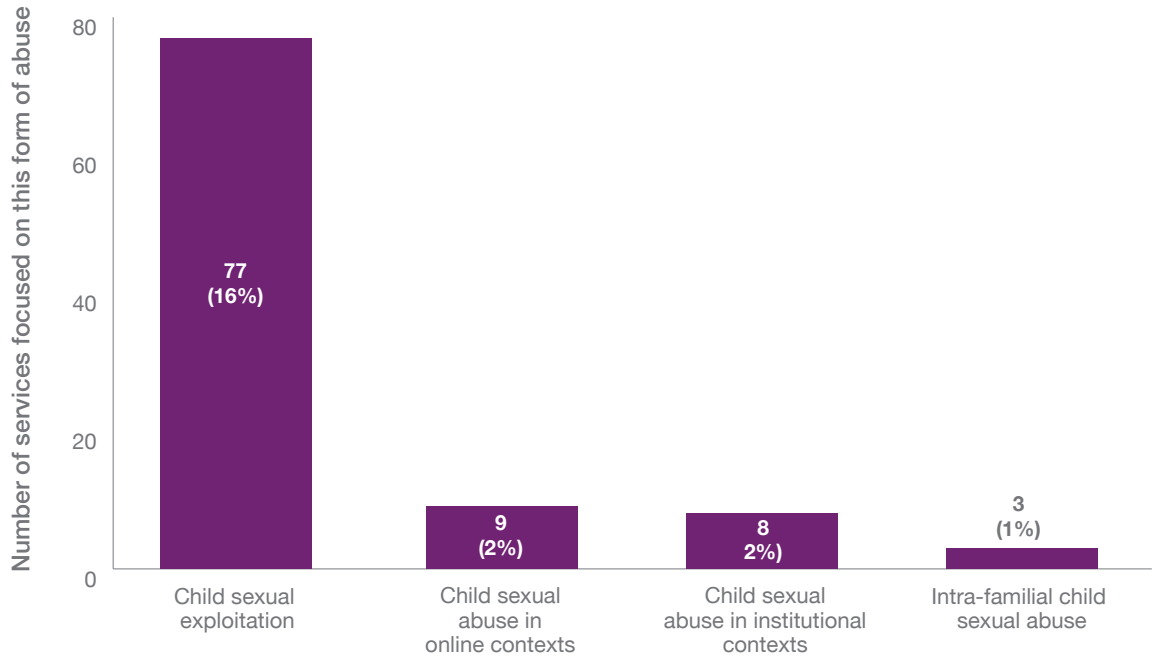
A fifth of all services (n=93, 20%) were principally providing support around specific forms of child sexual abuse. As Figure 10 shows, this tailored support most commonly related to child sexual exploitation. Very few services focused on offering support specifically in relation to child sexual abuse in online, institutional or intra-familial contexts; almost all those focusing on institutional or intra-familial contexts, and a third of those dedicated to abuse in online contexts, were operating at a national level (see section 3.3 above).

Figure 9. Services primarily supporting people with specific characteristics



n=468.

Figure 10. Services focusing on specific forms of child sexual abuse



n=468.

4. What kinds of support do services provide?

This chapter looks at the ways in which services were supporting victims/survivors of child sexual abuse and their families. Drawing primarily on our interviews with services, it covers the types of support being offered, who it was for, and how and when it was delivered.

Support provided by harmful sexual behaviour support services is considered separately in Appendix 3.

Key findings and reflections

1. One-to-one therapeutic support was the most common type of support provided, by three-quarters of services. However, two-thirds of services were providing multiple types of support.
2. Most services applied some criteria to their support offer, most commonly based on age. Support was widely available to adults, and to children aged 13–17, but considerably fewer services provided any support to under-10s.
3. Service users' location also affected the support available to them, as most services were working within a single region of England or Wales. Even a quarter of helplines and chat services restrict their support to people living in a specific area. These restrictions have created a 'postcode lottery' of access to support.
4. Services were delivering a wide range of models and approaches to one-to-one therapeutic support, including many well-recognised and some bespoke approaches. Many services described their support as trauma-informed and client-led.
5. Support provided to children who had been sexually abused was generally delivered one-to-one and in person, through creative- or activity-based therapeutic approaches. Group-based interventions were more commonly offered to adults.
6. The vast majority of support was delivered during office hours on weekdays – doubtless as a result of a lack of capacity/resources – although more than a third of services provided some support during weekday evenings. Therapeutic support, in particular, was much less likely to be offered at the weekend. This is likely to affect many victims/survivors' access to therapeutic support, especially if they are in full-time education or employment.
7. Most services restricted the length of time in which service users could access support, or the number of sessions offered. As Chapters 7 and 8 show later, these restrictions were often linked to funding arrangements or to the challenge of keeping up with demand. However, it is important that victims/survivors can receive support for as long as needed.

Implications

Funders, commissioners and policymakers should work with services to enable them to offer their support flexibly and in response to the diverse needs of their service users.

4.1 The range of support offered

Through our desk research, interviews and information emailed to us, we gathered data about the range of support provided by the 468 identified services in England and Wales supporting victims/survivors of child sexual abuse and their families.

As Figure 11 shows, three-quarters of services offered one-to-one therapy, counselling or emotional support, and more than half offered one-to-one advocacy, casework or support from an Independent Sexual Violence Adviser (ISVA) or Child Independent Sexual Violence Adviser (ChISVA). Two-fifths offered group-based interventions, a third provided a helpline or chat service, and a small number provided residential care.

Two-thirds of services (n=315, 67%) provided more than one type of support. Those providing only one type were most commonly offering one-to-one therapy, counselling or emotional support, with advocacy, casework or ISVA/ChISVA support also widespread.

4.2 Who was support aimed at?

The 166 services we interviewed told us about the target groups for the support they provided.

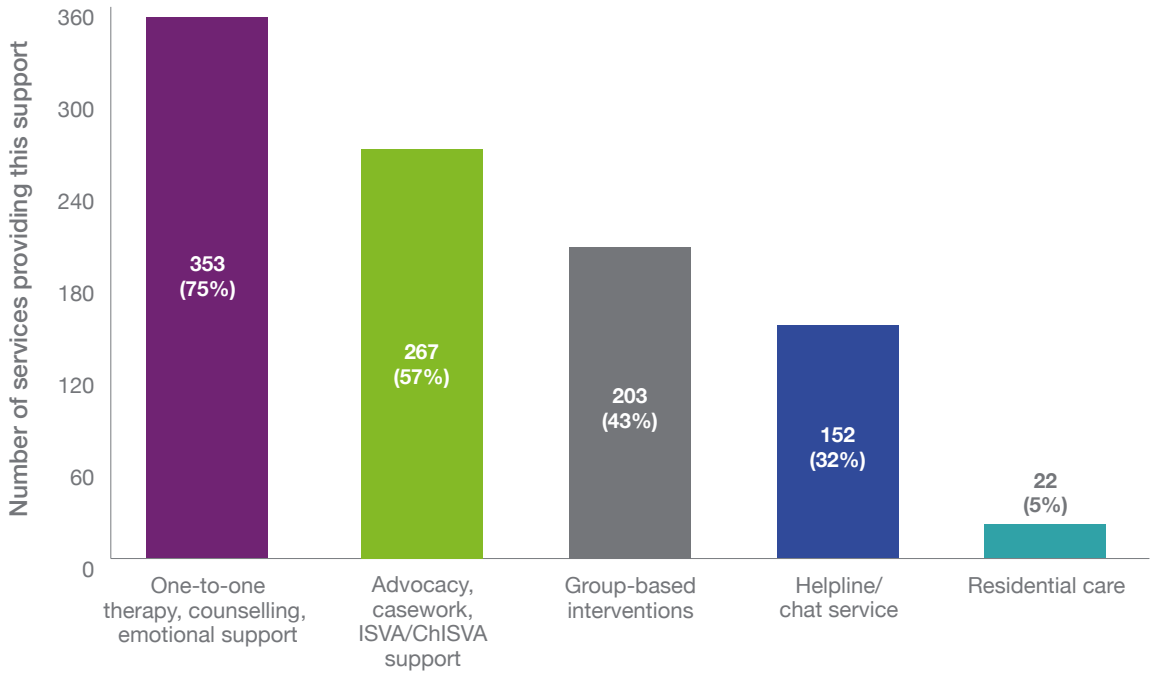
4.2.1 Age

Information about the age groups supported through different interventions was provided by:

- 129 of the 139 services providing one-to-one therapeutic interventions
- 70 of the 83 services providing advocacy, casework and ISVA/ChISVA interventions
- 76 of the 92 services providing group-based support
- 32 of the 54 services providing helplines/chat services.

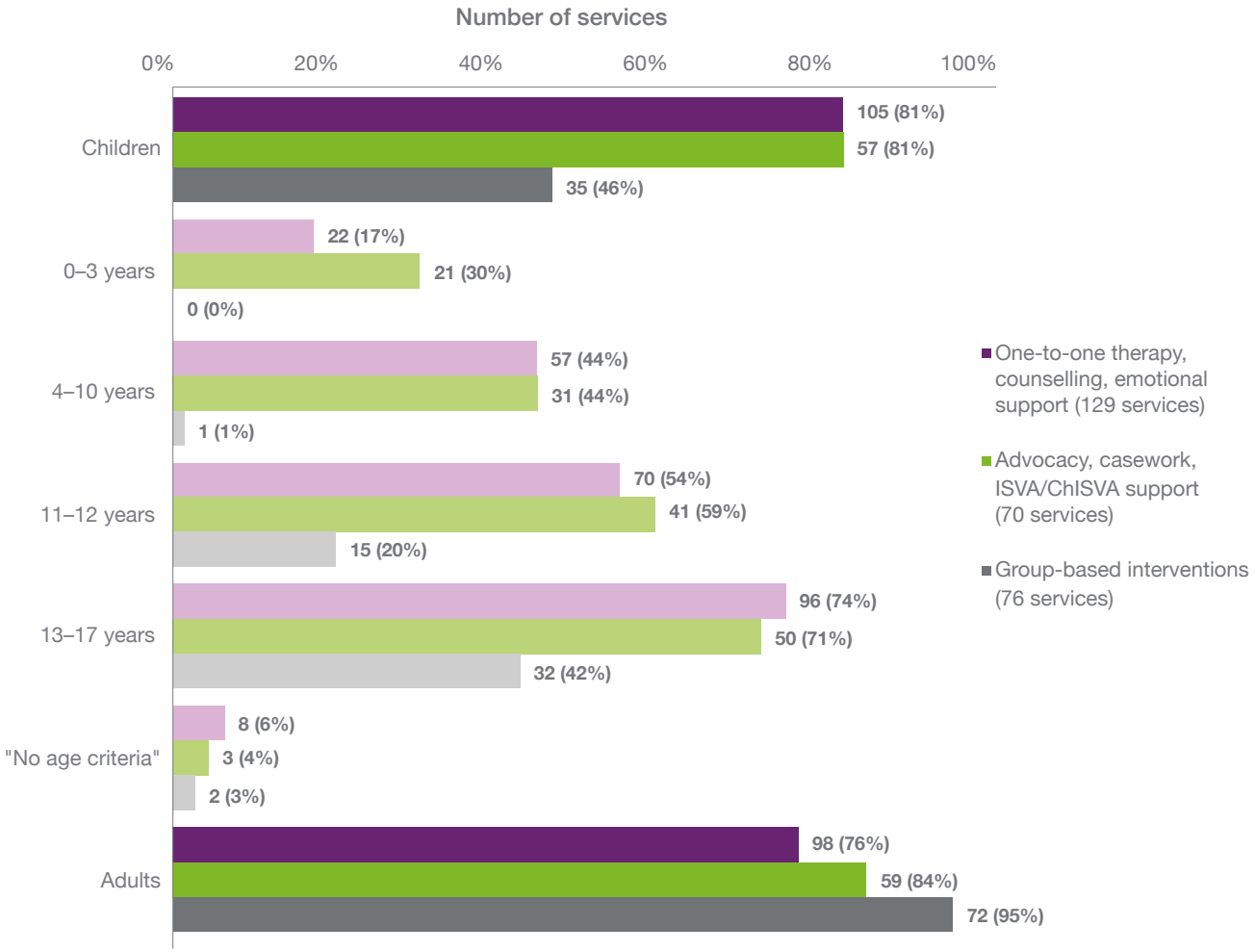
As Figure 12 shows, different types of one-to-one and group support varied in their availability to different age groups.

Figure 11. Types of support offered



n=468. This was a multiple-response question; many services provided more than one type of service.

Figure 12. Types of support offered, by age group



Figures for adults and children include the small number of services that said they applied no age criteria in relation to these interventions; figures for specific child age groups do not include these services (which are listed separately).

Three-quarters of services providing **one-to-one therapeutic interventions**, and five-sixths of those providing **advocacy, casework and ISVA/ChISVA support interventions**, made them available to adults.

Children had slightly greater access to one-to-one therapeutic interventions, and less access to advocacy, casework and ISVA/ChISVA support: among services providing each type of support, around four-fifths offered it to children. However, in many cases it was available only to those aged 13 and over; the provision of direct one-to-one one-to one support for younger children, and particularly the under-10s, was considerably lower.

> "With cases of younger children, we will work with the parents to enable the parents to support that younger child." [ID349, NFP; SV remit]

Almost all services offering **group-based support** said it was available to adults: examples included a group for people aged 50 or older, and three aimed specifically at parents. In contrast, fewer than half provided groups for children – and again, 'children' most commonly meant 13–17-year-olds, with hardly any interventions for under-10s.

Information about **helplines/chat services** is not presented in Figure 12 because two-fifths of services offering this support gave us no information about age, and another one in six said they applied no age criteria. Of the 32 providing any information about the target age range for their helpline/chat services, all told us they were for adults but only two-thirds (n=21, 69%) said they were for 13–17-year-olds; far fewer offered them to younger children.

Some services providing adult-focused helplines/chat services talked about challenges arising from being contacted by children:

> "We don't really get children calling our helpline. If we have children calling us, we refer them to ChildLine or something like that, because we're not really trained to be delivering that sort of support over the telephone." [ID398, NFP; SV remit]

> "The restrictions are 16-plus but we are supporting more and more children and don't want to turn them away. Because once they've disclosed abuse on the webchat, you don't want to say, 'Oh, by the way, can you go to this place?' You've lost them, and really you want to support them, to help them keep themselves safe or tell somebody that they trust what's going on in the family home. So it's tricky." [ID578, NFP; wider remit]

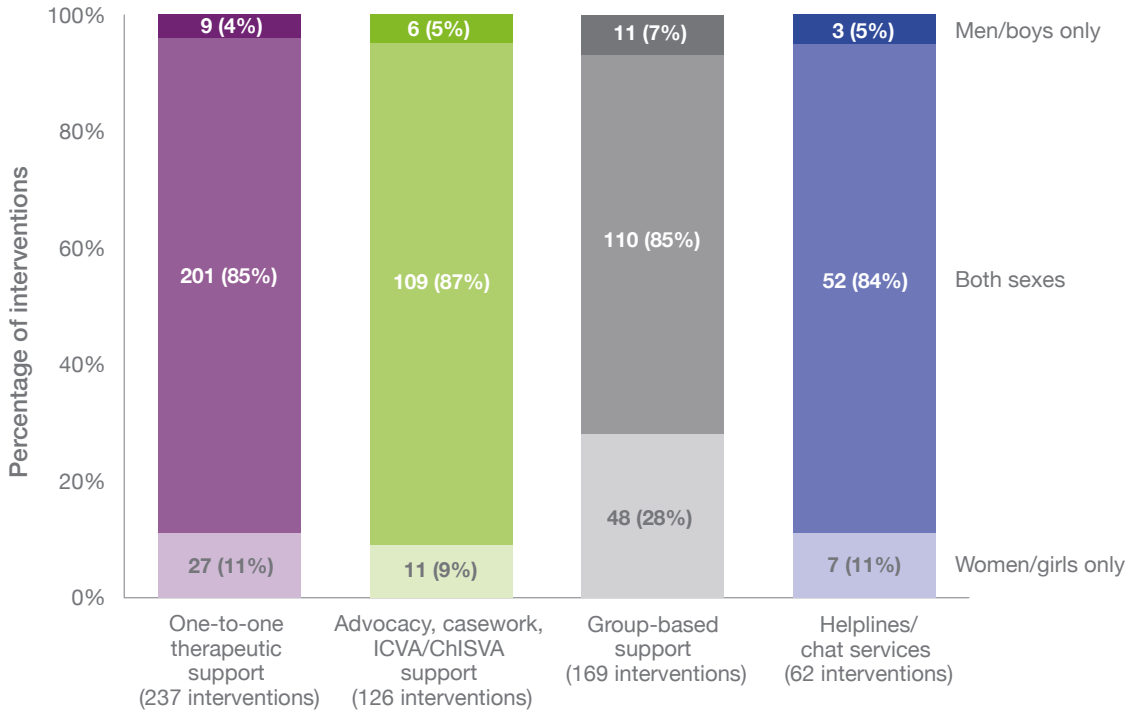
4.2.2 Sex and gender-identity

Services told us that the vast majority of **one-to-one therapeutic** and **advocacy, casework and ISVA/ChISVA support** interventions were available to both sexes – but one in nine therapeutic interventions and one in 11 advocacy interventions were for women and girls only. Fewer than one in 20 therapeutic and advocacy interventions were solely for men and boys – see Figure 13.

The proportions for **helplines/chat services** (11%) were similar. Services told us occasionally received telephone calls from people they were unable to support:

> "We do get men calling, but our charity's purpose is women and children. So we can't do the ongoing support, but we can definitely signpost people once we know what the needs are." [ID398, NFP; SV remit]

Figure 13. Support for women/girls and for men/boys



n=594 interventions provided by the 166 interviewed services. Additionally, one of the 127 advocacy, casework, ISVA/ ChISVA support services was said to be for adult women and both boys and girls.

Perhaps unsurprisingly, it was more common for **group-based interventions** to be single-sex: more than a quarter were for women and girls only, with one in 15 solely for men and boys. And a further 16 interventions were said to be for both sexes but with separate groups for women and men.

Twelve services said they offered one-to-one therapeutic interventions specifically to service users who identified as transgender – and five said the same of their advocacy, casework and ISVA/ChISVA support.

Nine services specified that they offered group-based interventions on the basis of service users' gender identity rather than their sex.

4.2.3 Ethnicity and faith

Four services providing one-to-one therapeutic support, and six offering advocacy, casework and ISVA/ChISVA support, said this was targeted at people of specific ethnicities or faiths.

Six group-based therapeutic interventions were said to be for people from particular faith or ethnic communities, including Chinese and Tamil communities.

While no services said their helplines or chat services applied access criteria based on faith or ethnicity, one helpline was for people who had been sexually abused within faith organisations, and another was for victims/survivors of 'honour'-based abuse.

4.2.4 Geographical restrictions

Services told us that three-quarters of one-to-one therapeutic interventions (n=181, 76%) were available only to people living in a particular geographical area, reflecting the fact that only one in seven of the interviewed services were operating across both England and Wales. A few services specified that service users had to be registered with a GP within their geographical remit in order to access support.

Fewer **advocacy, casework and ISVA/ChISVA support interventions** – almost two-thirds (n=86, 63%) – were available only within a limited area. Some services said they extended their support to looked-after children placed outside their geographical area, or placed in their geographical area despite living outside it.

Three-fifths of **group-based interventions** (n=102, 58%) – a type of support more commonly provided by services operating across England and/or Wales – were available only to service users living within a specific area. A few services providing group-based support online said that this had removed geographical restrictions:

> "We also do an online [group] now, and that means we get people from across the UK." [ID83, NFP; wider remit]

> "Because it's online at the moment we have left it open. So we're not publicising it nationally, but we're not worrying too much about who is joining." [ID483, NFP; wider remit]

Only a quarter of **helpline/chat services** (n=16, 26%) imposed geographical restrictions on the people they supported.

4.2.5 Experience of child sexual abuse

Services said that a small proportion of one-to-one therapeutic interventions required that the sexual abuse experienced was non-recent (n=13, 5%), or were only available to service users facing current concerns or risk of sexual abuse (n=6, 3%).

Similarly, 16 advocacy, casework or ISVA/ChISVA support interventions (13%) were only available to people with specific experiences of sexual abuse – for example, those who had been abused recently, whose risk of sexual abuse was current or ongoing, or whose abuse was non-recent.

Thirteen group-based interventions were exclusively for victims/survivors whose sexual abuse was non-recent. Another four had other criteria related to specific experiences of sexual abuse.

4.3 One-to-one therapeutic support

One-to-one therapy, counselling or emotional support to victims/survivors and/or their family members was offered by three-quarters of the services we identified – and by five out of six (n=139, 84%) of those we interviewed. Between them, these 139 services provided 237 different therapeutic interventions.[7]

As Figure 14 shows, most of the 139 services provided a single therapy or counselling intervention to victims/survivors of child sexual abuse and their families. A quarter offered two therapeutic interventions, but only a fifth offered three or more.

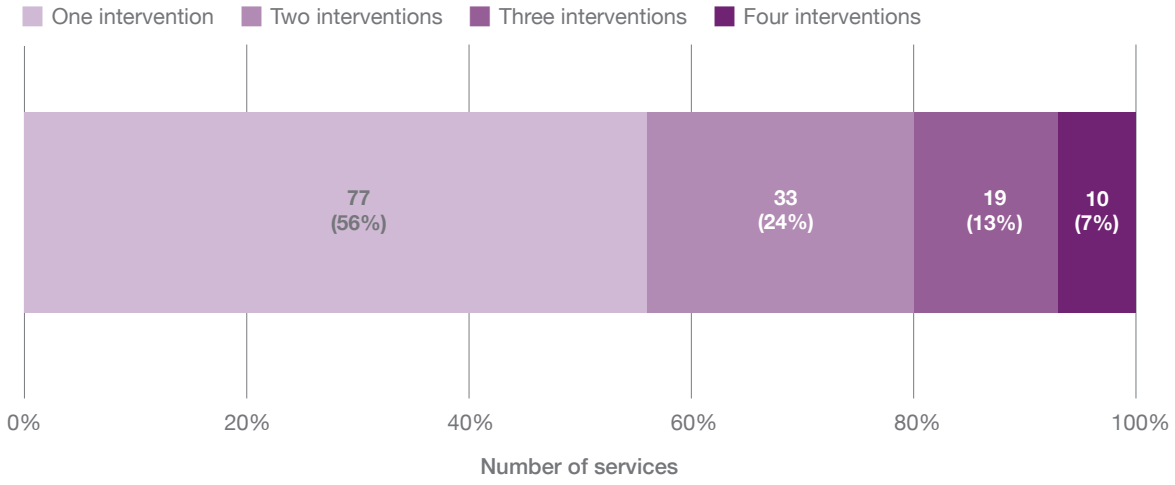
4.3.1 What did one-to-one therapeutic support involve?

Asked to describe their one-to-one therapeutic, counselling and emotional support in more detail, services described a large number of different therapies, models and approaches (see Appendix 4). These ranged from the more traditional and recognised counselling and therapy models to one-off and bespoke approaches developed locally or for a specific service.

Cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) were among the most frequently mentioned therapies offered, but services delivered a wide spectrum of psychotherapies, psychoeducation and other somatic therapies, including psychodynamic, cognitive, behavioural, humanistic and integrative therapies.

A few larger organisations running multiple services, such as the NSPCC and Barnardo's, had developed their own approaches to supporting people in relation to child sexual abuse. This included the NSPCC's 'Letting the Future In' model and Barnardo's TIGER (Trauma Informed Growth and Empowered Recovery) approach, used in interventions supporting children. Some smaller services described using specific models or approaches, in many cases devised by the service's founder, while services in one locality were using a therapeutic approach called 'REACH'.

Figure 14. Number of different one-to-one therapeutic support interventions provided by services



n=139.

7. By 'intervention', we mean a particular type of therapeutic, counselling and/or emotional support activity or project that a service delivered. For example, if a service offered one-to-one emotional support to adults, and play therapy to young children, we treat these in this chapter as two interventions.

The range of therapies or modalities offered by some services appeared to be determined by their counsellors' training and qualifications. And while most services offered types of therapy based primarily on the service user's age and assessed needs, a few allocated therapies much more pragmatically, based largely on which counsellor was available:

> "Children will receive play therapy, they will be working with the ones qualified to work with children, and aside from that it's first come, first served on the waiting list. For instance, we know that EMDR is very popular at the moment. We don't have enough people trained in it to just be able to offer that as a separate standalone service. So it will be, you know, if the counsellor you're assigned to happens to be trained in that, then you'll get that." [ID118, NFP; SV remit]

A number of services highlighted how they followed specific therapy standards, protocols or frameworks. Many mentioned their counsellors having regular clinical supervision:

> "Play therapy is standalone profession, the therapists have to be part of the Play Therapy UK association, [and we] have to work within their guidelines." [ID167, NFP; wider remit]

> "We have multiple modalities of children's counsellors. They all meet the BACP [British Association for Counselling and Psychotherapy] Ethical Framework for children's counsellors, which has outlined specific skills and training and experience. We also have a pathway for adult counsellors who might want to then work with children, to increase their skills and make sure they match against those BACP guidelines and ethics." [ID368, NFP; SV remit]

Many services described how they worked in a trauma-informed or trauma-focused way, supporting victims/survivors and those around them to recognise their emotional and behavioural responses as signs and symptoms of trauma. Trauma-informed work was often said to involve using trauma management techniques or tools, such as grounding techniques, breathing and release exercises. One intervention offered Reiki, an energy healing technique, while another included trauma-focused yoga as a way to help victims/survivors manage their day-to-day life.

A person-centred or individualised approach to one-to-one counselling and therapeutic support, based on a service user's assessed needs, was said to be key for many interventions:

> "Our survivors are extremely complex and so we generally use a mix of models, but the broad frame is a psychological talking therapy service. We would have an individualised plan with each particular client and we would use different models as appropriate to what their goals are." [ID651, stat.; wider remit]

> "[The intervention] uses an integrative model, a combined approach, bringing together different elements of therapies. [This] enables therapists to offer a tailored approach to meet the client's needs." [ID574, NFP; wider remit]

> "All professionally qualified counsellors [who] have a toolbox of qualifications to use for whatever best suits the client. Always client-led, [focusing] on what a client wants and needs." [ID663, NFP; wider remit]

A few services mentioned other approaches including empowerment, relational, asset-based, narrative, empathetic listening and capacity-building.

Many services supporting children provided play therapy, as well as other creative therapy approaches – principally art therapy but also music therapy, dance and movement therapy, and drama therapy. Such approaches were described as child-centred and evidence-based ways of supporting sexually abused children:

> "We are very much child-directed, so it would be that they process their experience through art, through movement, through sand tray, through play. And through that processing we try and enable the child to shift in, at their own pace, in their own way, to kind of a new normal." [ID59, NFP; CSA focus]

A few services said their one-to-one support with children came from a youth work perspective of engaging children in activities that allowed them to build relationships and receive support in a more informal manner:

> "The worker is a specific youth worker and has taken CBT training. For example, some young people can't cope with the thought of therapy… The idea of them seeing someone weekly in one place, sat in a chair, is too much for them or they're quite chaotic in their lifestyles, so it's really difficult to pin them down. So we can be much more creative with this work: [the youth worker] can meet them at a café, can take them for a walk and go rock climbing with them. It's a more youth work approach to still doing the same work… It's about trying to still give them that support, but in a more creative way." [ID615, NFP; CSA focus]

While adult victims/survivors were more likely to be offered talking therapies, a few services working with adults emphasised the value of non-talking or more creative approaches to one-to-one support:

> "We've got a mental health practitioner with quite an extensive experience in that field. We have one-to-one sessions, the sort of walk and talk, or scooter and talk, and we've got a session with a horse, and we find that's really therapeutic for our women." [ID105, NFP; wider remit]

Some services specified that they offered pre-trial therapy to service users waiting to go to court. And a few, which described their provision as emotional support rather than counselling or therapy, said this came from a peer support or victim/survivor-led perspective:

> "I would say it's a model that has been shaped by those that have accessed and delivered it. Because all of our peer support workers… are individuals who've accessed the service and used the service as a member and then reached a point where they felt they would like to help others… It's evolved because other people, we've been very fortunate other people have added their voice, their effort, their weight." [ID103, NFP; CSA focus]

4.3.2 Who received one-to-one therapeutic support?

Of the 237 therapeutic interventions provided by our interviewees, two-thirds were offered to children who had been sexually abused (see Figure 15), and more than half to adult victims/survivors. Almost half were available to parents of sexually abused children, while a quarter were for children who had engaged in harmful sexual behaviour. (Appendix 3 contains information about the support offered by services focused principally on this group.)

4.3.3 How and when was one-to-one therapeutic support delivered?

Almost all (n=228, 96%) of the 237 therapeutic interventions, including all but one of those available to children, could be provided in person. Three-quarters of therapeutic interventions offered online sessions (n=176, 74%), and half offered support by telephone (n=125, 53%). One in ten interventions (n=27, 11%) could deliver support via email or text.

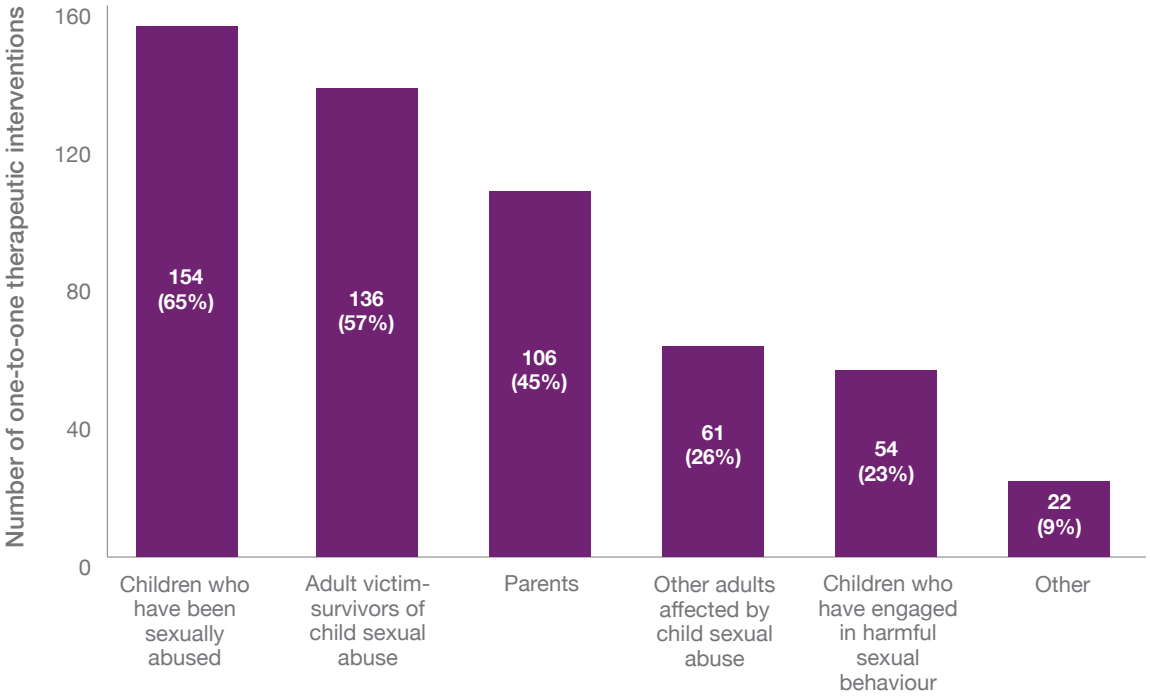
As Figure 16 shows, therapeutic interventions were overwhelmingly offered in office hours on weekdays. Two-fifths were available on weekday evenings, and one in nine at the weekend. Services said they tried to be as flexible as possible so that service users could access support when it suited them, even if it was not regularly available outside office hours.

A few interventions said they were available 24-hours, seven days a week.

> "It's generally weekdays, but if we have an extenuating situation, a woman at risk, it really is seven days a week, 24 hours and myself and the mental health practitioner take that on board. For example, this week we've had two partners die. Two men of our women. You wouldn't expect this, but because of that we are 24 hours, seven days a week in the immediacy because both of the women have a history of suicide attempts and self-harm and we want to protect them." [ID392, NFP; SV remit]

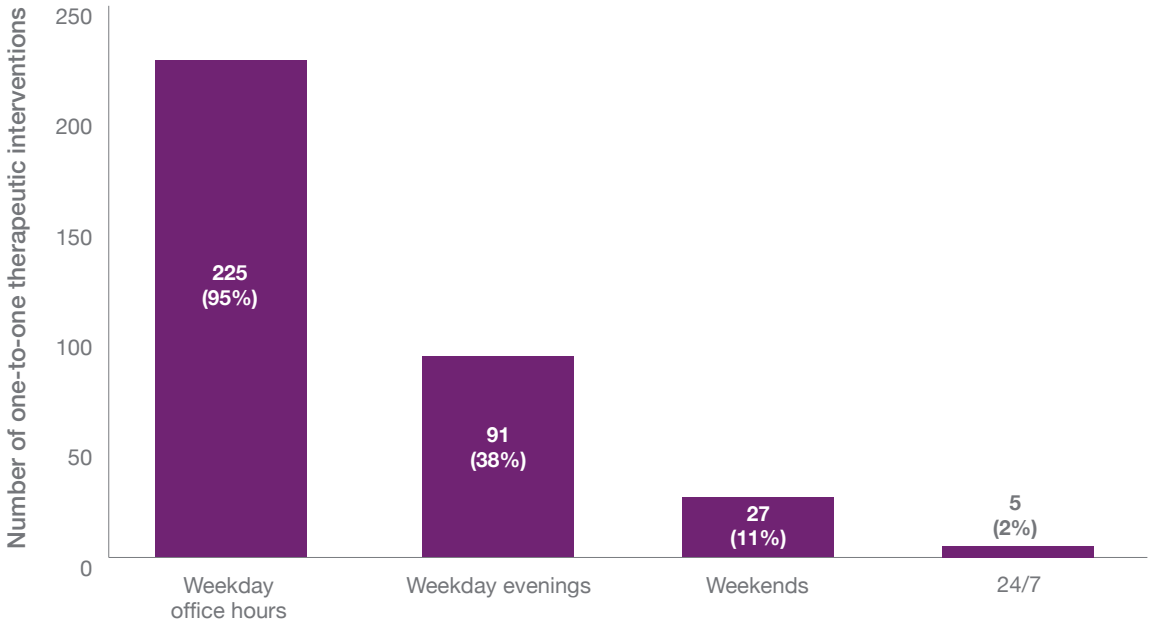
In terms of frequency, three-quarters of one-to-one therapeutic interventions (n=177, 77%) involved weekly sessions. A few services said that, depending on individual need, therapeutic support might initially be offered more frequently and then become less frequent.

Figure 15. Recipients of one-to-one therapeutic support



n=237. 'Other' includes children at risk of exploitation, and siblings and other family members of sexually abused children.

Figure 16. Times when one-to-one therapeutic support was available



n=237.

Two-thirds of one-to-one therapeutic interventions (n=155, 65%) had a limit to either the number of sessions or the length of time for which people could access support. Limits ranged from four to 52 sessions, with an average of 17 sessions; 19 interventions (8%) involved a maximum of eight sessions or fewer.

Many services emphasised their flexibility as they recognised that some people needed more sessions than others – some said they would review progress at regular points and allocate more sessions if needed:

"[We] tailor it specifically to the participant and their needs. No 'one size fits all' approach." [ID415, NFP; wider remit]

However, a few services highlighted that people requiring more sessions would have to rejoin the waiting list.

Others mentioned that they would look out for people becoming dependent on counselling, especially if support continued over a longer period.

A small number of services highlighted that they would cease providing interventions when a service user reached an upper age limit or when criminal justice processes had concluded. Others specified that the availability of funding might limit the number of therapeutic sessions provided.

4.4 Advocacy, casework and ISVA/ChISVA support

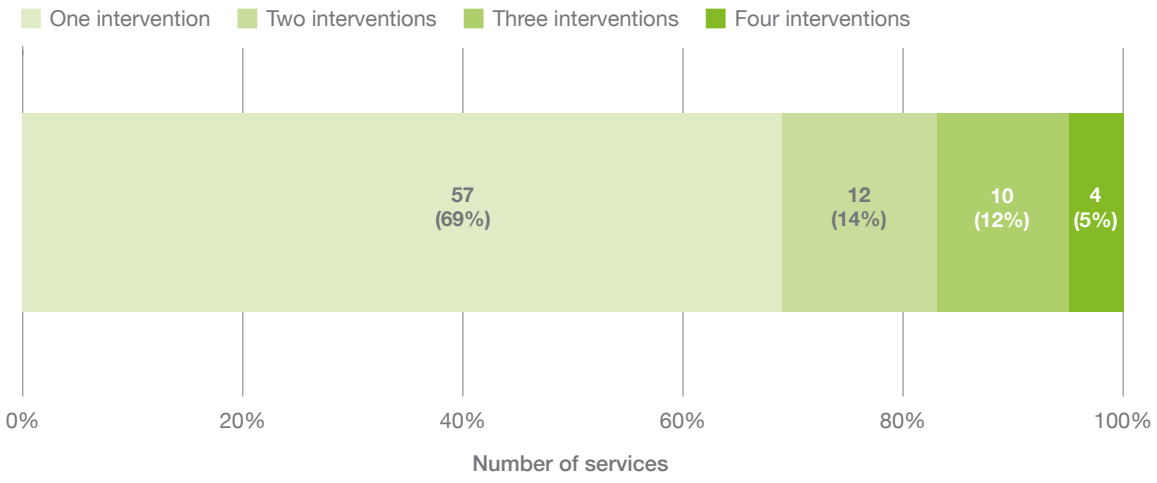
As Figure 11 above shows, almost three-fifths of all the services we mapped offered one-to-one advocacy, casework or support from an Independent Sexual Violence Adviser (ISVA) or Child Independent Sexual Violence Adviser (ChISVA).

Half of the 166 services we interviewed (n=83, 50%) offered this type of support; between them, these 83 services provided 127 different interventions.

As Figure 17 shows, two-thirds of these 83 services offered just one advocacy, casework or ISVA/ChISVA intervention as part of their suite of support to people affected by child sexual abuse.

> A few services said that people needing further one-to-one therapeutic sessions would have to rejoin the waiting list

Figure 17. Number of different advocacy, casework or ISVA/ChISVA support interventions provided by services



n=83.

4.4.1 What did advocacy, casework and ISVA/ChISVA interventions involve?

These interventions, when described by the services providing them, largely fell into three overlapping and interlinking categories: support related to the criminal justice process, practical support and emotional support.

Services described ISVA/ChISVA support as covering everything that people might need to **navigate the criminal justice system**. Following Ministry of Justice guidance (2021), interventions supported those affected by child sexual abuse in, for example, understanding the legal process and their rights relating to reporting to the police, police interviews, preparing for court, giving evidence, pre-trial court visits, injury compensations and victims' rights to review. Services also mentioned supporting victims/survivors in making decisions about whether to report their abuse to the police or not. The practical and emotional support provided in relation to court proceedings was generally available throughout the whole process, although the intensity could vary:

> "We use the phrase 'from report to court' – from the report to the police we will then come in and support the victim, and particularly with children there's an element of supporting the parents as well. It's not a therapeutic support, but a holding space." [ID167, NFP; wider remit]

> "This can involve support around the criminal justice system if they'd like to report, also includes practical support and emotional support all way through the criminal justice process. Advocates are trained in understanding the process, knowing the challenges, make sure they understand victims' rights at every stage of process, and that their voice is heard. This can include getting their voice heard with other people and other agencies in their life, like school or parents or other professionals. And it can be a lot of that linking in with other agencies as well. The advocates do a lot of one-to-one specialist sessions as well, which are more looking at the types of abuse that they've experienced and understanding trauma and ways to cope with trauma." [ID305, NFP; wider remit]

A few services said they had ISVAs/ChISVAs who specialised in a range of different service user groups including those with additional needs, learning difficulties or complex needs, people living in rural areas, young people, LGBTQ+ people, and those working in the sex industry.

Practical one-to-one support was also mentioned by many services. This type of support was overwhelmingly client-led, and services described how they would assess and develop a support plan to address the service user's specific needs.

The range of practical support – described by one service as "*a bit of a mixed bag*" – included liaising or communicating with schools, the police, the Crown Prosecution Service (CPS), GPs, employers, debt agencies or CAMHS, among others. If required, support workers would attend meetings with other professionals or work with the professional network around a child. Providing practical support with housing and accessing benefits was also frequently highlighted, as was providing transport and support to attend hospital and sexual health appointments, for example.

> "Ranging from writing support letters, GPs, employers, debt agencies, accompanying people to appointments for PIP [Personal Independence Payment], benefits or advice, advocacy to access ISVA services. This is wide-ranging." [ID168, NFP; SV remit]

A few services said they provided education on healthy relationships and sexual abuse, mainly through talking, or discussed safety in the community or online safety with children where appropriate.

> Services described ISVA/ChISVA support as covering everything needed to navigate the criminal justice system

Advocating on behalf of service users or helping them navigate systems to access onward support was an important aspect of some services' one-to-one casework support:

> "It's support accessing services, especially things like medication, health, mental health. Often women will have a door closed… We won't accept that. We find that, even though we're just a voluntary service, we've got skilled team members who are quite adept at politely challenging that closed door."
> [ID105, NFP; wider remit]

A few services emphasised how they actively advocated on children's behalf with their education provider:

> "…lots of work and advocacy with schools, because it so often the survivor that ends up having to leave school or move school, rather than the assailant, if the assailant's at school. We do lots of work with the school to try and help them to hold the survivor in mind and make school a safe place."
> [ID470, stat. sector; SV remit]

Many services said that providing **emotional support** throughout the criminal justice process formed an important part of their one-to-one support, alongside more practical support. Some described this as rebuilding or empowerment work, which aimed to increase service users' self-worth, confidence, positive attachments and healthy relationships. A few services offered emotional grounding techniques for service users to develop strategies while they waited for therapy; others provided one-to-one befriending or mentoring support, as well as activity-based work for children to meet new friends and develop life skills.

In terms of approaches to one-to-one advocacy, casework and ISVA/ChISVA support, most services we spoke to seemed to work in a client-focused, victim/survivor-led and flexible manner, and to develop bespoke support plans. A few mentioned other principles that were important to them, such as solution-focused, holistic, trauma-informed approaches and building trusting relationships. One service mentioned using a feminist framework, while another was shaped by Maslow's hierarchy of needs.

4.4.2 Who received advocacy, casework or ISVA/ChISVA support?

As Figure 18 shows, more than two-thirds of advocacy, casework or ISVA/ChISVA support interventions were available to children who had been sexually abused, and about the same number were available to adult victims/survivors.

Two-fifths of interventions were available to parents (n=50, 39%), while one in eight supported children who had engaged in harmful sexual behaviour.

4.4.3 How and when was advocacy, casework or ISVA/ChISVA support delivered?

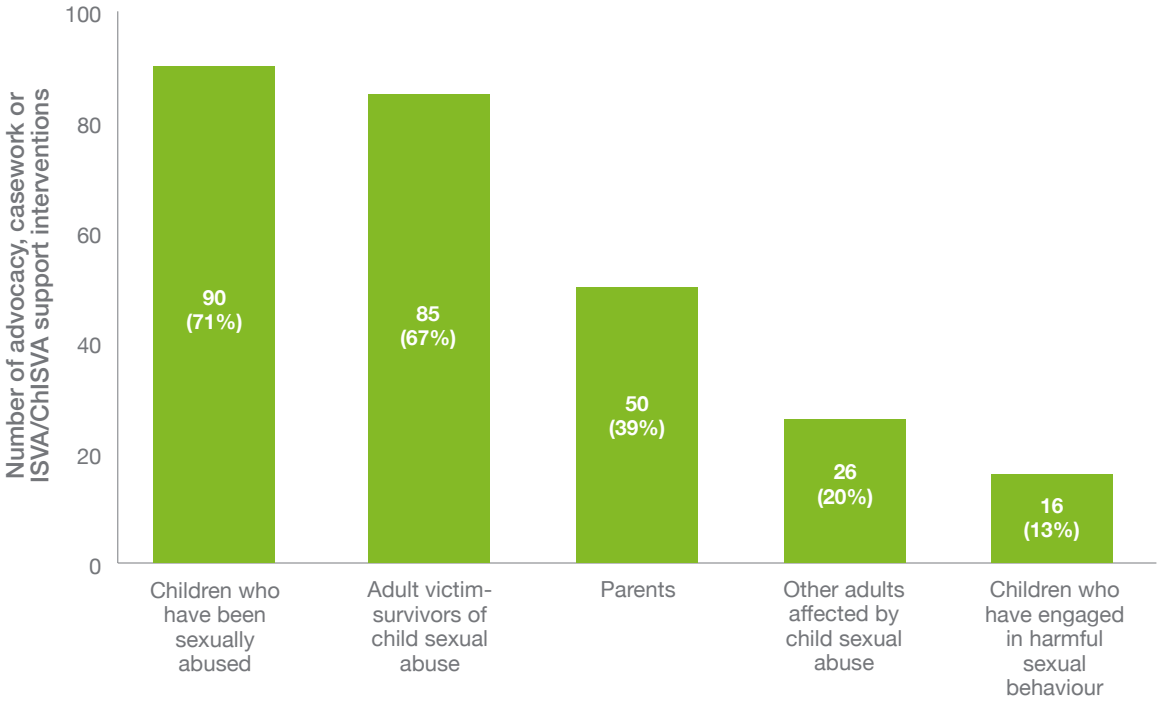
Almost all interventions (n=118, 93%) could be provided in person, four-fifths (n=100, 79%) offered support over the telephone, and most were available online (n=85, 67%), by text (n=78, 61%) or by email (n=76, 60%).

Overall, seven out of eight interventions (n=108, 87%) could provide advocacy, casework or ISVA/ChISVA support through multiple methods of communication.

As Figure 19 shows, advocacy, casework and ISVA/ChISVA support was predominantly available during working hours on weekdays, although two-fifths of interventions were available on some weekday evenings. One in ten regularly offered support at the weekend, mostly on Saturdays.

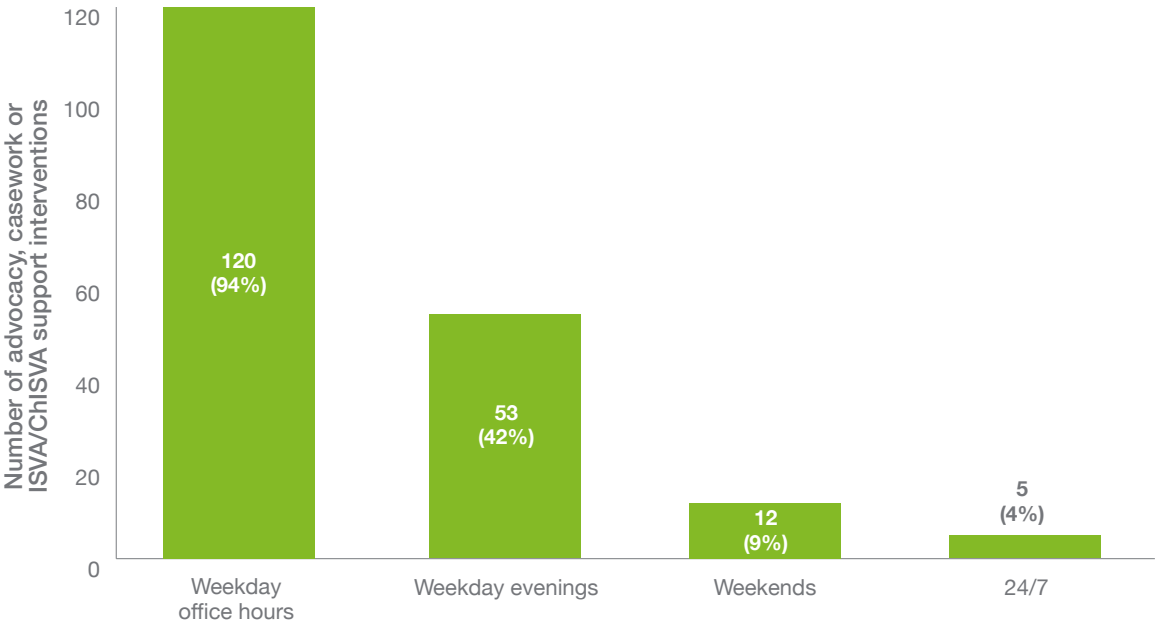
> Almost all of these interventions could be provided in person, and four-fifths offered support by telephone

Figure 18. Recipients of advocacy, casework or ISVA/ChISVA support



n=127.

Figure 19. Times when advocacy, casework or ISVA/ChISVA support was available



n=127.

Many services said they aimed to be as flexible as possible, and would offer evening or weekend support when needed:

> "[At the] weekend if, for example, there was going to be a police interview or court they would attend." [ID359, NFP; SV remit]

Two-thirds of interventions (n=86, 70%) were offered 'whenever people needed it', while one in eight (n=15, 12%) interventions provided support on a weekly basis:

> "Our normal offer is to do a weekly session, but some young people will contact us on the phone much more regularly, and some young people have specified that they would like it to be every other week." [ID630, NFP; CSA focus]

In contrast, only one in six one-to-one therapeutic support interventions (17%) were available whenever they were needed; however, as with therapeutic support, advocacy sessions would generally start off more frequently and then reduce.

Three-fifths of advocacy, casework and ISVA/ChISVA support interventions (n=75, 60%) were said to have no limitations on how long people could access them. Thirteen services mentioned 'length of time' or 'number of sessions' as a limitation, and many others indicated that these interventions would end shortly after the completion of the criminal justice process:

> "[We] do not stop support until the court case is over." [ID426, stat.; SV remit]

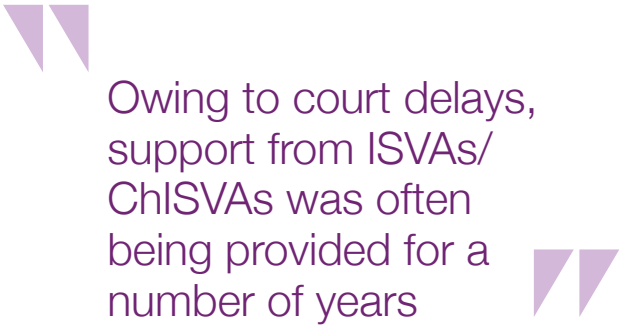
> "[It's] dependent on the client, but what we tend to do is support through criminal injuries compensation and try and end after this – a couple of months after the trial… Usually at the end or outcome of the criminal justice process, they would have to have some kind of ending." [ID390, NFP; SV remit]

Owing to court delays, however, support was often being provided for a number of years:

> "It used to be an average 12 to 18 months for the case to go to a court; we're now looking about three years. So ISVA caseloads just grow and grow and grow because people are in the system for a really long time and especially since COVID. Because of all the delays within the court process, it's just putting so much pressure on ISVA services." [ID349, NFP; SV remit]

Other services said they supported people who were considering whether or not to take their case to court, or had chosen not to do so:

> "[We] provide practical and emotional support through the police and court process. We also provide emotional support if they are not going through the police process – that will be a short-term package of support." [ID373, NFP; SV remit]



4.5 Group-based support

Group-based support interventions, such as support groups and online forums, were offered by more than two-fifths of the services we mapped (see Figure 11 above), and by over half of the services we interviewed (n=92, 54%). Overall, 169 different group-based support interventions were provided by these 92 services. Compared with the overall sample of interviewed services, services providing group-based support were more likely to be in the not-for-profit sector (n=84, 91%) than the statutory sector (n=4, 2%).

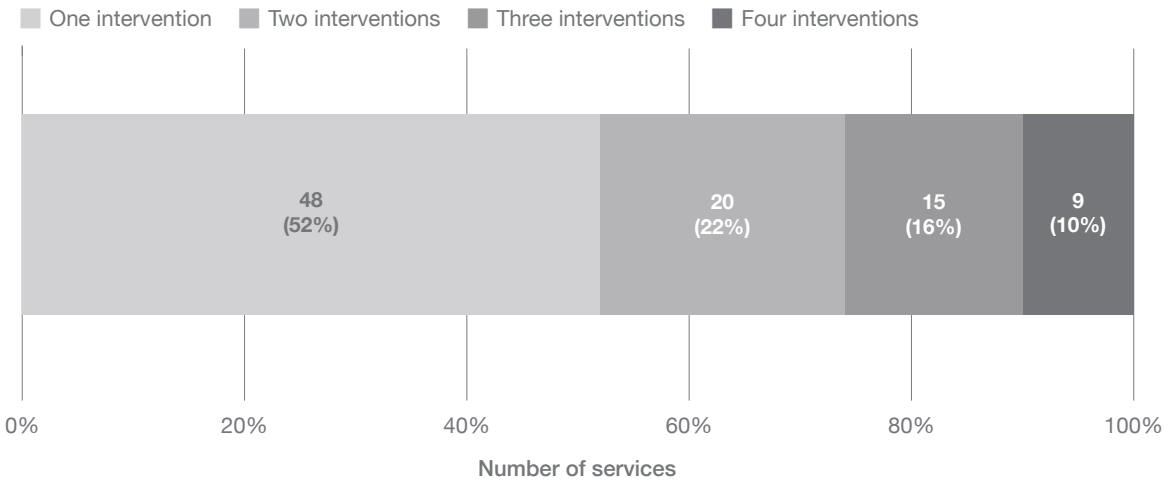
As Figure 20 shows, half of these services provided a single type of group-based intervention, with one in ten providing four different interventions.

4.5.1 What did group-based support involve?

Two main types of group support were offered in the 169 interventions. One type, which could involve either in-person or online delivery, was generally described as more structured, with elements of psychoeducation where facilitators would address a different topic each session, alongside peer discussion and support. Topics addressed typically depended on those attending the group, but included the impact of trauma, signs and symptoms of trauma, feelings of guilt, coercive dynamics, making good choices, parenting a child impacted by trauma, self-care, sexuality, and masculinity:

> "[It's a] 12-week psychoeducational and therapeutic group. We keep the group small, with up to four members. We cover topics such as embodiment and trauma and the nervous system, victim-blaming and self-blame, understanding grooming, sexual intimacy after sexual abuse. We have key topics that we talk about each week, with space for peer support and reflection." [ID676, NFP; wider remit]

Figure 20. Number of different group-based interventions provided by services



n=169.

The other type, always delivered in-person, tended to be less structured and more activity-based, while still providing a space for group support and talking. Activities were often creativity-focused, and included sewing, art, knitting, weaving, ceramics, music, creative writing and songwriting. Some groups were outdoor-focused (e.g. walking, fishing for men or boxing for young women), while others involved groups of children going bowling or to the cinema.

> "Mainly men that attend the fishing group, they find they are able to forget about all of the impact and there is a focus on mindfulness and recovery and it's a place for the men to be together in a serene and supportive environment. We have safeguarding in place and a support worker to make sure they are supported at all times. The group has been running for the past three years." [ID439, NFP; wider remit]

Just over a third of interventions (n=55, 31%) involved a structured programme, and a quarter (n=41, 23%) involved participant-led groups. Two-fifths (n=70, 41%) were said to use both approaches:

> "It's partly structured, partly participant-led. There is a structure, but all our services are client-led. So we ask people what information they'd like to cover, and through their feedback we will make any amendments as necessary and some of that material will be what the group want to discuss. So I would say it's probably a bit of both, but there is a structure to it and a PowerPoint, but we do always pay attention to what the group wants and needs." [ID219, NFP; wider remit]

Many group-based interventions focused on sharing grounding techniques, tools and strategies for dealing with the impact of trauma. A few services offered yoga or trauma-release exercise, or less traditional types of support such as residential weekends and a clinical hypnotherapy group.

Some services highlighted the social element of group work, using interventions as spaces for victims/survivors to socialise – for example, through a 'coffee and chat' approach, or as a lunch club inviting different speakers.

All the group-based interventions, regardless of how they were delivered, included an important element of peer support. Services highlighted the power of bringing together people with similar experiences to connect with each other, build a network of peer support, and consequently reduce isolation:

> "This is the calm space, the space where people can be vulnerable and be heard. It's really important that survivors meet other survivors. One of our facilitators, years ago on a group therapy programme, said, 'Sexual abuse happens in isolation, healing happens in community.' So it's that connection. It's hearing others' experiences, your experience coming out of somebody else's mouth. It's knowing you're not alone. It's knowing it's OK to say this and the world isn't going to collapse." [ID248, NFP; CSA focus]

> "[It's] an opportunity for peer support. You'll have a parent who maybe it's two years down the line and then another parent who is just a few months, and they'll say, 'Look, we were there, we were there, don't worry, we know you'll get through this.' They offer that empathy and hope to each other in some cases." [ID100, NFP; wider remit]

A few services said they used group support as a way to 'hold' people while they waited for one-to-one therapeutic support, or to provide ongoing support following the end of individual support:

> "It's a mindfulness course for those on the waiting list, with a view to focus in on anxiety and depression." [ID312, NFP; SV remit]

> However they were delivered, group-based interventions all included an important element of peer support

4.5.2 Who received group-based support?

Figure 21 shows that more than two-thirds of group-based support interventions were available to adult victims/survivors of child sexual abuse, while a third were for parents, and a fifth for other adults affected by child sexual abuse.

A quarter of groups were for children who had been sexually abused, and one intervention specifically supported vulnerable children in school settings. A few services supporting victims/survivors also provided group-based support to children who had engaged in harmful sexual behaviour; Appendix 3 outlines the support provided by services focusing *exclusively* on those children.

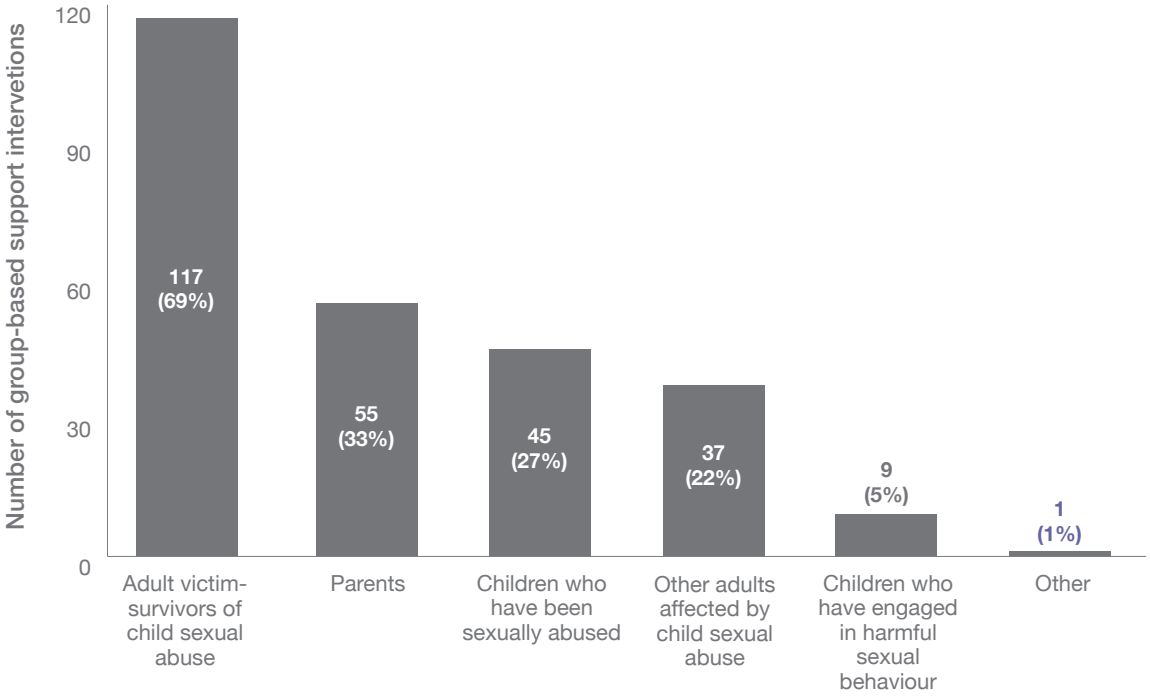
4.5.3 How and when was group-based support delivered?

As Figure 22 shows, half of group-based interventions met exclusively in person, while a quarter met exclusively online; another quarter involved a mixture of both:

> "Community-based through craft fairs, festivals etc. We go to events… in a service that's already established and we offer an opportunity to attend six sessions." [ID354, NFP; CSA focus]

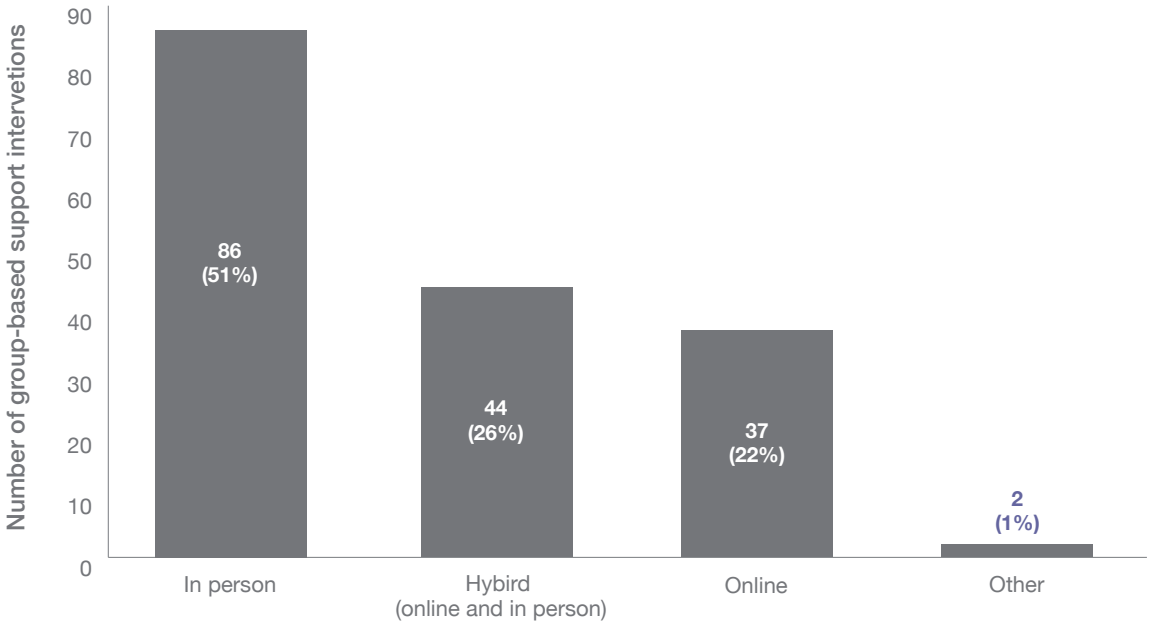
Almost all group-based interventions were facilitated or moderated by staff, including support workers, qualified therapists, trainee clinical psychologists, a qualified arts therapist, a LGBTQ+ specialist worker and counsellors trained in group therapy. Only four interventions (2%) involved non-facilitated groups.

Figure 21. Recipients of group-based support



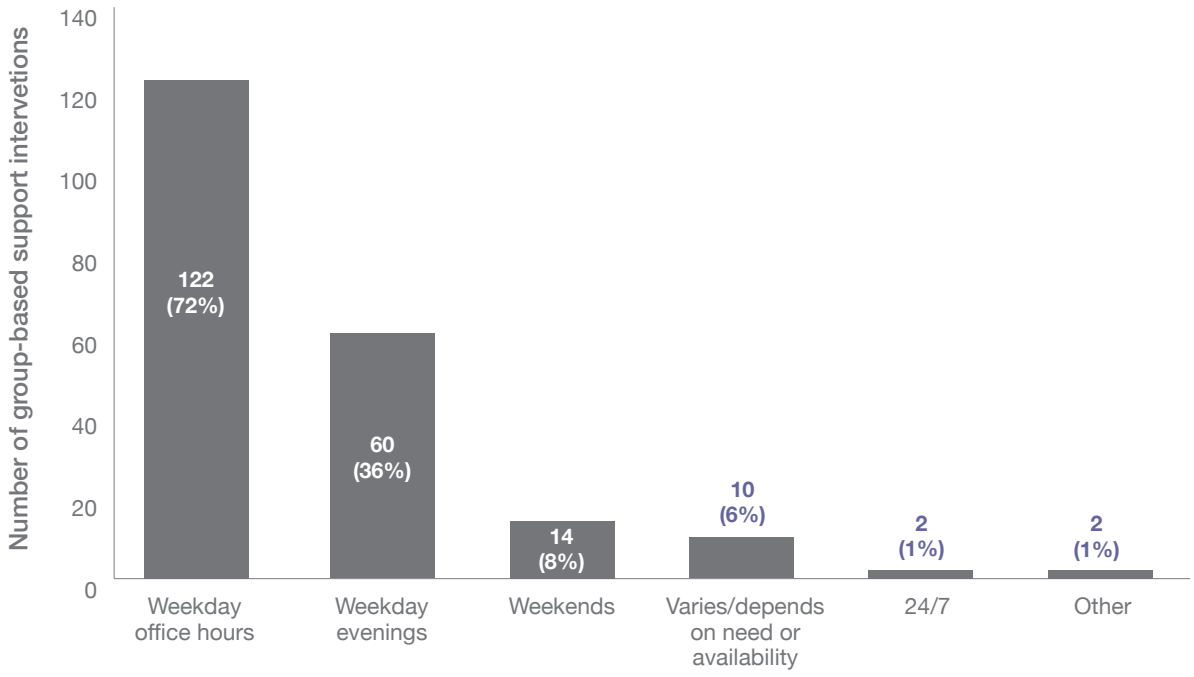
n=169.

Figure 22. Method of delivery for group-based support



n=169.

Figure 23. Times when group-based support was available



n=169.

As Figure 23 shows, almost three-quarters of group support was delivered during weekdays, and a third on weekday evenings. One service highlighted the limitations of only being able to offer support on weekdays:

> "It's weekdays again, 9 'til 5, so I would say that is a bit of a limitation for the parents. And we sometimes have parents say, obviously because of work commitments, 'Sorry, I'm not going to be able to attend.'"
> [ID100, NFP; wider remit]

Fourteen interventions (8%) provided group support during the weekend, and another 10 (6%) ran groups depending on need and participants' availability. One service ran its group support during the school holidays and another said that participants accessed the group in their own time. One intervention delivering group support 24-hours, seven days a week, did so via its app-based peer support.

Three-quarters of interventions ran groups on a weekly basis (n=124, 73%), while one in six ran monthly groups (n=24, 14%):

> "Peer group monthly, core group weekly, ad hoc one-off sessions."
> [ID347, NFP; SV remit]

Most group-based interventions limited either the number of group sessions (n=60, 36%) or the length of time a service user could be in the group (n=45, 27%), generally between six and 13 sessions or weeks. However, over a third of interventions (n=60, 36%) imposed no limitations:

> "There aren't [any limitations], but there is usually a life to a therapeutic group, which is two years. It's running three blocks each year, so you can roll over. It's good to have a break from it maybe [after] two years, but again it's tailored and individual, so we review it."
> [ID359, NFP; SV remit]

Three services had other limitations: one specified that parents could no longer access the group-based support once their child 'graduated' from the service while another was only available to service users while they were accessing other interventions within the service. A third intervention was limited by the number of people that could access the group.

4.6 Helplines and chat services

A third of all the services we mapped provided a helpline or chat service – as did a third (n=54, 33%) of the 166 services we interviewed. Between them, these 54 services were running 62 helplines or chat services supporting people affected by child sexual abuse, with most (n=46, 85%) offering just one helpline or chat service. Compared with the overall sample of interviewed services, services providing helplines and chat services were more likely to be not-for-profit (n=48, 89%) than in the statutory sector (n=6, 11%), and were also much more likely to have a sexual violence remit (n=47, 87%).

4.6.1 What did the support provided through helplines and chat services involve?

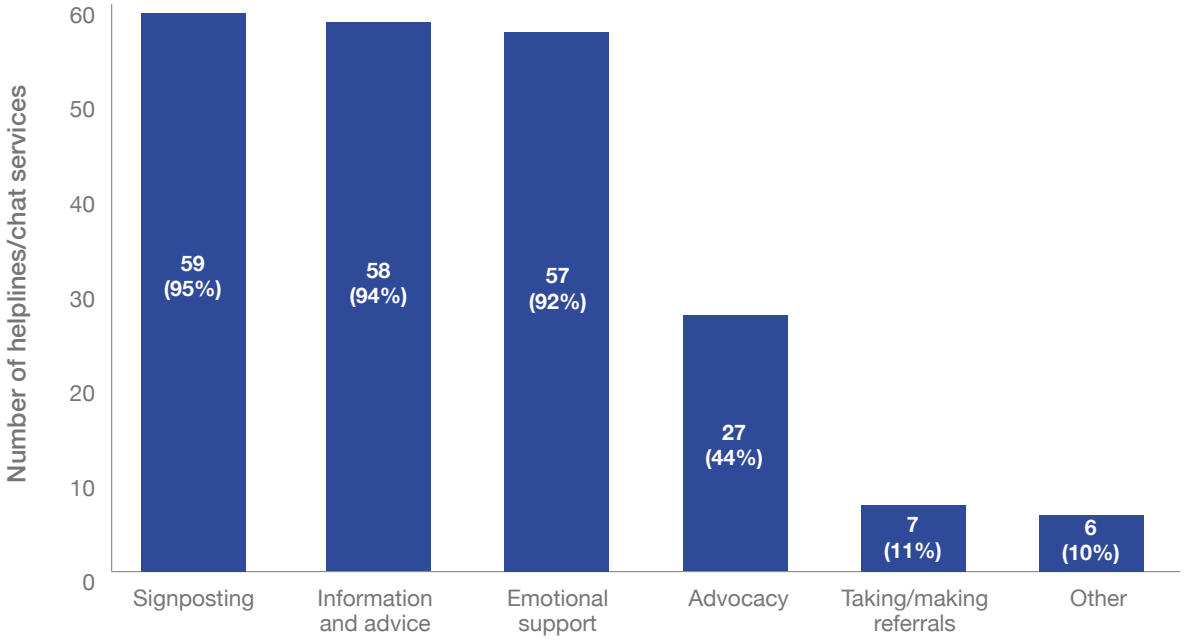
As Figure 24 shows, the vast majority of helplines and chat services offered information and advice, emotional support and/or signposting to other sources of advice or support. This included supporting victims/survivors with, for example, sexual health, housing or debt. Nearly half also provided advocacy support.

A few services described their helplines as a way of empowering people affected by child sexual abuse:

> "It's a support line rather than a helpline. There is a subtle difference for us. 'Help' kind of suggests that we're doing something for other people, where 'support' is encouraging people to do things for themselves."
> [ID254, NFP; wider remit]

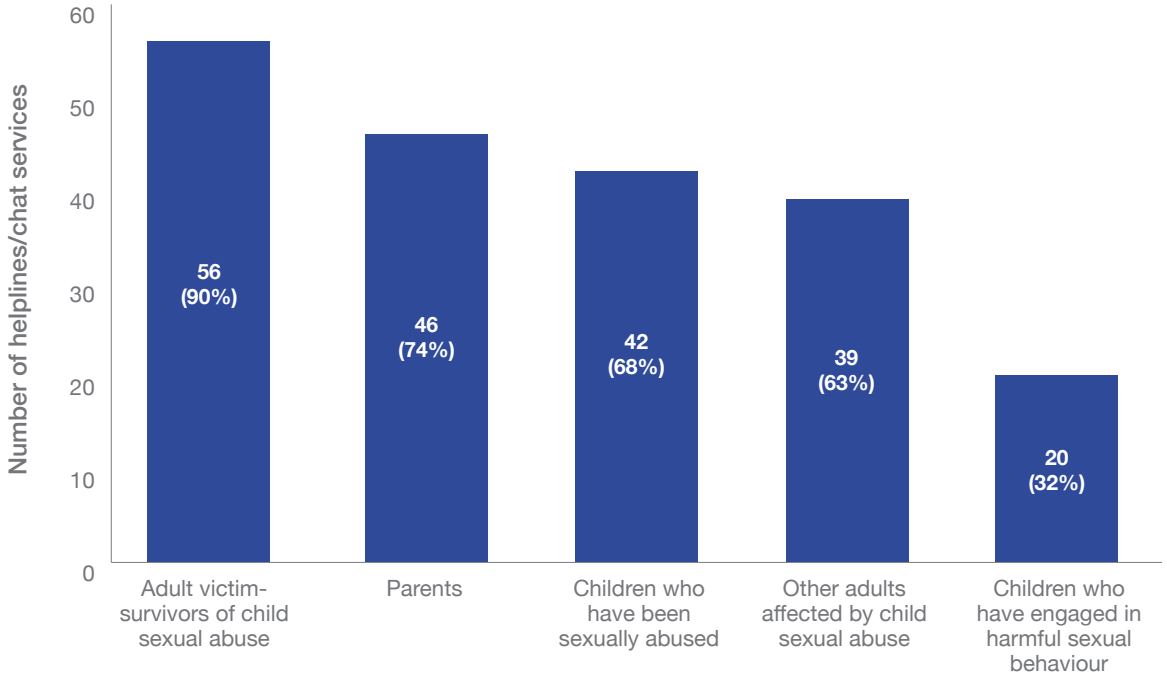
> Nine out of ten services providing helplines and chat services were not-for-profit, and most had a sexual violence remit

Figure 24. Types of support provided through helplines and chat services



n=62.

Figure 25. Recipients of helpline/chat service support



n=62.

4.6.2 Who were helplines and chat services provided for?

As Figure 25 shows, most helplines and chat services were for adults – primarily victims/survivors of child sexual abuse or parents of sexually abused children. Two-thirds were available to children who had been sexually abused/exploited, while one third supported children who had engaged in harmful sexual behaviour.

Two service said their helplines supported children on a range of issues, such as children's competency, safeguarding and parental consent:

> "The difference between this [helpline] service and probably other services, [it's] in general a self-referral service for young people, so they don't need to have reported their abuse to access it. So they may not have reported it to the police or anyone else… There are quite stringent safeguarding requirements around that. But one of the things we acknowledge, and the reasons we've set the service up, is because we recognise that about 70% of young people disengage from the criminal justice process. So this is an attempt to do things a bit differently and get support in place before, and ensure young people are well supported before they report." [ID446, NFP; CSA focus]

4.6.3 How and when were helplines and chat services delivered?

As Figure 26 shows, the vast majority of helpline/chat services offered their support by telephone, and half by email (n=31, 50%). Support via webchat, online and text were each provided by a quarter, and one service had a specific app.

A fifth of helplines/chat services (n=11, 18%) – a mixture of local, regional and national services, including one supporting children only – were available 24 hours a day, seven days a week. Another two-thirds (n=42, 68%) were mostly available during weekdays, while more than half (n=34, 55%) offered support during weekday evenings:

> "[It's open] 21 hours per week, including two evenings." [ID308, NFP; SV remit]

Over three-quarters of helplines/chat services (n=47, 78%) had no limitations in place in terms of how often or for how long people could access them. Others applied a limit to the length of telephone calls:

> "Some people do come back, returning callers. Ideally, we want people to not be dependent on our service for ongoing support. It's not meant to be an ongoing support service, but for some people, that's all they've got. So those people we limit to 10 minutes a week. The normal target call length is a maximum of 30 minutes." [ID254, NFP; wider remit]

A few services mentioned that their helpline/chat service was staffed by volunteers, meaning that its availability was affected by their ability to recruit, train and retain volunteers:

> "Difficult to get volunteers for that service. Apart from the national commissioned line, nobody really funds paid workers for local helplines. We rely on volunteers and we've had a huge drop since COVID and cost of living – people can't afford to volunteer. We lost over half of the voluntary workforce since COVID." [ID142, NFP; SV remit]

Figure 26. Method of delivery for helpline/chat service support

n=62.

4.7 Residential care

Only a small proportion of the services we mapped (n=22, 5%) provided residential care, including three (2%) of the 166 services we interviewed.

All three services providing residential care were located in the not-for-profit sector. One was focused solely on supporting people affected by child sexual abuse, while another worked in the sexual violence sector and the third had a wider remit that included sexual abuse.

The three residential care services were very different. One ran residential weekends (three nights) where adults in a specific region of England who had been sexually abused/exploited as children were offered a number of trauma-informed, facilitated workshops:

> "We have two trained counsellors, 24/7 over the weekend, and a number of workshop facilitators that are trauma trained. It is the only one in the country." [ID392, NFP; SV remit]

Another service, operating nationally, provided longer-term residential support for girls aged 12–17 who were referred by children's social care because they had been (or were at risk of being) sexually exploited, or had engaged in harmful sexual behaviour. The care provided included one-to-one therapeutic support, as well as support to their parents:

> "We're working with young people due to return home or part of the care plan to resolve difficulties or issues within the parenting. We have a whole-family approach and the way that we work will involve supporting the insight and understanding of parents and carers and thinking about their responses to things." [ID621, NFP; CSA focus]

The third provided refuges for adults from a minority ethnic group who needed to leave their homes as a result of other forms of abuse or immigration issues; around a fifth of these adults had been sexually abused as children. Its support included providing an advocate within the refuges, access to counselling and a 'Surviving to Thriving' training course. The length of stay depended on service users' ability to access follow-on accommodation.

4.8 Other types of support

In addition, 21 of the 166 services we interviewed were providing other types of support for victims/survivors of child sexual abuse and their families.

There was considerable variation in the types of support that they provided, but self-help resources and financial support were the most common. Self-help resources took the form of online resources such as podcasts, videos and information supporting recovery:

> "It's an online programme that our survivors have lifetime access to, and it has YouTube and podcast videos on grounding techniques, how to manage their emotions and if they dissociate or if they have a panic attack. So there's a variety of different videos there and self-soothing videos as well. There's journals for them to keep and complete, information about the effects, and just so it reiterates what's normal, so they know how they feel is normal." [ID344, NFP; SV remit]

Financial support might involve helping service users to access therapeutic support or supporting children's education:

> "We'll get them a laptop if they don't have one so they can do their schoolwork." [ID371, NFP; CSA focus]

Another service explained that it could access funds to help service users feel safer or access services:

> "We used it for a video doorbell… to make victims feel safe, or for a taxi to get to face-to-face services. It's capped at £100 per person." [ID70, NFP sector; wider remit]

Some also mentioned arranging activities for children to take part in, or work experience for adult victims/survivors:

> "We have a young people's panel, and we ask them if there is anything they would like or that we are not doing. Our teenagers said they would like to go to Brighton, so we organised a trip. We have a box at Crystal Palace football stadium." [ID359, NFP; SV remit]

> "One of the modules in our programme is to provide opportunities for participants to go on work placements to do volunteering, to do an apprenticeship… just to gain experience, to add to their CV." [ID415, NFP; wider remit]

One service described a range of tools it had developed to support parents and professionals in "how to navigate the modern, technologically based life of teenagers." [ID680, NFP; wider remit]

> Self-help resources provided to service users included podcasts and videos to support recovery

5. Who are services supporting?

This chapter looks at the numbers and characteristics of people being supported by the services we interviewed, including recent changes in the demographics of service users.

Key findings and reflections

1. Around half of services had supported fewer than 100 people in 2021/22; this was consistent across services for children and for adults. A small minority – mainly in the not-for-profit sector – had each supported thousands of children and adults that year.
2. A large majority of service users supported by services in 2021/22 were women and girls. Although the CSA Centre estimates that a quarter of children sexually abused in England and Wales are male (Karsna and Kelly, 2021), most services said that men and boys represented fewer than a quarter of their service users.
3. Four-fifths of services told us most or all of their service users were White British. The few services that worked solely or mainly with minority ethnic communities typically supported very few service users in relation to child sexual abuse (fewer than 50 children or adults a year in almost all cases), with most providing this support as part of a wider remit.
4. More than a third of services supporting children said they had not seen any physically disabled children in 2021/22, and the vast majority told us that these children represented less than 10% of their child service users. This is significant under-representation of a group who are nearly twice as likely as non-disabled children to be sexually abused (ONS, 2020), but it mirrors the findings from Allnock et al (2015) that few disabled children receive support from services. However, almost three-fifths of services supporting children estimated that more than 10% of their child service users had *learning* disabilities/difficulties.
5. In contrast, a third of services supporting adults said that more than 10% of their adult service users were physically disabled; this is in line with the higher prevalence of physical disabilities among the adult population. On the other hand, fewer than two-fifths said that adults with learning disabilities/difficulties accounted for more than 10% of their adult service users, and one in seven had not supported any adults with learning disabilities/difficulties. Around 2% of adults in England are believed to have a learning disability (Public Health England, 2016), but there is no information about the prevalence of learning difficulties in the adult population.
6. A quarter of services supporting children, and a third of those supporting adults, told us that 10% of their service users in the relevant age group(s) were LGBTQ+. Sexual violence support services were most likely to support a high number of LGBTQ+ young people and adults. Around half of services said they had supported children or adults who identified as transgender, although these people generally represented a tiny proportion of their service users; this reflects the findings from the 2021 Census, in which well under 1% of the UK population aged 16+ said their gender identity did not match their birth sex (ONS, 2023b).

7. Many services were unable to provide any information on the numbers of disabled children and adults they had supported; this highlights a need for services to improve their recording of service users' protected characteristics under the Equality Act 2010.
8. Three-fifths of services said the diversity of their service users had increased in recent years: the number of minority ethnic, LGBTQ+, disabled and male victims/survivors of child sexual abuse accessing services were all said by different services to have increased. Suggested reasons for this included outreach work, the employment of specialist workers, and development of services for specific groups; it was also thought to reflect changes in local demographics and increased societal awareness of child sexual abuse across different groups.

Implications

While the findings here are based on services' estimates of their service users' demographic characteristics, they highlight the need for more reliable information on which groups are under-represented among those receiving support for child sexual abuse. This may require:

- support for services to improve their data collection systems and analysis – the CSA Centre's ***Improving Your Data on Child Sexual Abuse: A Practical Guide for Organisations*** can help services with this
- further research into access to services for specific groups – particularly boys, children and adults from minority ethnic backgrounds, and physically disabled children
- funding to support both of the above.

5.1 How many people do services support in response to child sexual abuse?

Services were asked how many people they had supported in response to child sexual abuse in 2021/22, Three-quarters (n=123, 74%) of the 166 interviewed services answered this question; where the information was difficult to retrieve, some services provided an estimate.

As Figure 27 shows, services supporting adults and those supporting children looked quite similar in terms of the number of service users they had supported in 2021/22.

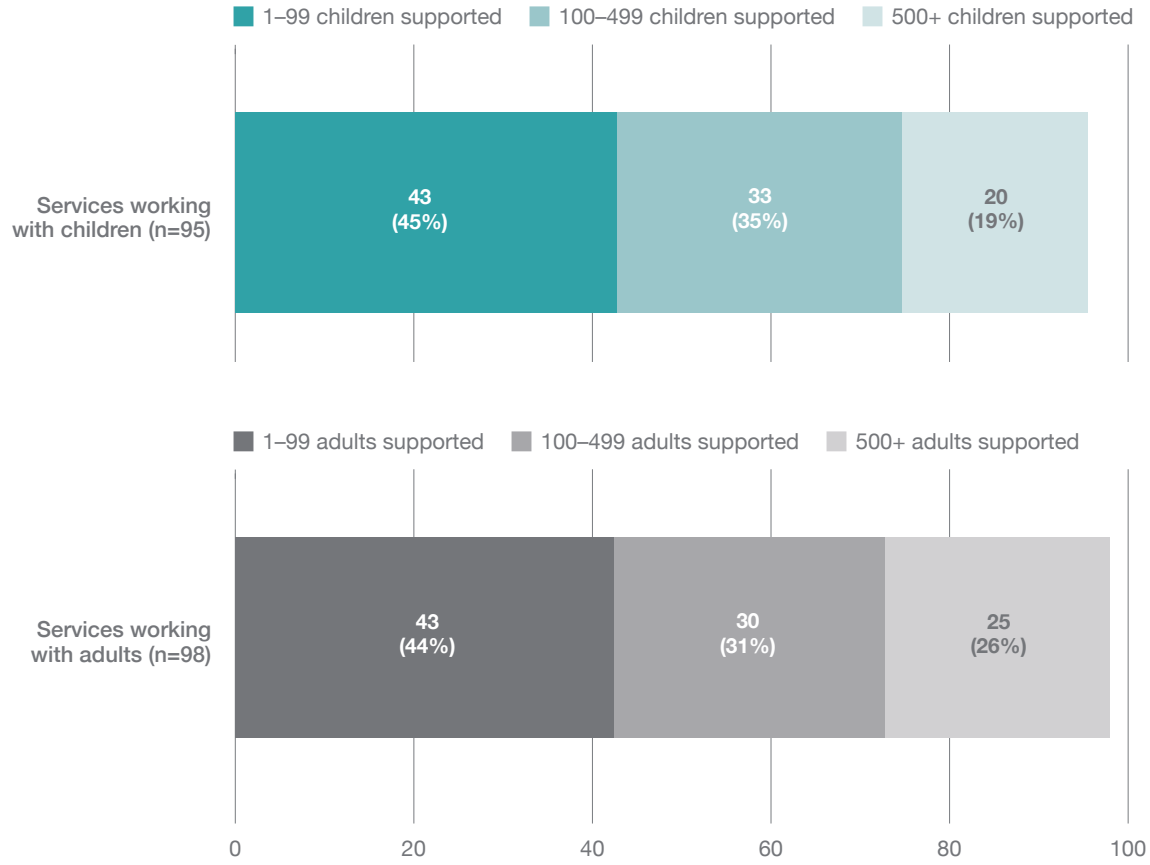
5.1.1 Children

Of the 130 interviewed services that supported children, nearly three-quarters (n=95, 73%) provided either exact or approximate numbers of children they had supported in the previous year.

As Figure 27 shows, nearly half of these services had supported fewer than 100 children in response to child sexual abuse in the year, and a third had supported between 100 and 499 children. One in five services had supported more than 500 children; all but four of these were in the not-for-profit sector, three were SARCs, and one was a statutory-sector helpline supporting victims of crime.

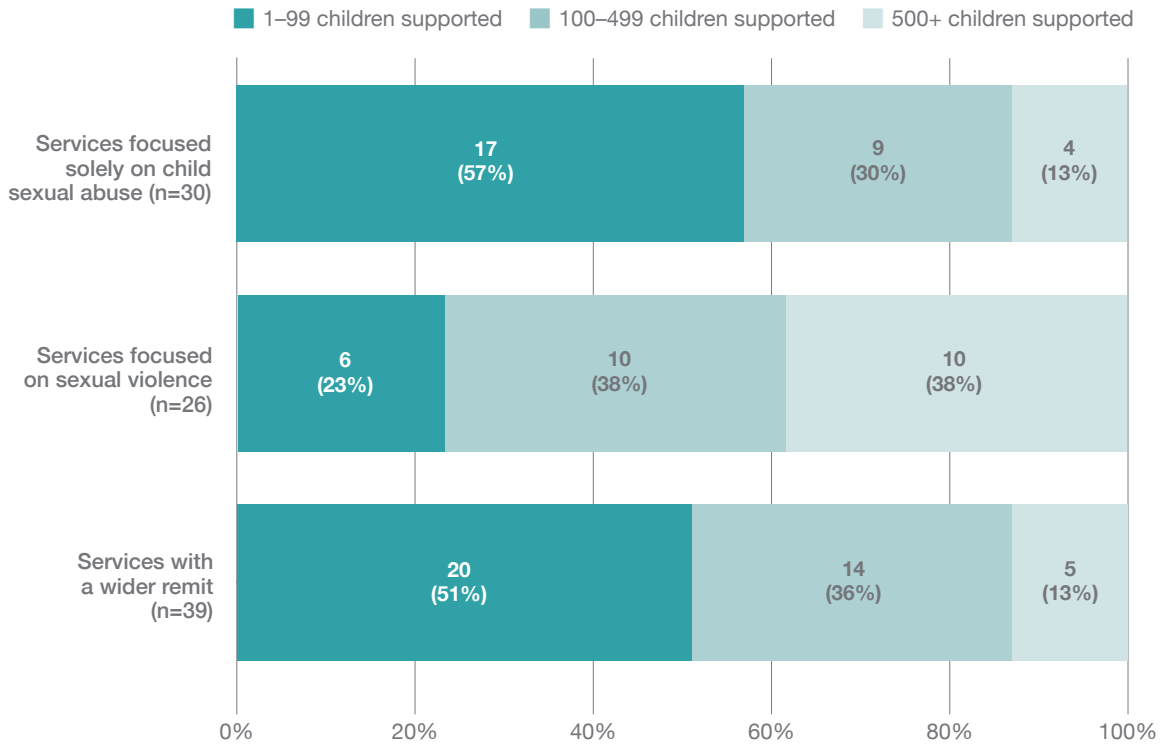
As Figure 28 shows, services focused solely on child sexual abuse, and those with a wide remit, tended to have seen fewer children in the year than those (such as Rape Crisis centres) responding to sexual violence more widely. Two-fifths of sexual violence support services had supported more than 500 children during the year.

Figure 27. Numbers of children and adults receiving support in response to child sexual abuse



n=123.

Figure 28. Numbers of children receiving support in response to child sexual abuse, by service remit



n=95.

Large services in our sample

Our sample included 19 services which said they had supported more than 500 children affected by child sexual abuse in 2021/22. All but three of them also worked with adult victims/survivors of child sexual abuse, and typically reached large numbers of adults too.

Most of these services provided a mix of services for children. Generally, the largest number of children were reached through helpline/chat services, but at least six services supported more than 500 children through counselling or therapeutic services, and at least three supported more than 500 children through advocacy or ChISVA services. (Some did not provide information about the type of service children had accessed.)

One was a national service, and two operated in multiple regions; the other 16 were all single-region.

5.1.2 Adults

Two-thirds (n=98, 70%) of the 142 interviewed services that supported adults – either adult victims/survivors of child sexual abuse or non-abusing parents/family members of sexually abused children – told us how many adults they had supported in relation to child sexual abuse in 2021/22.

As Figure 27 above shows, fewer than half of these services had supported fewer than 100 adults in response to child sexual abuse, nearly a third had supported between 100 and 499 adults, and a quarter had supported more than 500 adults. All the services that had supported more than 500 adults were in the not-for-profit sector.

Reflecting the findings on services supporting children, services focused solely on child sexual abuse and those with a wide remit tended to support fewer adults affected by child sexual abuse than services responding to sexual violence (see Figure 29).[8]

Services whose support to adults focused primarily on parents[9] of sexually abused children tended to be smaller than those primarily working with adult victims/survivors[10] of child sexual abuse (see Figure 30). The 57 services supporting both adult victims/survivors *and* parents tended to be the largest, with more than a third reaching more than 500 adults in 2021/22.

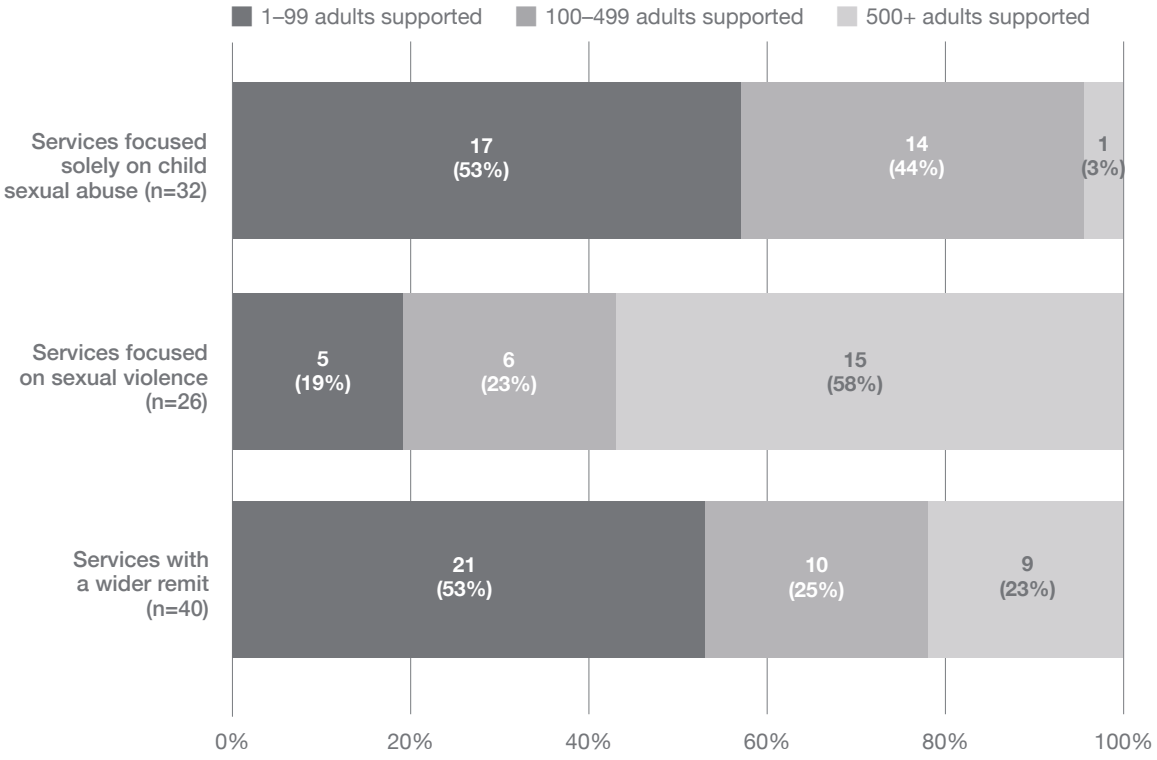
> All the services that had supported more than 500 adults in 2021/22 were in the not-for-profit sector

8 Some services' figures may have included all adults who had told them about being sexually abused as children in their service setting, even if the support they received focused on more recent sexual violence and did not directly address their childhood abuse.

9 We categorised services as working primarily with parents if they said they supported solely parents of sexually abused children (n=6) or parents and "other adults affected by child sexual abuse" (i.e. not victims/survivors) (n=10).

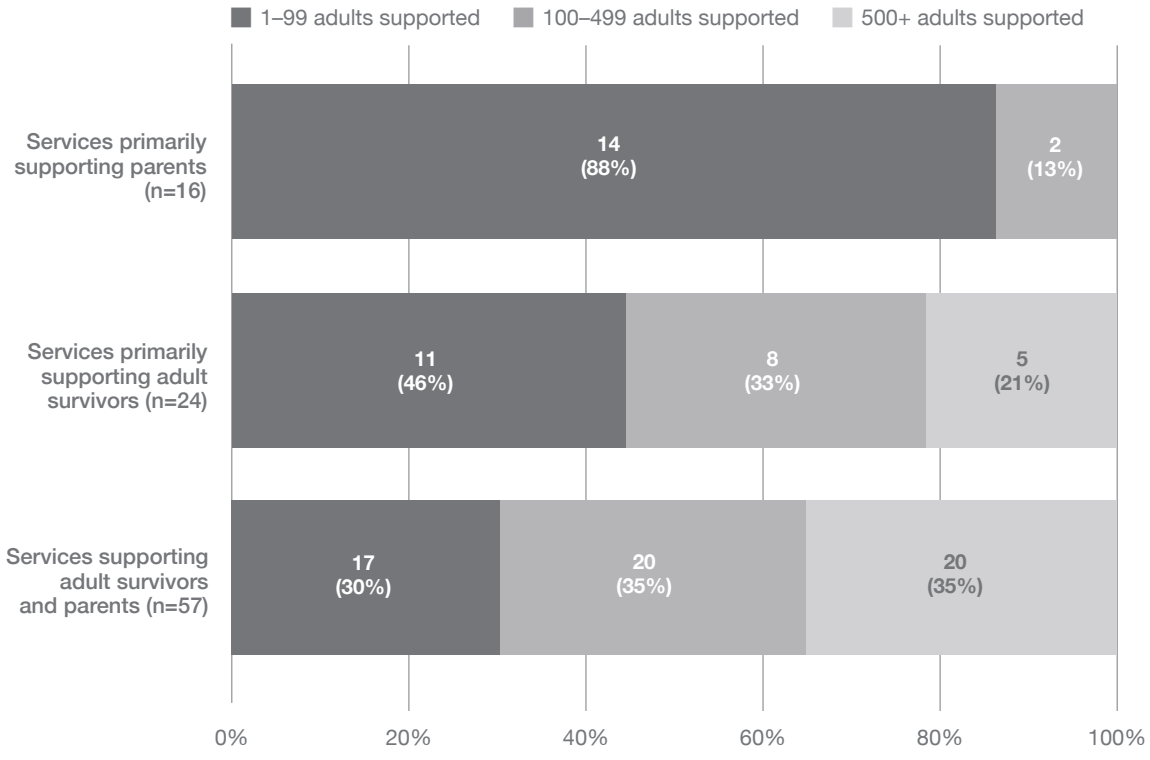
10 We categorised services as working primarily with adult victims/survivors if they said they supported solely adult victims/survivors (n=17) or adult victims/survivors and "other adults affected by child sexual abuse" (not parents) (n=7).

Figure 29. Numbers of adults receiving support in response to child sexual abuse, by service remit



n=98.

Figure 30. Numbers of adults receiving support in response to child sexual abuse, by type(s) of adult supported



n=97; one of the 98 services working with adults did not specify the type(s) of adults it supported.

5.2 Service users' characteristics

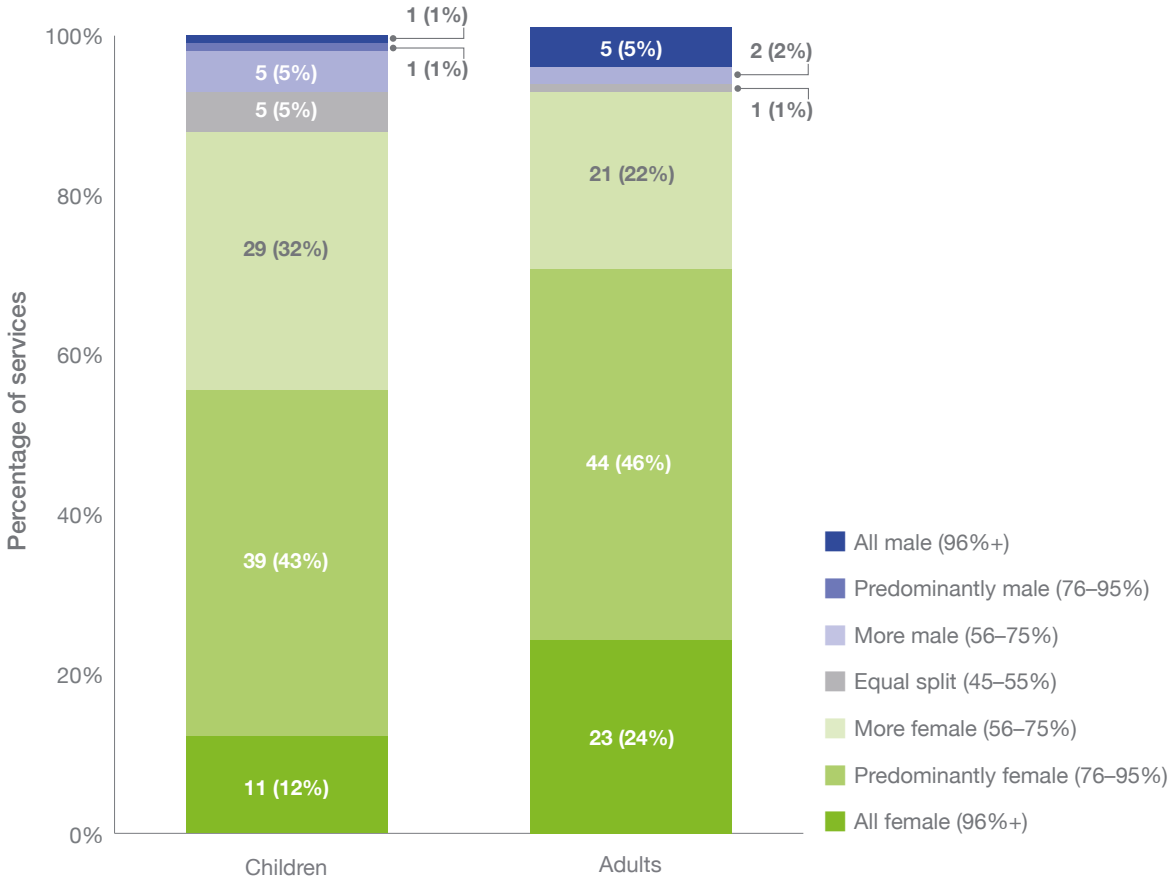
We asked services to tell us about the characteristics of the people they had supported in response to child sexual abuse: their sex, gender identity, ethnic background, sexual orientation, and disabilities or learning difficulties. Most services had to estimate the proportions of service users with different characteristics, with only a few having the exact numbers available. The findings in this section are therefore indicative of broad trends rather than providing a record of the characteristics of children and adults supported by services. Owing to the face-to-face nature of the interviews, social desirability bias – the tendency for interviewees to provide answers they think their interviewer will want to hear – may have led some services to overestimate their reach to people with certain characteristics.

5.2.1 Sex

About two-thirds of services – 91 of the 130 supporting children and 96 of the 142 supporting adults – provided information about the extent to which they supported people of different sexes.

As Figure 31 shows, a large majority of service users supported by services in 2021/22 were women and girls. While it is estimated that around three-quarters of child sexual abuse victims/survivors are female (Karsna and Kelly, 2021), more than half of services supporting children and two-thirds of those supporting adults estimated that the proportion of girls/women in their setting was higher than this.

Figure 31. Service users, by sex



n=129, of which 91 supported children and 96 supported adults. Services supporting both were asked separate questions about the children and the adults they supported. Data relates to 2021/22.

Women and girls

Among the services supporting children, seven out of eight said the children they supported in 2021/22 had been only or mainly girls. An even greater majority of services supporting adults said these had been only or mainly women in 2021/22, with a quarter of services having supported only women.

A total of 29 services had supported *only* women and/or girls in 2021/22; all these services were in the not-for-profit sector.

More than half (n=16, 55%) had a wide remit which included child sexual abuse, while a quarter (n=7, 24%) focused solely on child sexual abuse and a fifth (n=6, 21%) focused on sexual violence. Three services focused specifically on child sexual exploitation, and one each on intra-familial child sexual abuse and abuse in institutional contexts.

Four-fifths (n=23, 79%) of the 29 services provided their support to people across one or more local authorities within a single region of England or Wales.

Men and boys

Fewer than half (n=41, 45%) of services supporting children said that boys had represented at least 25% of those children in 2021/22; this included one service that had supported only boys in 2021/22, and six which said that boys had accounted for over 50% of their child service users.

Sexual violence support services for children were even less likely to have supported significant numbers of boys; seven (28%) of these services reported that up to 25% or more of their child service users were male.

Among services supporting adults, five had supported only men in 2021/22, and another two reported that more than half of their adult service users had been male. Overall, however, fewer than a third (n=29, 30%) of these services – and just one in six (n=4, 17%) of adult sexual violence support services – said that men had represented at least 25% of their adult service users.

Of the seven services that had supported solely or mainly men in 2021/22, six addressed sexual abuse in childhood *and* sexual violence in adulthood. The other service had a wider remit of trafficking.

Two of these services – a sexual violence support service and the one focused on trafficking – supported boys as well as men.

All seven services were in the not-for-profit sector. Four operated at a regional level; another was a national service, and two operated across multiple neighbouring local authorities.

> Services supporting *only* women and/or girls were all not-for-profit, and few operated in multiple regions

5.2.2 Ethnic background

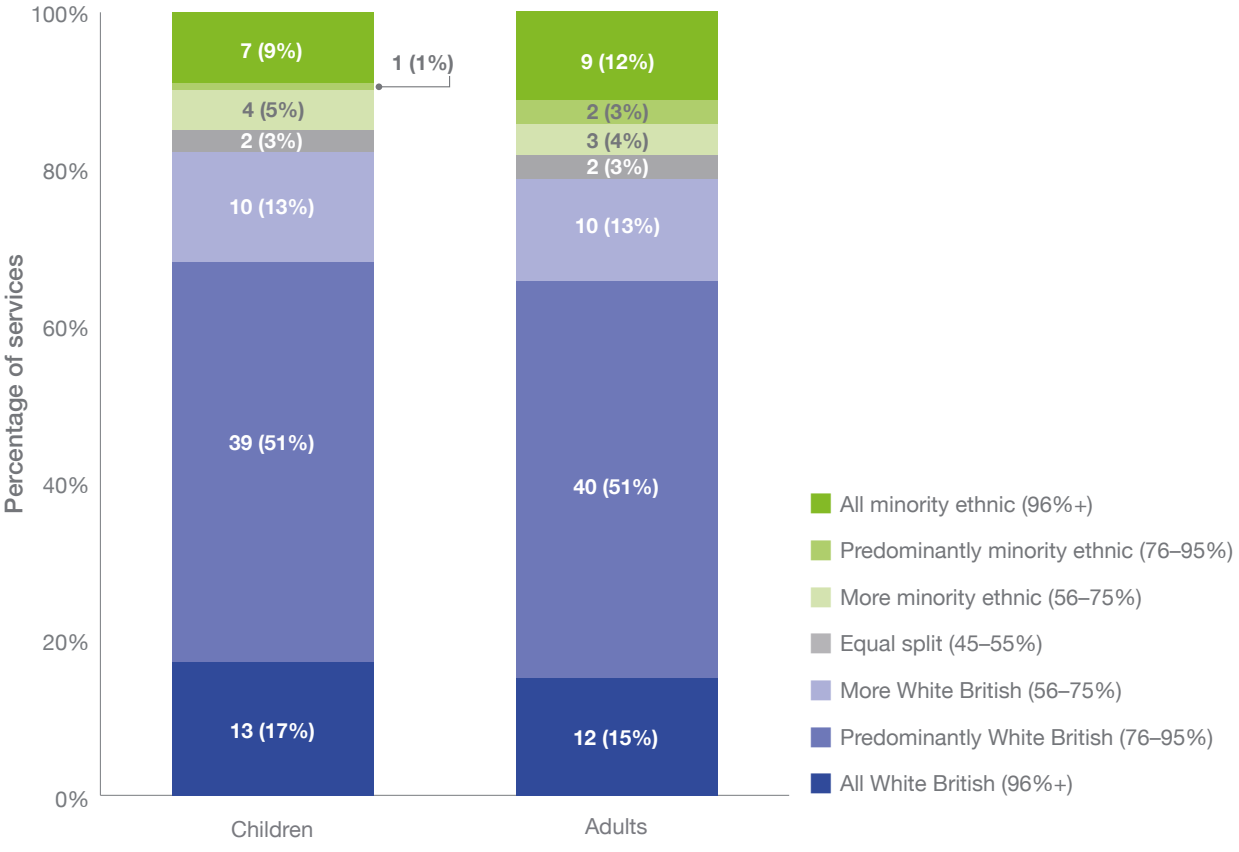
We did not attempt to collect detailed data on the ethnic backgrounds of children and adults supported in response to child sexual abuse, as we felt it was unlikely that many services would be able to provide this level of detail, so we asked services to estimate the overall proportion of supported children and adults who were of any minority ethnic background (e.g. Black African, Caribbean, Asian, and White backgrounds other than White British).

Three-fifths (n=76, 58%) of the 130 services supporting children in response to child sexual abuse, and more than half (n=78, 55%) of the 142 services supporting adults, were able to provide estimates for 2021/2022.

There was a very similar pattern across both types of service, as Figure 32 shows, with four in five services reporting that their service users were mainly or solely White British.

The prevalence of child sexual abuse has been found not to vary significantly with ethnic background (Bebbington et al, 2011). Ethnic diversity varies by region in England and Wales, with the proportion of minority ethnic residents ranging from over half of the population in London[11] to just under one in ten in Wales and the North East (see Appendix 5).

Figure 32. Service users, by ethnic background



n=110, of which 76 supported children and 78 supported adults. Data relates to 2021/22.

11 The latest Census data shows that only 37% of London residents were White British in 2021 (ONS, 2023a). In all other regions of England and Wales at least 70% of residents were White British, although at a more local level several local authorities outside London (e.g. Slough and Leicester) also have high ethnic diversity.

Children

Seven services (9%) said they had only supported children from minority ethnic backgrounds in 2021/22, and another five said they had mainly supported those children.

The 12 services that had only or mainly supported children from minority ethnic backgrounds were all in the not-for-profit sector. All but one of them also supported adults.

Ten of these services addressed wider forms of abuse (e.g. domestic or 'honour'-based violence,[12] trafficking) in minority ethnic communities, and responded to sexual abuse of children as part of that wider remit. Only one service focused on supporting sexually abused children and their parents, and another responded to sexual abuse and violence in childhood or adulthood.

The services typically supported a small number of children in relation to sexual abuse. Of the seven services devoted solely to minority ethnic communities, none had supported more than 50 children in relation to sexual abuse in 2021/22, and only two of five services supporting mainly minority ethnic communities had reached more than 100 children. A similar pattern applies to the number of adults supported: only one service had supported more than 100 adults in relation to child sexual abuse in 2021/22.

Five of the 12 services were national services operating across England and Wales. Another five were based in London; some of the London-based services said they responded to all local minority ethnic groups, while others only supported people from a specific ethnic group. The other two services were based in the North East and Yorkshire & the Humber.

Adults

Nine (12%) of the services supporting adults said that their support was focused solely on adults from minority ethnic backgrounds; a further five (6%) supported mainly adults from those backgrounds. Three of these services were solely for adults.

The three services that had supported only or mainly adults from minority ethnic backgrounds, and did not also support children, included two in the not-for-profit sector and one university support service in London. One of the not-for-profit services was working within a specific ethnic community while the other supported people from all minority ethnic backgrounds.

All three services responded to child sexual abuse within a wider service remit. Two of them had supported fewer than 50 adults in relation to child sexual abuse in 2021/22.

> Services focused on minority ethnic groups were almost all national or operating in London only

12 'Honour'-based violence refers to practices committed in order to protect an individual's perceived cultural and religious beliefs and 'honour' – it is their perception of their faith or culture, rather than the faith or culture itself, that motivates the violence.

5.2.3 Physical disabilities

Only two-fifths of the services we interviewed – 56 (42%) of those supporting children and 54 (38%) supporting adults – were able to give us information about the proportion of their service users who had physical disabilities.

As Figure 33 shows, services were reaching far more physically disabled adults than physically disabled children. This might be expected, since around 7% of children but 21% of adults in England and Wales are disabled (ONS, 2023c).[13]

In the Crime Survey for England and Wales 2019, physically disabled adults were nearly twice as likely as non-disabled adults to have been sexually abused in childhood (ONS, 2020).

Children

Four-fifths of services supporting children said that physically disabled children accounted for fewer than 5% of their child service users, including more than a third which had not supported any physically disabled children in 2021/22.

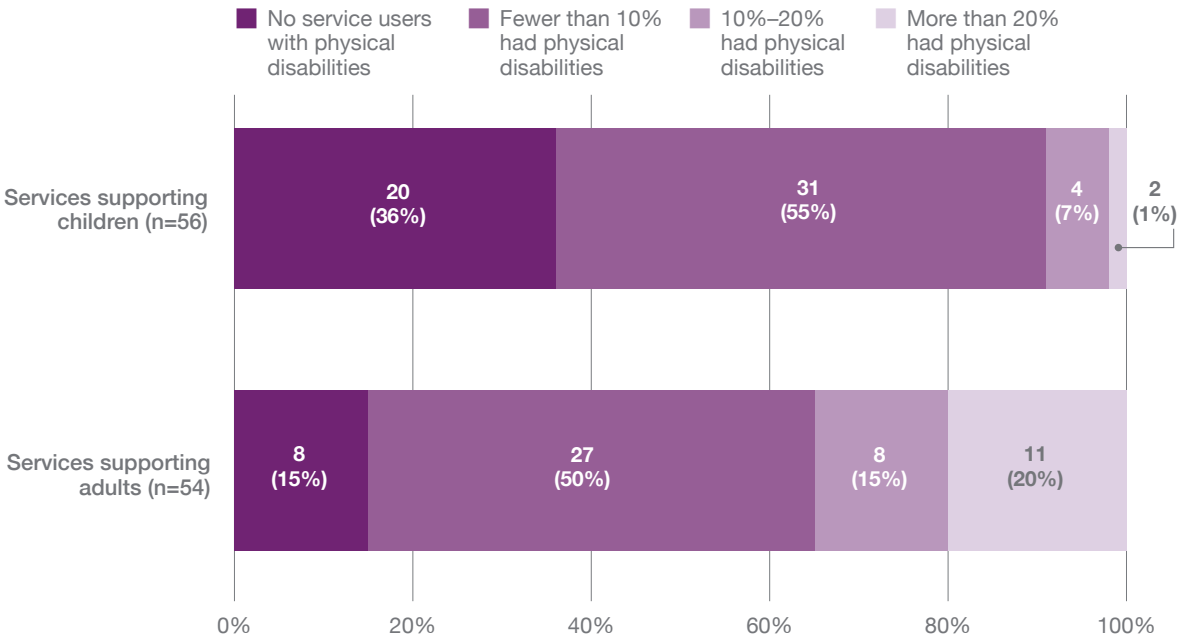
The five services that had supported a high proportion (10%+) of physically disabled children all operated at a local or regional level and were in the not-for-profit sector. These services were typically larger, with all but one of them supporting over 100 children in 2021/22.

All were mainly supporting White British children, and all but one were mainly supporting girls.

Adults

Only a third of services supporting adults said that more than 10% of those they had supported were physically disabled – and a sixth said that none of their adult service users had physical disabilities.

Figure 33. Proportion of service users with physical disabilities



n=80. Data relates to 2021/22.

13 Disability was defined as "any physical or mental health conditions or illnesses lasting or expected to last 12 months or more".

Seventeen of the 19 services that had supported a higher proportion of physically disabled adults (10%+) were in the not-for-profit sector; the other two were statutory services.

Two were national services and the rest operated locally, across neighbouring local authorities or regionally.

Again, these services were typically larger, with 12 supporting more than 100 adults a year. Only one of the 19 services supported mainly men, and another supported an equal share of men and women.

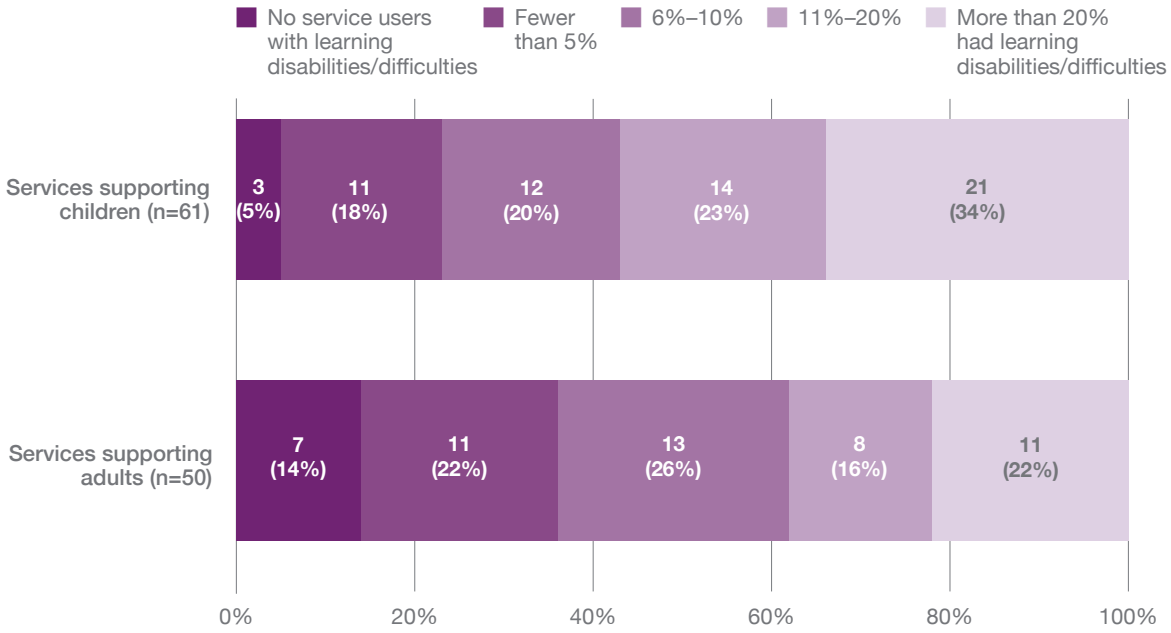
All but one of the services were mainly supporting adults of White British background, while the other had service users from a range of ethnic backgrounds.

5.2.4 Learning disabilities/difficulties

As with physical disabilities, data on the extent to which services supported children and adults with learning disabilities/difficulties was available from fewer than half of the services we interviewed; 61 services (46%) supporting children and 50 services (35%) supporting adults. There was some variation in how these services had collected data: while most services recorded self-identified learning disabilities/difficulties, a few recorded only diagnosed conditions.

As Figure 34 shows, learning disabilities/difficulties were more common in children supported by services than in adult service users.

Figure 34. Proportion of service users with learning disabilities or difficulties



n=81. Data relates to 2021/22.

Children

Learning disabilities/difficulties were present in a significant proportion of children supported by the 61 services providing this information. Almost three-fifths of these services estimated that more than 10% of the children they had supported in 2021/22 had learning disabilities/difficulties, with a third saying this was true of more than 20% of their child service users. Only three of the services said they had not supported any children with learning disabilities/difficulties.

In the academic year 2012/22, 4% of primary- and secondary-school children in England were on Education, Health and Care (EHC) plans, and a further 13% received support other for special educational needs (Department for Education, 2022).

Among the 21 services estimating that more than 20% of children supported in 2021/22 had learning disabilities/difficulties, 17 were not-for-profit and four in the statutory sector. One was a national service but each of the other 20 operated in a single regional (and, in some cases, a single local authority). There was a mix of service size, with both smaller and larger services seeing a high proportion of children with learning disabilities/difficulties.

Most of these services supported only or mainly girls, but two supported mainly boys and another two an equal proportion of boys and girls. One service provided support only to children of minority ethnic backgrounds and another supported an equal share of White British and minority ethnic children; all others said that they supported only or mainly White British children.

Adults

Fewer than two-fifths of the 50 services supporting adults estimated that those with learning disabilities/difficulties accounted for more than 10% of their adult service users, and only one-fifth said they accounted for more than 20%. One in seven services said they had not supported any learning-disabled adults due to child sexual abuse in 2021/22.

While about 2% of adults in England are believed to have a learning disability (Public Health England, 2016), there is no information about the scale of learning difficulties in the adult population.

All 11 services supporting a high proportion of adults with learning disabilities/difficulties (20%+) were in the not-for-profit sector. Each was operating within a single geographical region.

Typically the services were relatively large, with eight supporting more than 100 adults a year. One service supported solely men, while the other 10 supported only or mainly women. Only one of them worked primarily with people from minority ethnic backgrounds.

Four of the 11 services also supported a high proportion of physically disabled adults, but the remainder said that they had supported few adults with physical disabilities.

> No statutory services said that more than 20% of their adult service users had learning disabilities/difficulties

5.2.5 Sexual orientation and gender identity

Information on the number of service users who were lesbian, gay, bisexual or identifying as transgender or queer/questioning (LGBTQ+)[14] was available from 44 (34%) services supporting children and 65 (46%) of the services supporting adults that we interviewed.

As Figure 35 shows, the majority of these services said that fewer than 10% of their services users were LGBTQ+.

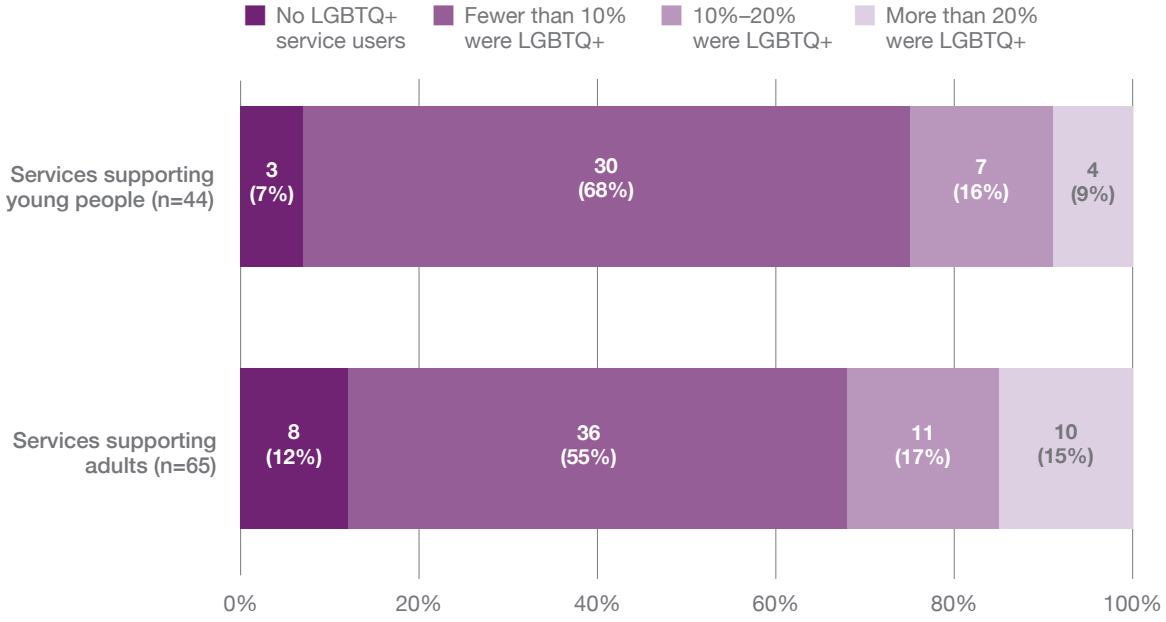
The prevalence of child sexual abuse has been found to be two to three times higher among lesbian, gay and bisexual people than those who are heterosexual (ONS, 2020). The 2021 Census found that 3.2% of the population aged 16+ in the UK said they were LGB and that 0.5% said their gender identity did not match their sex registered at birth (ONS, 2023b), although the latter figure is under review as it may overstate the true number of people identifying as transgender (Office for Statistics Regulation, 2023).

Young people

Three-quarters of services told us that LGBTQ+ young people represented fewer than 10% of their service users, including three which said they had not supported any LGBTQ+ young people in 2021/22.

Services focusing on sexual violence were most likely to support a higher proportion of LGBTQ+ young people in relation to sexual abuse: eight of the 16 services answering this question said that more than 10% of their young service users were LGBTQ+, compared to only two out of 15 services whose support in relation to child sexual abuse was part of a wider service offer.

Figure 35. Proportion of LGBTQ+ service users



n=90. Data relates to 2021/22.

14 This question was only relevant for services that worked with post-pubertal young people.

Adults

A third of services supporting adults said that more than 10% of their adult service users were LGBTQ+, and one in seven said they accounted for more than 20%.

Again, most services supporting large numbers of LGBTQ+ adults were focused on sexual violence: nine out of 17 such services said that more than 10% of their adult service users were LGBTQ+.

Only four out of 20 services focusing solely on child sexual abuse, and seven out of 28 services with a wider remit, said that LGBTQ+ adults made up more than 10% of their service users.

Transgender young people and adults

Services were asked specifically about the extent to which they had supported young people and/or adults who identified as transgender. Three-fifths (n=103, 61%) provided this information, representing two-thirds of services supporting children and two-fifths of those supporting adults.

Almost a third (n=30, 29%) of these services said they had not knowingly supported anyone identifying as transgender, and the vast majority (90%) of the other 73 services said they represented a tiny proportion of service users. From this we can infer that most of the LGBTQ+ service users identified by services above were lesbian, gay or bisexual.

5.3 Demographic changes in service users

We received information from 154 of the 166 interviewed services about changes in the diversity of their service users over the past few years – with three-fifths of them (n=95, 62%) saying that diversity had increased.

Most commonly, services said they had seen **greater ethnic diversity** in their service users: most did not specify which ethnic groups they were supporting in larger numbers, but some mentioned seeing more Black African or Caribbean, Asian, Eastern European or Traveller/Roma service users. Two services had observed increases in dual-heritage children accessing their support. The rise in ethnic diversity was attributed either to demographic changes in the local area or – more frequently – to services' efforts to increase uptake in specific communities through outreach, recruitment of specialist workers or development of dedicated services:

> "We've started to see uptick from Asian communities… Last year we had a significant increase in volunteer applications from those communities and … because obviously we've got the language abilities and the connections within the community, that's enabled us to spread the word."
> [ID234, NFP; CSA focus]

Seven participants said that they had seen **more refugees or asylum seekers** accessing their services. This too was linked to changes in the local demographic or the employment of specialist workers.

> Many services said they had seen greater ethnic diversity in their service users over the past few years

Services also noted an increase in **LGBTQ+ service users**, both young people and adults. However, one service thought that the apparent increase was simply the result of more LGBTQ+ service users feeling comfortable to disclose their sexual orientation or gender identity in its setting:

> "LGBTQ+ numbers have gone up. I think that's because people are self-reporting with more confidence. I'm not actually sure that number has gone up. I just think they're telling us comfortably now." [ID237, NFP; CSA focus]

Several services told us that they were supporting more **male victims/survivors** of child sexual abuse, which some felt was linked to greater public awareness of the sexual abuse of boys as well as services' efforts to reach out to male victims/survivors:

> "Because we had more girls and young women accessing the service previously, we have started a specific youth group for boys and young men." [ID147, NFP; wider remit]

An increase in **disabled service users** was also noted. In particular, support was being accessed by more children and adults with neurodevelopmental conditions such as attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD), or those with learning disabilities. Services said they had become more aware of learning difficulties among their service users, and some had introduced specialist workers:

> "[We support] more people with learning disabilities or difficulties, and that's particularly because we've got a learning disability ISVA." [ID135, NFP; SV remit]

Finally, some services said there were **more children and young adults** accessing their services. This was related to wider campaigns such as the 'Everyone's Invited' website, or the introduction of support delivered online during COVID-19 lockdowns. Others noted a rise in victims/survivors of particular forms of child sexual abuse accessing their service, including those abused in online contexts and/or by other young people.

"Several services told us that they were supporting more male victims/survivors of child sexual abuse"

6. Is support widely available?

This chapter looks at gaps in the provision of support for people affected by child sexual abuse, and highlights specific groups which services find hard to reach.

Key findings and reflections

1. Services were scarce across England and Wales. Even in the regions with the highest levels of provision, we estimated that there were thousands of people living with the consequences of child sexual abuse for each service available to support them. There were an estimated 10,000 victims/survivors for each service we identified in Wales, and in the West Midlands there were twice as many – 20,000 victims/survivors – per service.
2. We estimate that there were between 2,500 and 5,000 child victims/survivors in each region for every service available to support them, but between 10,000 and 23,000 adult victims/survivors per service. While safeguarding and supporting children who have been sexually abused is a priority, it is also important to recognise the crucial role of support services for adult victims/survivors in mitigating the impact of their abuse.
3. Nearly two-thirds of services supporting children did not appear to offer any support to their parents. This support is vital in helping parents to manage their own feelings and support their child, and it is well-established that the response of the non-abusing parent(s) is critical to enabling a child to heal from their sexual abuse.
4. There were major gaps in local and regional provision for people affected by specific forms of child sexual abuse, such as intra-familial abuse, and for people with specific characteristics. Services primarily supporting men and boys affected by child sexual abuse were scarce in all regions, with London, Wales and the North East having no such provision at all – and only 67 services across the whole of England and Wales were focused specifically on providing support to women and girls. Additionally, very few services specifically focused on the needs of disabled people or LGBTQ+ people affected by child sexual abuse.
5. There were very few services outside London focused on supporting people from minority ethnic backgrounds, and none in the South East or South West. Previous research (Gilligan and Akhtar, 2006; Allnock et al, 2015; Warrington et al, 2017) has identified that children from minority ethnic backgrounds are less likely than White British children to receive support in response to child sexual abuse.
6. When we asked services which groups they would like to reach better, by far the most common response related to ethnic diversity, yet workloads and a lack of ring-fenced funding made this difficult to address.

Implications

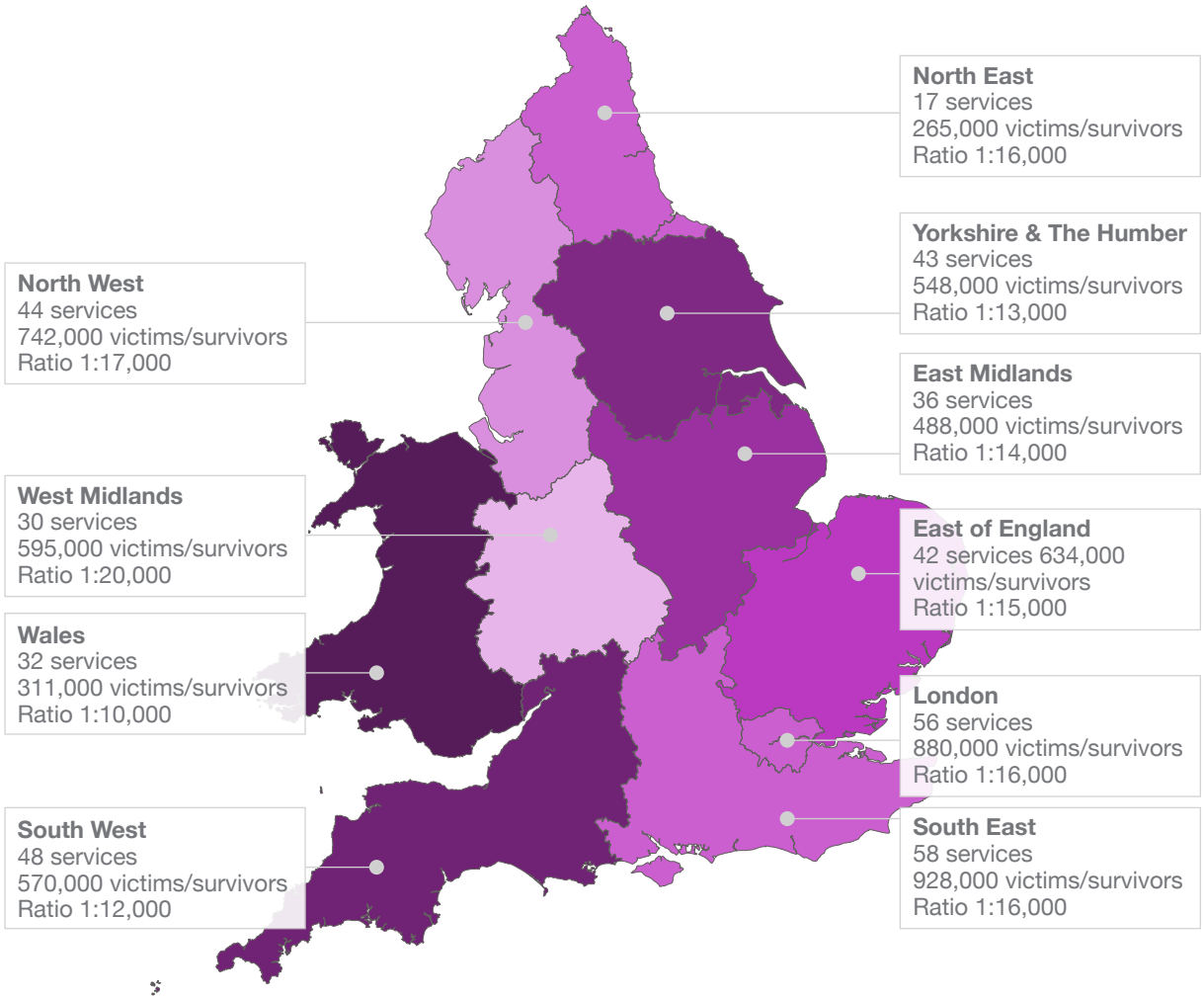
These findings highlight the need for greater investment in the sector so that services can sustain and expand their support. Funders, commissioners and policymakers need to consider the likely number of victims/survivors in their region when assessing the need for services, bearing in mind also that a holistic range of support services is needed to address the differing needs of victims/survivors and their families at different points in time.

6.1 Gaps in provision

To assess the availability of support across England and Wales for victims/survivors and family members affected by child sexual abuse, we compared the number of services that we had mapped with the estimated number of victims/survivors of child sexual abuse in each region. These estimates were based on the CSA Centre's assessment that at least 10% of children are sexually abused in England and Wales (Karsna and Kelly, 2021), and that the prevalence of child sexual abuse does not differ significantly between regions (Karsna and Bromley, 2023).

As previous chapters have shown, the size of services and the number of people they support varies considerably, so the ratio of services to victims/survivors is only a crude indicator of service provision. Furthermore, some services respond only to certain forms of sexual abuse or to a specific service user group. Nonetheless, our analysis suggests that services with the largest capacity or with specific remits were fairly equally distributed across England and Wales. We therefore concluded that calculating the ratio of services relative to the population of victims/survivors would help to demonstrate the availability – and lack of availability – of support for people affected by child sexual abuse.

Figure 36. Distribution of services relative to the estimated number of victims/survivors in each region



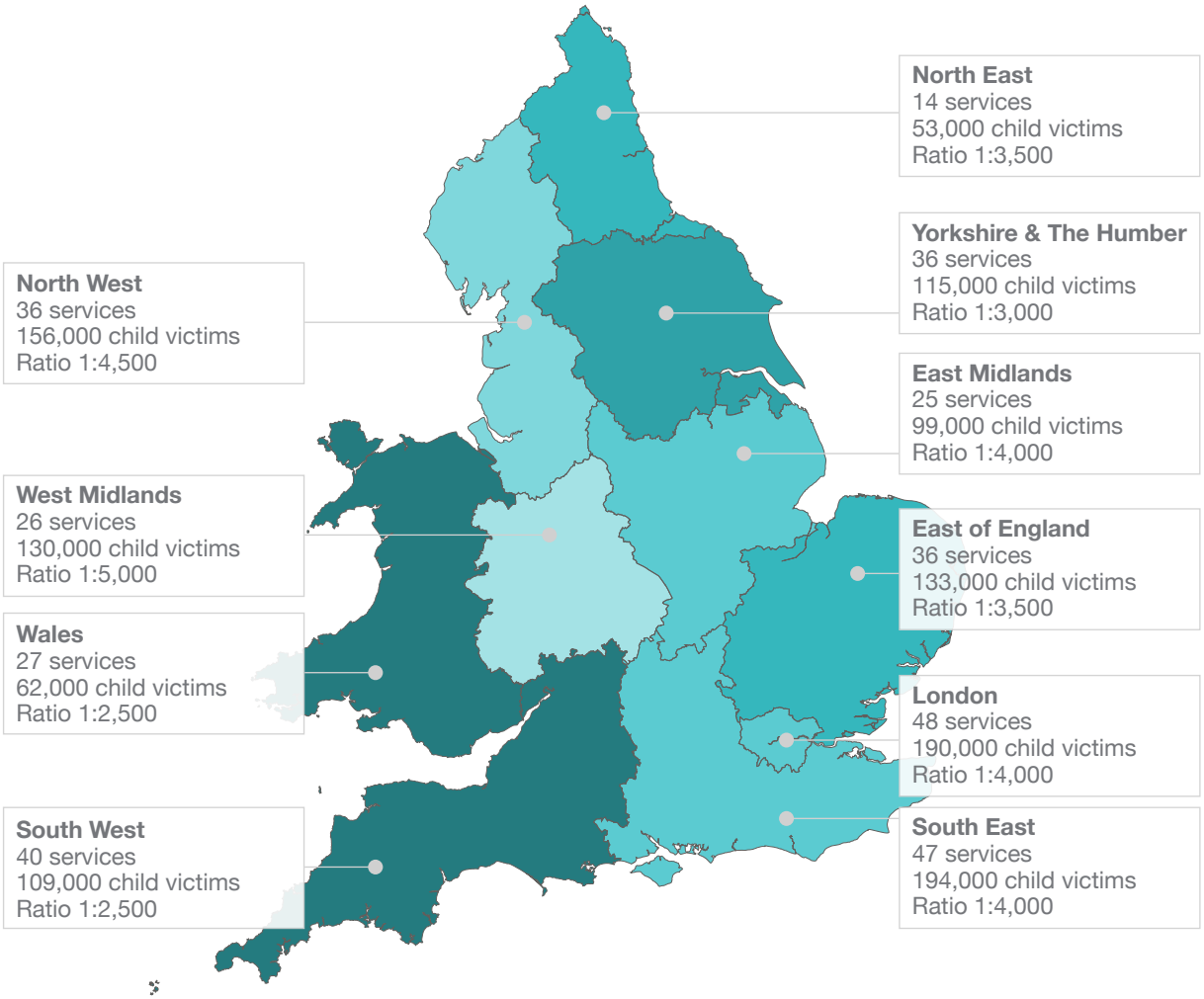
n=382 local, regional and multi-regional services; the 86 services working across England, or across England and Wales, are not shown. Darker shading represents a higher number of services relative to the estimated number of victims/survivors in the region, calculated as 10% of the Census 2021 population figures per region (ONS, 2023a). Figures (population and ratio) are rounded to the nearest thousand. Multi-regional services are listed in each of the regions where they operated.

Figure 36 shows that there are between 10,000 and 20,000 victims/survivors for each service providing support to people affected by child sexual abuse. Wales has the highest number of services, and West Midlands the lowest, relative to the estimated number of people needing support. Although we identified a similar number of services in Wales and the West Midlands (32 and 30 respectively), the estimated population of victims/survivors is almost twice as high in the West Midlands as in Wales. The second-highest provision was in the South West, while the North West had the second-lowest provision.

6.1.1 Support for children and adults

Figure 37 shows that, in each region, there are between 2,500 and 5,000 sexually abused children for every service supporting children affected by sexual abuse. As with the findings relating to all services (see above), Wales and the South West had the highest provision; provision was lowest in the West Midlands, and was also low in the North West, the East Midlands, London and the South East.

Figure 37. Distribution of services supporting children, relative to the estimated number of child victims/survivors in each region

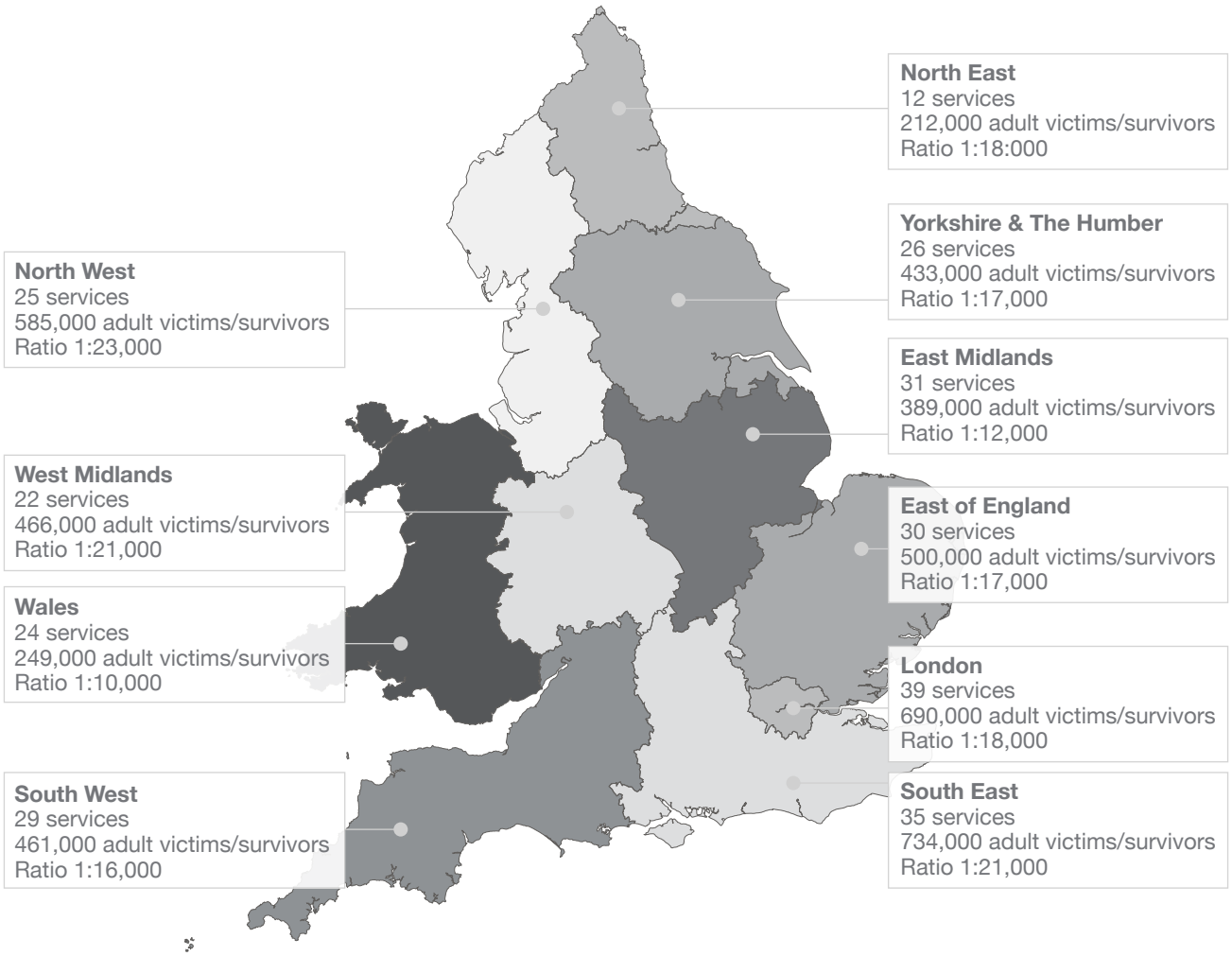


n=314 local, regional and multi-regional services; the 57 services working across England, or across England and Wales, are not shown. Darker shading represents a higher number of services relative to the estimated number of victims/survivors in the region, calculated as 10% of the Census 2021 child population figures per region (ONS, 2023a). Figures are rounded to the nearest thousand (population) or 500 (ratio).

Our analysis revealed a lack of services for adults across all regions of England and Wales, with between 10,000 and 23,000 adult victims/survivors for each service providing support to those affected by child sexual abuse (see Figure 38). Once again, Wales had the highest provision, with the East Midlands close behind; the lowest provision was in the North West, followed by the West Midlands.

There were fewer services overall for adult victims/survivors (n=316) than for children (n=371), and the adult population – and consequently the number of adult victims/survivors – is far larger than the child population. This explains why our estimates of the number of victims/survivors per service were four to five times higher for adults than for children.

Figure 38. Distribution of services supporting adult victims/survivors of child sexual abuse, relative to the estimated number of these adults in each region



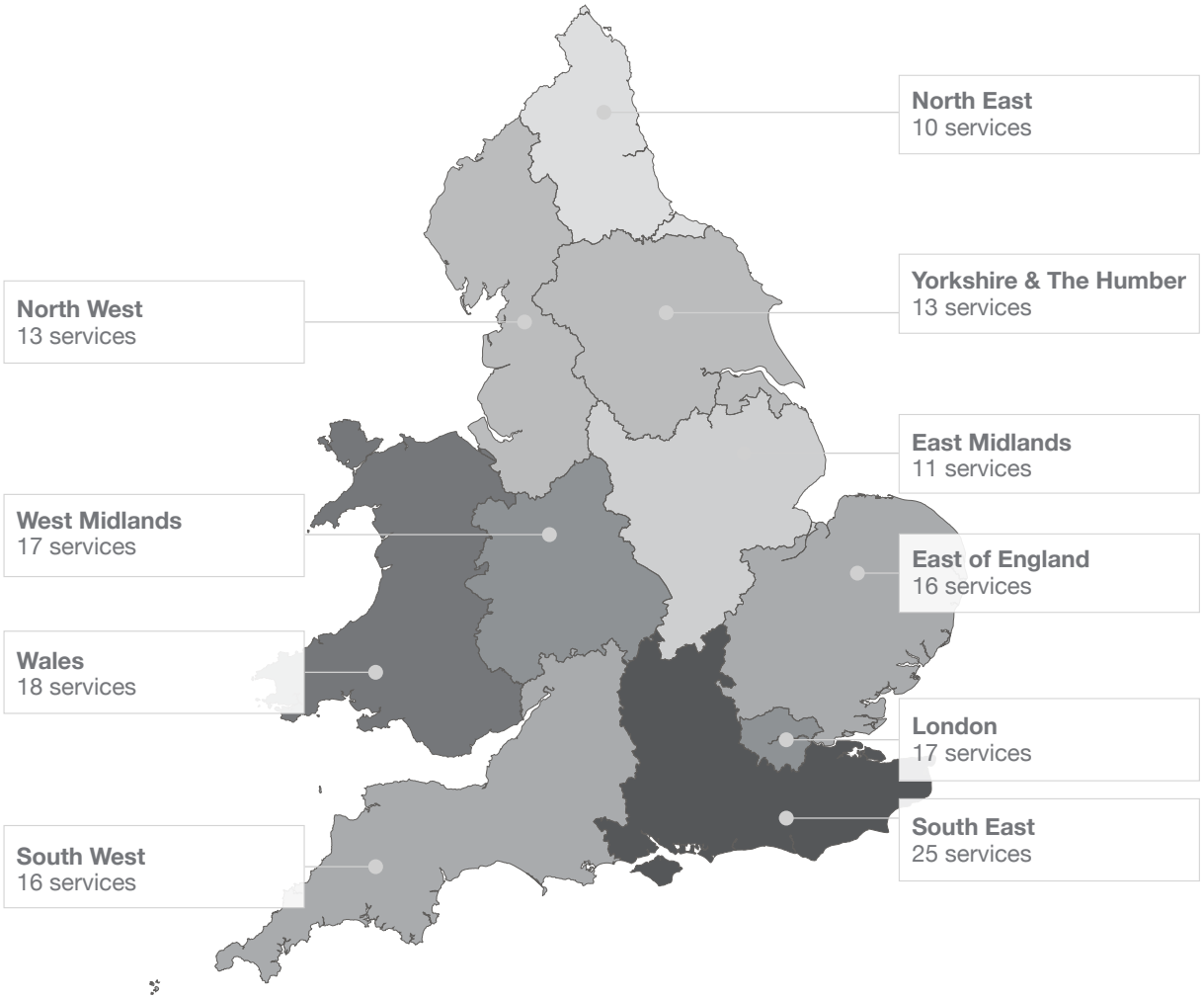
n=260 local, regional and multi-regional services; the 56 services working across England, or across England and Wales, are not shown. Darker shading represents a higher number of services relative to the estimated number of adult victims/survivors in the region, calculated as 10% of the Census 2021 adult population figures per region (ONS, 2023a). Figures (population and ratio) are rounded to the nearest thousand.

Support for **parents** of sexually abused children was available from 165 services (35% of all services), 40 of which had child sexual abuse as their sole focus. Just four services were available to parents only; in contrast, there were 230 services (62% of all services supporting children) which appeared to be providing support to children but not to their parents.

As Figure 39 shows, local service provision for parents varied considerably, with the number of services in each region ranging from 10 in the North East to 25 in the South East.

> While a third of services supported the parents of sexually abused children, just four were *only* for parents

Figure 39. Distribution of services supporting parents of sexually abused children



n=135 local, regional and multi-regional services; the 30 services working across England, or across England and Wales, are not shown.

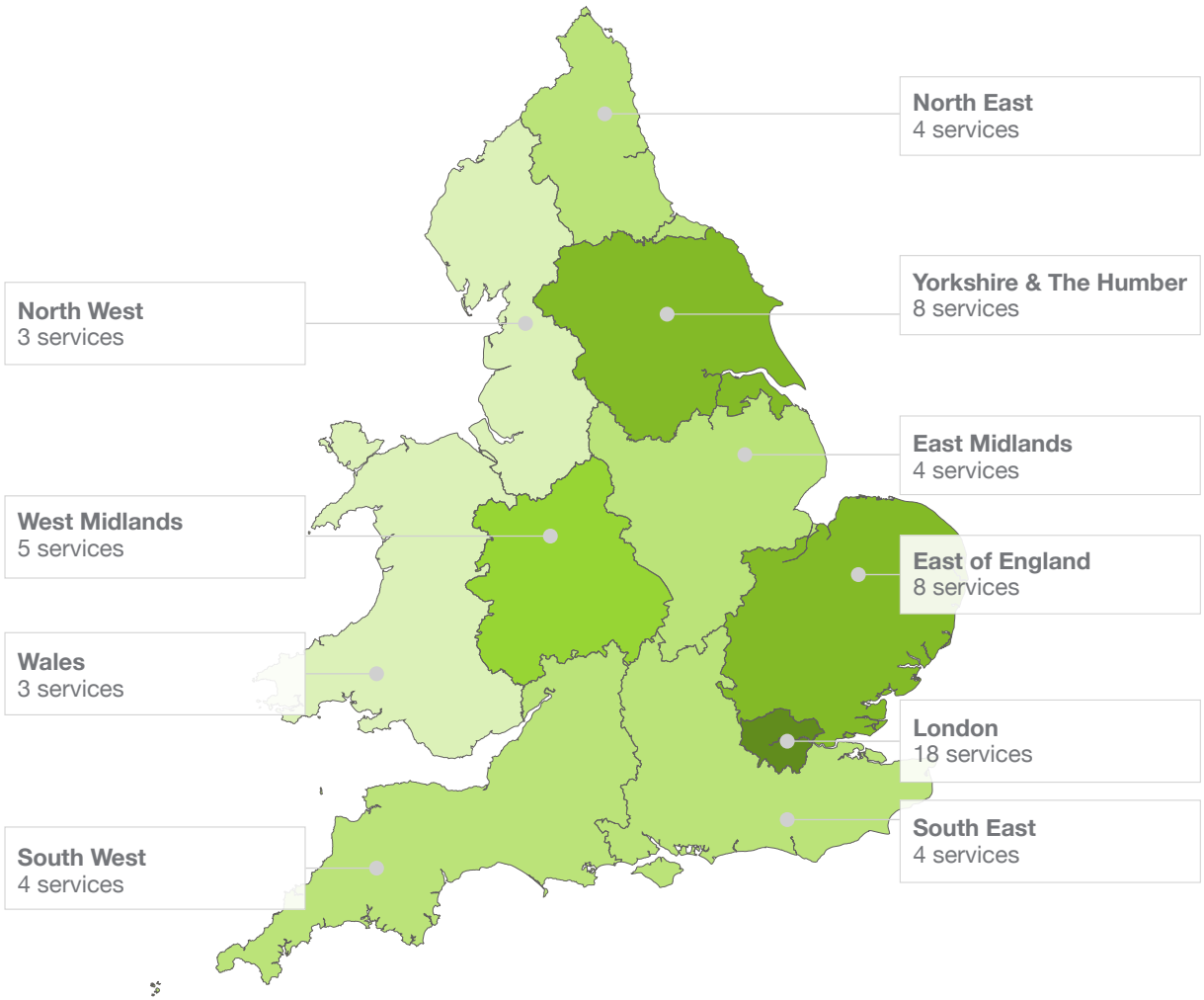
6.1.2 Specialist support based on sex or ethnicity

Women and girls

Our mapping exercise identified 67 services (14% of all the services mapped) whose support relating to child sexual abuse was solely or principally aimed at women and girls. Five of these services focused solely on child sexual abuse.

As Figure 40 shows, London had a particularly high number of services (n=18), while every other region had between three and eight local/regional/multi-regional services providing specific support for women and girls. An additional 11 services were operating at national level.

Figure 40. Distribution of services primarily supporting women and girls affected by child sexual abuse



n=56 local, regional and multi-regional services; the 11 services working across England, or across England and Wales, are not shown.

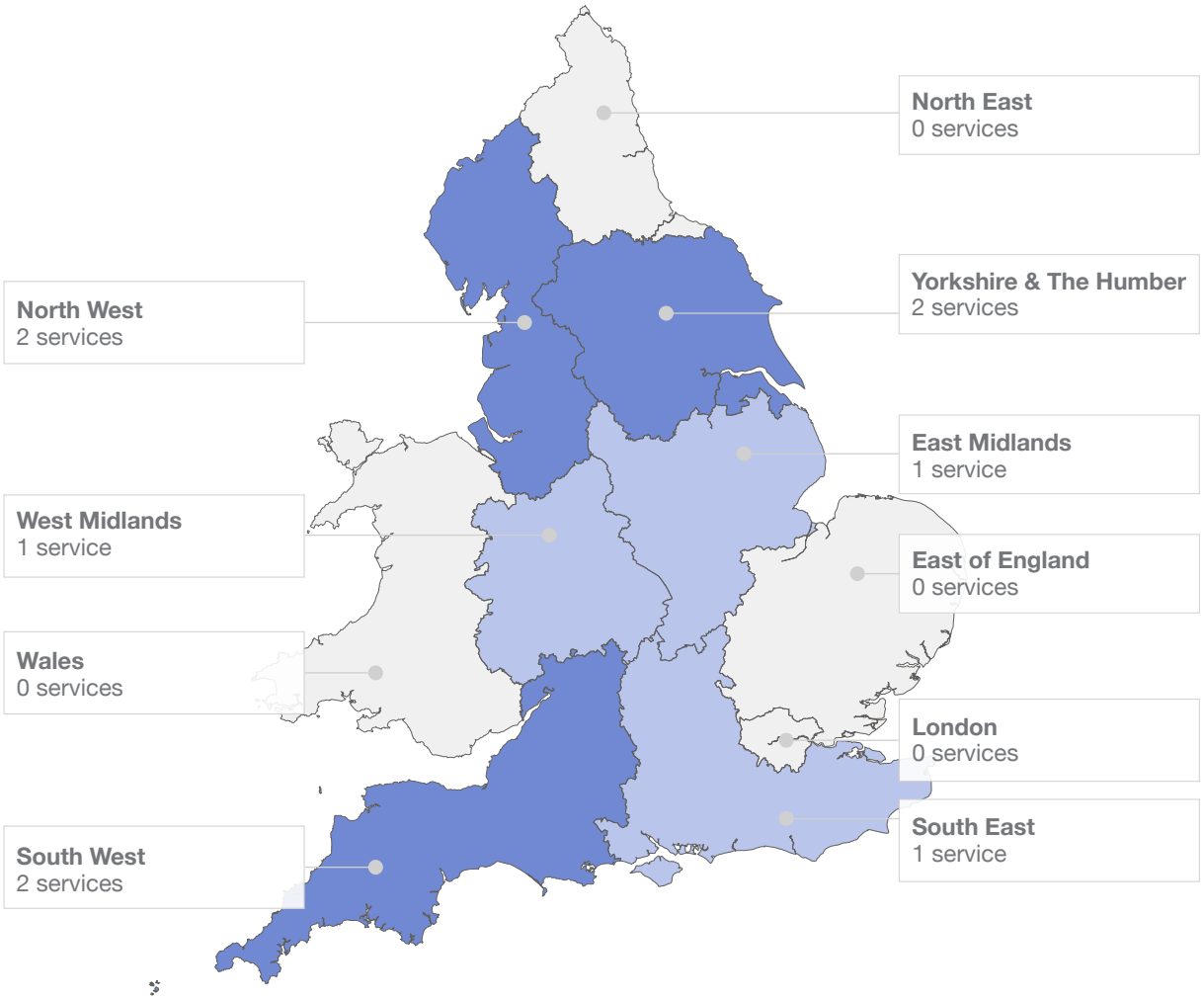
Men and boys

We identified a total of 13 services (3% of all services) – including six focused solely on child sexual abuse – which targeted men and boys in their support around child sexual abuse. Four of these services were operating at national level.

As Figure 41 shows, London, the East of England, Wales and the North East had *no* local, regional or multi-regional services which were focused on supporting men and boys, although many other services were providing support for both sexes.

Given that boys are estimated to account for one in four of children who are sexually abused in England and Wales (Karsna and Kelly, 2021), and that close to one in four adult victims/ survivors of child sexual abuse are male (ONS, 2020), these are significant gaps in provision, particularly given the small number of boys and men accessing services (see Chapter 6).

Figure 41. Distribution of services primarily supporting men and boys affected by child sexual abuse



n=9 local and regional services; there were no multi-regional services, and the 4 services working across England, or across England and Wales, are not shown.

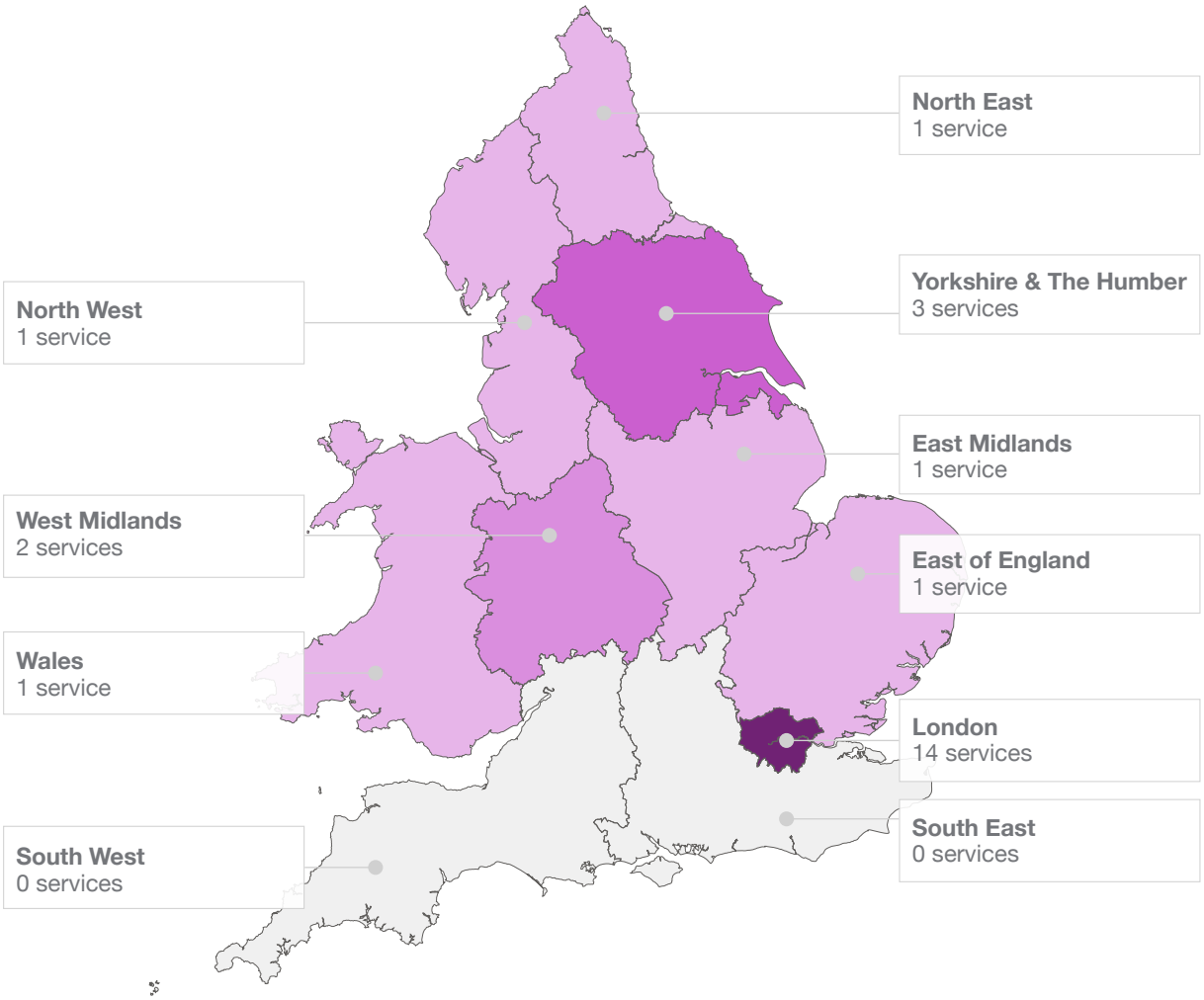
People from minority ethnic backgrounds

Of the 29 services (6% of all services) whose support around child sexual abuse was exclusively or primarily for people from minority ethnic backgrounds, only three had child sexual abuse as their sole focus.

As Figure 42 shows, London had 14 services, no services at all were identified in the South West or the South East, and most other regions only had one service.

Research has found that the likelihood of experiencing child sexual abuse does not vary significantly between ethnic groups (Bebbington, et al, 2011) and the latest Census estimated that one in three children in England and Wales are from minority ethnic backgrounds (ONS, 2023a).[15]

Figure 42. Distribution of services primarily supporting people from minority ethnic backgrounds affected by child sexual abuse



n=19 local, regional and multi-regional services; the 10 services working across England, or across England and Wales, are not shown.

15 This includes all ethnic groups other than White British.

6.1.3 Specialist support relating to specific forms of child sexual abuse

While many services may have provided support relating to different forms of child sexual abuse, only one in five focused principally or exclusively on a specific form of child sexual abuse (see section 3.5.3). These most commonly provided support around **child sexual exploitation**: we identified 77 services (69 local services and eight national) with this focus. Except in the North East, support services were identified in all regions of England and Wales, ranging from three in Wales to 11 in Yorkshire and the Humber.

We identified only three services focused on support around **intra-familial child sexual abuse**. One of these provided support for children only, while the other two supported adult victims/survivors. Only one, a national service, was operating across more than a single region.

Eight services, all operating nationally, were focused on supporting people affected by **child sexual abuse in institutional contexts**. Four provided support for adult victims/survivors only, while three supported both child and adult victims/survivors. Only one service appeared to support both children and parents.

Nine services were identified as focusing their support around **child sexual abuse in online contexts**. Three were national services (two of which supported adult victims/survivors), while four were operating within a single region.

6.2 Gaps in reach and accessibility

During our interviews, we invited services to say whether there were any groups of people they were not reaching. Nearly all services (n=160) responded, with only 14 (9%) of them saying there were *no* groups that they were not reaching. The remaining services talked about a wide range of characteristics that they felt were under-represented in their service users.

The largest number said they found it difficult to reach various **minority ethnic groups**. Some identified specific ethnic groups, of which the most frequently mentioned were Asian, Traveller or Roma, Black African or Caribbean, and Eastern European children/adults. Services pointed out that it was difficult to develop responses appropriate to under-represented ethnic groups, owing to a lack of ringfenced funding or a lack of capacity because of the overall high demand for support:

> "I don't think any service here is very good around ethnic diversity… I think we're not helped by the fact that we are not commissioned explicitly to [reach out to minority ethnic groups] or given additional funding for interpretation, for example. You're not going be resourced to enable [employment of specialist workers] down here. But then how are we ever going reach some people who perhaps otherwise might never know that they could benefit from a service like ours?" [ID50, NFP; CSA focus]

> "I think one of those communities is the Traveller community: they rarely reach out to statutory or not-for-profit services. A bit of work around reaching out to that group would be good and useful… But we have a really long waiting list. So I think we'd have to identify counsellors who could work immediately with that group. Otherwise we're just inviting them to sit on a waiting list, which is not really ethical." [ID99, NFP; CSA focus]

Some services highlighted the absence of **refugees, asylum seekers, recent migrants** and **people who do not speak English** among their service users. They explained that cooperation with refugee organisations, a budget for interpretation, or the employment of workers speaking different languages would help them reach these groups better:

> "People experiencing this type of abuse may not speak English, so being able to offer support in their language would mean it would probably lead to more disclosures of the abuse… There's a lot more trust when language is the same." [ID207, NFP; wider remit]

Male victims/survivors were another group who services wanted to reach better. The under-representation of males within service users was linked to the shame and stigma attached to disclosing sexual abuse:

> "We know that the male population access services less than they should and if they do, it's far later than they should." [ID470, stat. sector; SV remit]

Services that primarily supported women and girls found it particularly difficult to reach men who had been sexually abused in childhood:

> "We don't reach men well enough because we're [a centre for women]: they obviously presume they can't be seen. It is on our website [that we support them too], and we do. And when we know we've got the funding again… we can go and promote, promote, promote and we try and get the word out that we support men as well." [ID353, NFP; wider remit]

There was a recognition that disabled people – and particularly those with **physical disabilities** – were under-represented among service users. Specific concerns were expressed around children and adults who were severely disabled, or whose disability impaired or prevented verbal communication:

> "We see quite a lot of neuro-diverse children but not with significant impairments – we don't get them referred so I worry about where's the voice of these children. If children are using the carers to communicate and if they are the ones that are abusing them, we don't hear those voices." [ID144, stat.; CSA focus]

Some services also wished to improve their reach to victims/survivors from **religious groups**; where specific religions were identified, Muslim victims/survivors were mentioned most frequently. Others felt that religious groups generally were more likely to be closed to external intervention, and therefore more difficult for services to interact with. Specialist workers or closer engagement with religious leaders were suggested as ways of reaching more victims/survivors from different faiths:

> "Within religious communities, we think there's still hidden exploitation that doesn't very often get reported to us. We've just put a bid in. We're looking for a faith worker to try and do some more work on that." [ID371, NFP; CSA focus]

Other groups considered to be under-represented were LGBTQ+ people, older victims/survivors of child sexual abuse, younger adults, marginalised groups such as homeless people, and those being commercially sexually exploited. Some services suggested that victims/survivors of particular forms of sexual abuse were not reached well, and others wished to expand their reach to a different part of their geographical area. Finally, services expressed concern about their accessibility to people affected by poverty and the cost of living or housing crises:

> "Because of where we're based, if people have to get a bus I think people on lower incomes aren't able to access us… Even if they were able to… access online counselling, we've had a lot of people who have nowhere to be and do the online counselling. We thought by offering [services] online that we'd addressed that problem because we could even send people a phone to do video calls on, but they don't have Wi-Fi and don't have anywhere to be. That's a poverty challenge as well." [ID237, NFP; CSA focus]

Despite the challenges of making their support accessible to more service users, almost all services said they had taken action to improve accessibility; this is explored in section 13.3. And services told us that they considered their outreach work, recruitment of specialist workers and development of dedicated services had resulted in a more diverse range of service users; see section 5.3.

7. How quickly can people receive support?

This chapter draws on our interviews with 166 services providing support to people affected by child sexual abuse, to explore their ability to meet the demand for the support – and the consequences when they cannot.

Access to support services for children who have engaged in harmful sexual behaviour is covered in Appendix 3.

Key findings and reflections

1. Only half of services felt they were able to meet the demand for support. Nearly two-thirds of not-for-profit services and those providing support with all forms of sexual violence reported that they could not keep up with demand. Services highlighted the pressure this put them under, and their concerns for people not receiving appropriate support.
2. Recent increases in the numbers of people seeking support were commonly attributed to the COVID-19 pandemic or increased awareness of child sexual abuse.
3. Two-thirds of the services we interviewed – and three-quarters of those in the not-for-profit sector – were operating with waiting lists for people seeking support. The average (mean) length of a waiting list was more than six months, and more than 10% were longer than a year. Average waiting times to access support appear to have doubled since 2015, when a study of therapeutic support services for children (Allnock et al, 2015) reported average waiting lists of three months.
4. On average, each waiting list contained 180 people waiting for support. Extrapolating from the data, we estimate that more than 55,000 people in England and Wales were on a waiting list to receive support around child sexual abuse at the time of our research.
5. Services highlighted the negative impacts of waiting lists on victims/survivors – and particularly on their mental health, their subsequent engagement in support, and (for children) their education and social relationships with peers.
6. The barrier that waiting lists pose for people seeking support has been highlighted in research with adult victims/survivors (Smith et al, 2018). Alaggia et al (2019:260) showed that, "timely access to supportive and therapeutic resources for child sexual abuse can mitigate the risk to the health and mental well-being of children, youth, and adults".
7. Some services said they were forced to prioritise people waiting to access support on the basis of highest risk or need. This may mean that "equally traumatised children who do not manifest that trauma in problematic behaviour are less likely to get a service when they need it" (Allnock et al, 2009:69).
8. Many services were providing some sort of support to those waiting to access their service. This included keeping in regular contact through check-in calls, text messages or emails; providing people with resources; and establishing psychoeducational programmes or support groups.

9. Having a waiting list was forcing services to reduce the number of support sessions they offered, or was making it impossible for them to continue providing open-ended support. Staff were said to be overwhelmed and in despair in the face of increasing waiting lists. Some services avoided promoting their services in case this made their waiting lists longer. This is likely to make it more difficult for those seeking support to find it, and – as Allnock et al (2009) highlighted – could result in services not reaching out to under-represented groups such as disabled people or people from minority ethnic backgrounds.

Implications

Victims/survivors of child sexual abuse should not have to wait months or even years to access support. This means that funders, commissioners and policymakers should:

- ensure services have capacity to meet demand by providing long-term, sustainable funding for services' core costs as well as allowing for service development, allowing services to make themselves easily identifiable to those in need of support and to offer support in a timely fashion.
- enable services to explore ways of providing different models of support, so they can respond to people waiting to access support and respond to service users' individual needs (e.g. with flexibility around length of support and an open-door policy allowing service users to return for further help if needed).

7.1 Services' ability to meet demand

During the interviews, 158 of the 166 services told us about their ability to meet the demand for support from people affected by child sexual abuse. Half (n=79, 50%) said they were unable to meet this demand.

While all three private-sector services and nearly three-quarters (n=17, 71%) of the 24 statutory services answering this question said they could meet the demand for support, fewer than half (n=58, 45%) of the 130 services in the not-for-profit sector said the same.

Among the 37 services focusing on all forms of sexual violence, fewer than a third (n=11, 30%) felt able to meet demand for support around child sexual abuse. In contrast, more than half (n=27, 54%) of the 50 services focusing solely on child sexual abuse, and three-fifths (n=41, 58%) of the 71 with a wider remit, felt they could keep up with demand.

Twelve of the 18 interviewed services focusing solely on child sexual exploitation said they could meet demand.

However, even those services that could meet demand said they were under considerable pressure, with some fearing that they would not be able to keep up if anticipating further increases in demand that would leave them unable to keep up. A number avoided activities that might increase awareness of their services (such as outreach, promotion or training of professionals in referring organisations) as a way of limiting the demand:

> "The reason we're able to meet the demand for our service is because we don't outwardly and actively promote it... It's really hard to know whether you're doing the right thing or not as a manager by saying, 'Please don't go out and promote.' I've been in this situation before where you just go out, you 'overpromote', you have massive influx… and all of a sudden you have a great big flurry of professionals recognising [child sexual exploitation], which is brilliant, but then you're left with a service that then can't manage with what you've drummed up." [ID26, NFP; wider remit]

Services also explained that, while their commissioning arrangements enabled them to manage workloads or expectations set on the service, these did not reflect the reality of demand they were seeing for child sexual abuse support:

> "Approximately a third of all initial enquiries we get end up in the person receiving a service. So that leaves two-thirds of people and I don't know if they receive a service at all… So it's a nuanced answer to that question... Everything that is commissioned, we pick up, but I don't think everything is commissioned that should be." [ID53, NFP; CSA focus]

> "Within the resources they have given us, we are meeting KPIs [Key Performance Indicators]. Are we meeting the demand? No." [ID308, NFP; SV remit]

7.1.1 COVID-19's impact on the demand for support

Asked about the impact of COVID-19, four-fifths (n=121, 81%) of the 149 services responding said the pandemic had affected the number of people seeking their support.

More than three-quarters (n=94, 78%) of these 121 services had seen demand increase after social restrictions ended:

> "We've had a huge increase since COVID for young people. I think it's around about 40% increase in referrals since COVID." [ID58, NFP; CSA focus]

> "With children, there was an initial decrease – but very quickly it escalated massively and it's now the most in demand it's ever been." [ID139, NFP; SV remit]

Some had also seen a change in the issues presented by those coming to them for support:

> "[We saw an] increase in sibling abuse referrals and online harm referrals… We were getting referrals for children who had been harmed online. They'd been safeguarded, but we had a group of parents who were saying, 'That's fine, but our child is still self-harming,' 'Our child is still struggling,' or 'Our child is displaying sexualised behaviour.'" [ID28, NFP; CSA focus]

> "We've seen a lot of the hidden harm that's happened since COVID… There was a lot of online exploitation… People in more organised gangs got really savvy in how they would use COVID as a benefit to them in terms of how they could exploit and harm children." [ID106, stat.; wider remit]

However, some felt that the increase in demand they had seen was unrelated to the pandemic:

> "Our referrals have gone from 208 nine years ago to 1,000 this year, but they were significantly increased even before COVID." [ID344, NFP; SV remit]

Conversely, seven services reported that fewer people were seeking their support, with some linking this to changes in the provision of health services:

> "Maybe because people are not accessing their own GP. There's lots of online consultations. If they're not seeing a GP face to face, it's much harder to disclose child sexual abuse. Also, I think that people access for one issue, but child sexual abuse might be disclosed during a face-to-face consultation because of probing – but there's less probing in an online consultation." [ID442, NFP; wider remit]

> Many services had seen demand increase after the lifting of social restrictions imposed because of COVID-19

7.2 Waiting lists

Of the 166 services we interviewed, 160 told us whether they operated a waiting list for people seeking their support: as Figure 43 shows, two-thirds of them said they did so – but this represented fewer than half of services in the statutory sector but three-quarters of those in the not-for-profit sector.

Of the 13 statutory-sector services which said they did not have a waiting list:

- six were NHS services (such as SARCs and hospital-based ISVA services)
- five were services provided by local authorities (such as complex safeguarding teams)
- two were victim support services in the criminal justice sector.

Among the 34 services in the not-for-profit sector without a waiting list:

- 15 supported adult victims/survivors only
- eight supported children and young people aged up to 25, including five dedicated to victims/survivors of child sexual exploitation and/or online abuse
- three were victim support services for adult and child victims of crime
- three supported children and adults from specific minority ethnic communities.

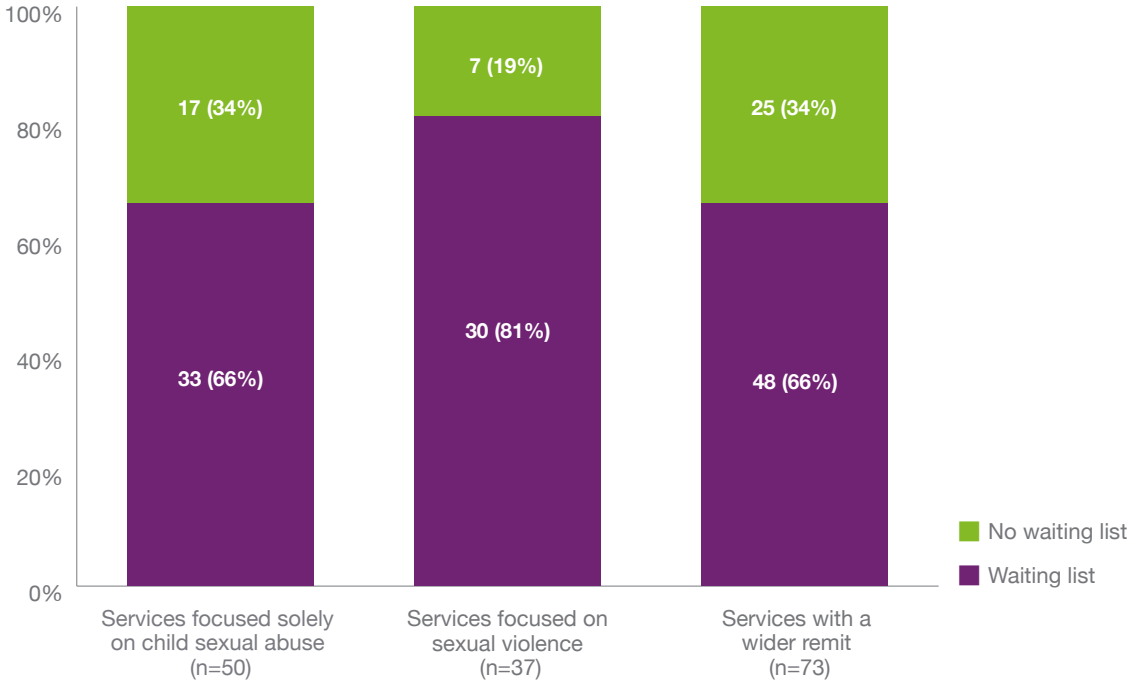
Two of the three private-sector services we interviewed were operating without waiting lists: a university-based counselling service and a large, local-authority funded organisation specialising in working with complex issues such as developmental trauma and complex post-traumatic stress disorder.

Waiting lists were particularly common among services with a sexual violence remit, as Figure 44 shows.

Figure 43. Services with/without a waiting list, by sector

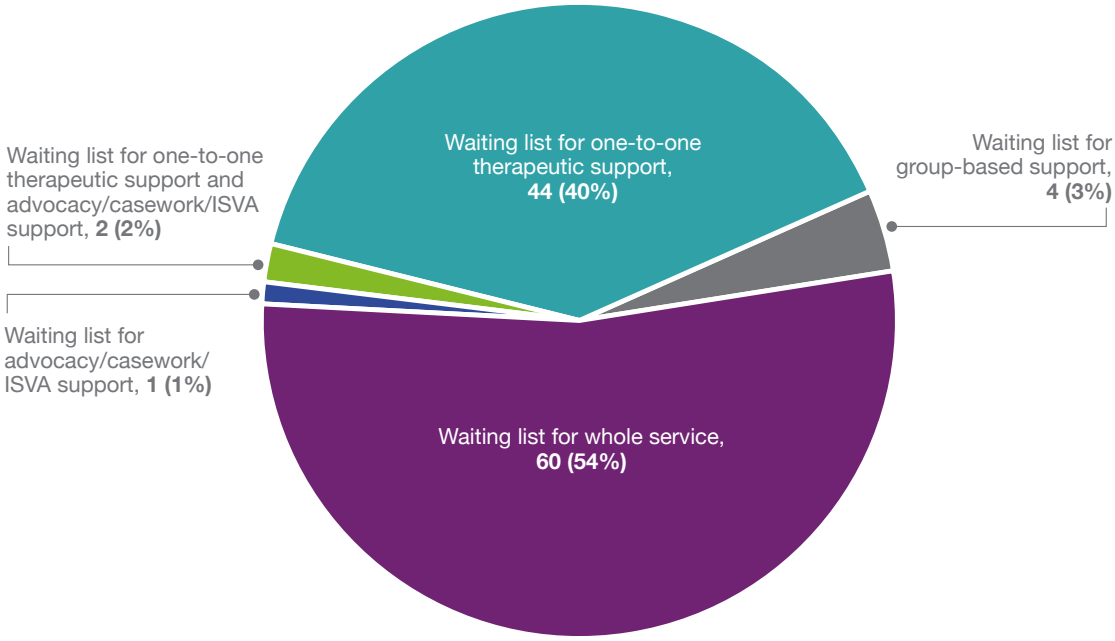
n=160. Two of the three private-sector services had waiting lists, as did one of the two statutory/not-for-profit partnership services.

Figure 44. Services with/without a waiting list, by service remit



n=160

Figure 45. Services with a waiting list for all or part of their service



n=111. Two services had separate waiting lists for therapy and for ISVA support.

7.2.1 'Partial' and 'whole-service' waiting lists

Among the 111 services with a waiting list, a little over half had a list related to the whole service – see Figure 45. Most of the others had a waiting list for therapy/counselling support, while a few had waiting lists for group-based support or advocacy.

7.2.2 How many people were waiting for support?

Eighty-seven of the 111 services with waiting lists told us how many people were waiting to access their support, indicating that 15,792 people were waiting to access their support at the time of our interviews. These services' waiting lists each held around 180 people on average.

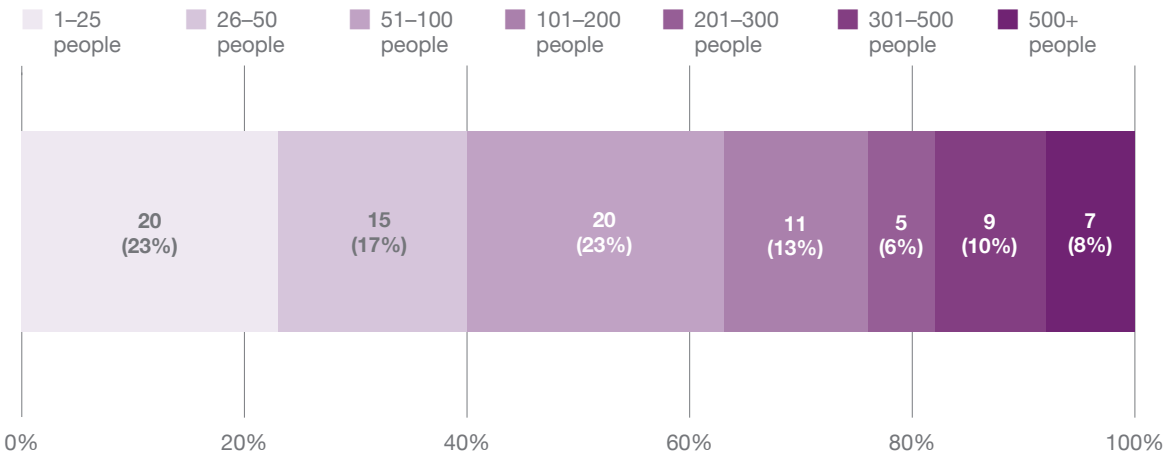
- The 27 services focused solely on child sexual abuse reported a total of 2,208 children and adults waiting to access support – an average of 82 people per service.
- The 24 services with a sexual violence remit reported a total of 10,382 children and adults waiting to access support – an average of 415 people per service.
- The 36 services with a wider remit reported a total of 3,202 people waiting to access support – an average of 91 people per service.

As shown in Figure 46, the number of people on waiting lists varied considerably. While nearly two-thirds of services had waiting lists of fewer than 100 people, almost one in ten had more than 500 people on their waiting lists.

To recap, a little over two-thirds of services we interviewed said they had a waiting list, and the average reported waiting list length was around 180 people. If we assume the same was true among the 301 services we identified but were unable to interview, we can estimate that more than 55,000 people in England and Wales were waiting to access support in response to child sexual abuse at the time we carried out our research.

> There were an average of 180 people on each waiting list, with lists for sexual violence services tending to be longest

Figure 46. Number of people on waiting lists



n=87.

7.2.3 How long were people waiting for support?

The same 87 services told us how long people had to wait to access the support they provided. As Figure 47 shows, only one in six held waiting lists of up to three months, and the average (mean) waiting time to access support was over six months.[16] One in nine services had waiting lists of over a year, with people having to wait two to three years to access one service's support.

Based on our estimate of the number of people on waiting lists (see section 5.2.3), this suggests that across England and Wales:

- more than 30,000 people were waiting three to six months to access support
- nearly 9,000 people were waiting seven to 12 months for support
- more than 6,000 people were waiting over a year for support.

Among services with waiting lists, Figure 48 shows that those with a sexual violence remit tended to require a longer wait – at least seven months in more than half of cases.

Although only 10 statutory-sector services had waiting lists (see Figure 43 above), those lists were typically long: of the eight services providing details, none had a wait of less than three months, and three had waits of at least seven months.

7.2.4 Maximum waiting time policies

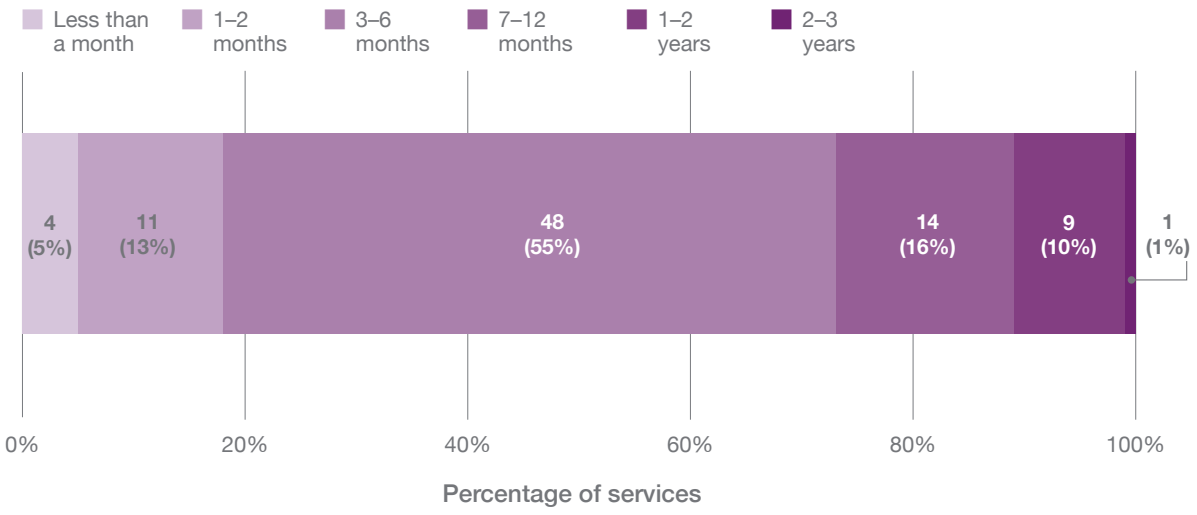
We also asked services if they had a maximum waiting time policy, meaning that they would close their waiting list if the waiting time exceeded a set limit. Of the 85 services who responded, four-fifths (n=70) did *not* have such a policy.

Fifteen services did operate a maximum waiting time policy, with most setting a limit based on the amount of time they felt people could reasonably be asked to wait. However, enforcing this could be a challenge:

> "Normally we would close the waiting list but right now, we feel that we're not in a position to because there's no other services available for the young people." [ID222, NFP; wider remit]

> "We have guidelines that we should be following but we don't have enough staff to meet them. Ideally [we see people] within 12 weeks." [ID426, stat.; SV remit]

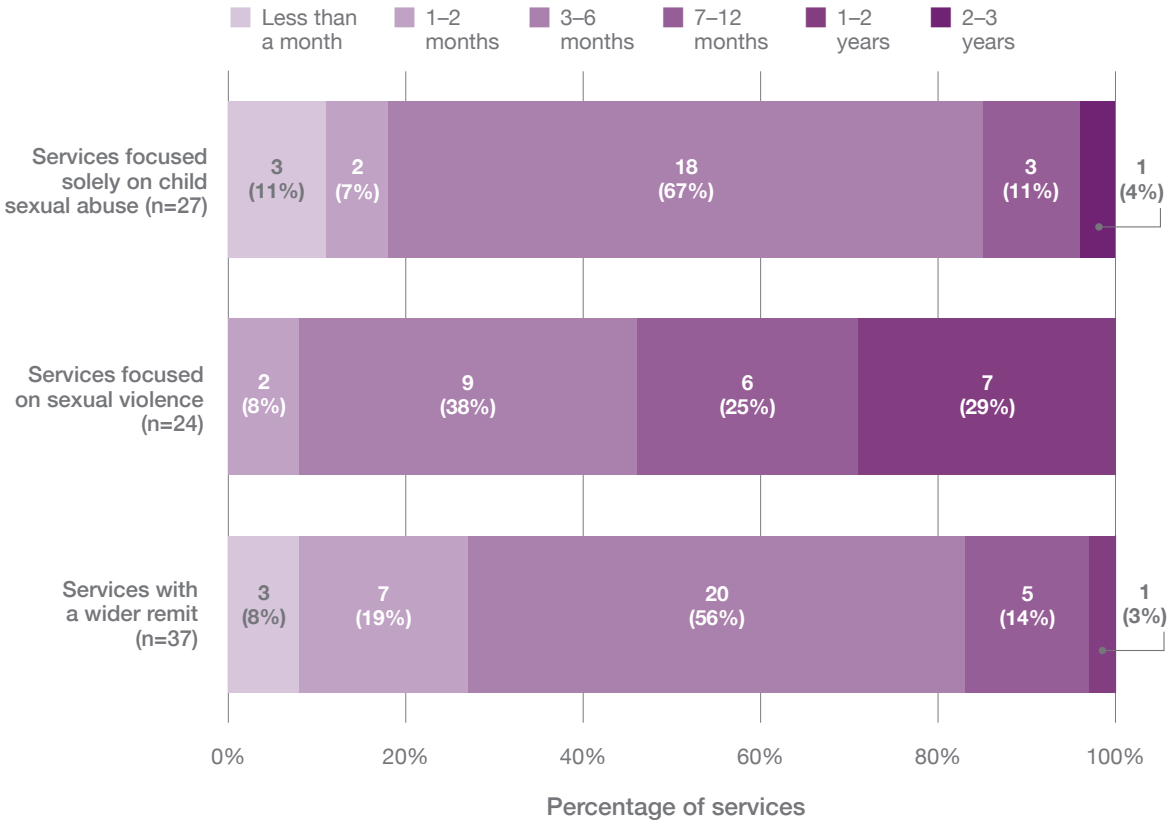
Figure 47. Length of time spent on waiting lists



n=87.

16 When services gave a range of wait times (e.g. "two to six weeks"), we used the midpoint in our calculation.

Figure 48. Length of time spent on waiting lists, by service remit



n=87.

7.2.5 Changes in the length of waiting lists

We asked services whether the number of people on their waiting lists had changed over the last few years. Again this question was answered by 85 services, with three-fifths (n=50, 59%) saying that their waiting lists had lengthened while a further fifth (n=18, 21%) said it varied.

Many services said their waiting lists had lengthened simply because they could not keep up with increased demand:

> "The demand increases every year. It increases by about 20% every year. So we're sort of constantly struggling to keep up with that increased demand." [ID89, NFP; SV remit]

> "We can't keep up with the amount of referrals. It's an ever-increasing list that we don't have capacity to put a dent in." [ID615, NFP; CSA focus]

One linked this specifically to a lack of capacity within statutory services:

> "[There are] issues within the statutory sector where they are trying desperately to find some support for people. They lean really heavily on the third sector." [ID378, NFP; wider remit]

Some identified their own capacity issues, which meant they could not see new service users as quickly as they would like:

> "I've got counsellors who say, 'I'd love to stay with you, but I can't afford to volunteer any more. I've got to get a paid job, you know.'" [ID99, NFP; CSA focus]

Increased awareness of a service could also increase the length of its waiting list:

> "One of our managers went out and did a talk to children's social care and we had 11 referrals the following week." [ID575, NFP; SV remit]

7.3 Interim support for people on waiting lists

We asked services whether they provided any interim support to people waiting to access their service. Of the 95 services that responded to the question, over three-quarters (n=74, 78%) said they were providing some sort of support.

7.3.1 Types of interim support provided

More than half of these 74 services maintained regular contact to people on their waiting list through check-in calls, text messages or emails. This enabled services to let those people know how long the wait to access support would be, assess their risk and monitor their wellbeing, and make sure that "*people know they are not forgotten*". The frequency of the contact varied: daily, weekly, fortnightly, every two months, after someone had been on the waiting list for over six months, and as frequently as the service user wanted.

Others said that people waiting for therapeutic support were given access to other types of support provided by the service, such as a helpline, peer support groups, targeted group work, advocacy or ISVA support. Some also provided resources – mostly self-help or psychoeducational wellbeing resources – to those waiting. One service shared an NHS-approved app with people on their waiting lists, and another used a moderated app created by the service itself:

> "We have a range of self-help guides that are accessible for people and we also have an online self help guide: eight modules that an individual can work through, that includes grounding techniques and psychoeducation." [ID384, NFP; SV remit]

Some services told us that they had established a specific programme to support people on the waiting list. Examples given included a psychoeducational or support group/workshop, a listening service, a wellbeing service and an emotional skills support programme. The psychoeducational groups were described as giving people skills to manage their anxiety and develop coping strategies and grounding techniques:

> "We've also got a new service starting this month. It's a psychoeducational workshop, an hour-and-a-half session that we're going to offer everyone on the waiting list. We also have an online programme." [ID344, NFP; SV remit]

7.3.2 Services not providing interim support

Of the 21 services that did not provide interim support, some explained that people on their waiting lists would receive support from the agency or organisation that had referred them. Another reported that its staff did not have time to engage with those waiting for support:

> "We generally won't have too much contact, just because it heightens the risk of disclosure or trying to form a relationship when our project workers don't really have the capacity to [provide support]." [ID584, NFP; CSA focus]

Another service said it did not provide support to people on waiting lists because it was not resourced to do so, but it was interested in looking at how to develop such support.

> A number of services maintained regular contact with people on their waiting list through calls, texts or emails

7.4 Issues and challenges caused by waiting lists

We asked services with a waiting list to tell us whether this had raised any issues or challenges. Of the 83 services that responded to this question, almost all (n=76, 92%) reported that it had.

7.4.1 Impacts on people waiting to access support

Nearly half of the 83 services highlighted the negative impacts experienced by victims/survivors when they could not access support immediately.

For children, services said, there could be negative impacts on their education and their social relationships with peers. Delays in support could also lead to a decline in a child's mental health or ability to manage symptoms of trauma.

Some services told us that waiting lists could cause people to disengage with accessing support, and described putting someone on a waiting list as a potential "*missed opportunity*" to support them:

> "We need to get a service out to them as soon as possible because some people, especially those adults who have experienced child sexual abuse, they could have waited 30 years before they access our service and when they've opened that door and opened themselves to therapy, they need it then." [ID344, NFP; SV remit]

> "We've got kids that are wanting a service and a lot of the ones who are waiting a long time – by the time we got to open them, the families have moved on and the kids aren't talking about it anymore. So, they are 'over it'." [ID61, NFP; CSA focus]

However, they noted that those who disengaged from services at this point were still likely to require support in the future.

Waiting lists were felt to pose a particular challenge in relation to people referred from other services/agencies. One service noted that children's social care were closing cases once they had made a referral, leaving the person unsupported if the service had to put them on a waiting list. Another highlighted the challenges of inappropriate referrals from external agencies, leading people with increasingly complex mental health needs to be placed on a waiting list for support:

> "CAMHS are not able to provide an effective service to this group of young people. They don't routinely screen for child sexual abuse… Young people are coming to us with an increasingly complex range of needs that we do not have the resources or capacity to deal with. But the challenge is that if they're not on our waiting list, they are nowhere else in the system. And so, we feel really obliged to provide that support as much as we can." [ID467, NFP; CSA focus]

> Waiting lists were said to have negative impacts on children's education and social relationships

7.4.2 Organisational challenges

More than two-fifths of the 83 services reported that having a waiting list posed organisational challenges, such as needing to make alterations to service provision. For example, some had reduced, or were considering reducing, the number of support sessions provided to service users, or withdrawing the offer of open-ended support.

Funding and contractual challenges were also associated with having a waiting list. One service told us it was difficult trying to meet key performance indicators while carrying a waiting list. Others described how, despite attempts to source funding to manage their waiting lists, the lists continued to grow:

> "We are receiving small pockets of funding to reduce it, but it seems to be ever growing." [ID426, stat.; SV remit]

Several services said that managing waiting lists creased additional workload, which was not always acknowledged by service commissioners:

> "We're always looking at how we can get it down – which is time consuming… It would be lovely for commissioners to understand the needs and the unmet needs that exist." [ID19, NFP; SV remit]

An additional challenge was prioritising the needs of people on the waiting list who presented with higher levels of risk or need:

> "If the risk really heightens around exploitation, we [will] try and see if we can bump them up the list a little bit." [ID584, NFP; CSA focus]

One service said it was not advertising or raising awareness of itself because of its waiting list:

> "That's the reason why we don't advertise, and we don't really encourage referrals, which is awful… For example, six months ago I did some social media posts and we got 23 referrals that week, so I just had to stop doing it because we can't manage that." [ID237, NFP; CSA focus]

Another told us that the size of its waiting list influenced whether it felt able to accept people in crisis:

> "The longer the waiting list, the more that affects what kind of cases we can take on. If it's a very short waiting list, then somebody where there is a little bit of clinical risk, we might be able to say, 'Well, it's only six weeks. We'll give them some strategies [to cope]'… But if it's going to be a really long wait, then that doesn't feel OK." [ID100, NFP; wider remit]

A waiting list was also perceived as being damaging to a service's reputation:

> "As soon as you get a waiting list, your reputation for being a good service is shot anyway, isn't it?" [ID50, NFP; CSA focus]

An additional challenge was the negative impact on staff. Services told us that waiting lists were "*overwhelming*" and "*disheartening*", which led to "*helplessness*", "*frustration*", "*a sense of pressure*", "*burnout*", and poor mental health among staff members.

> "We're all at our limit. We couldn't possibly be doing any more. We're looking at the welfare of staff because we're having to say, 'You just have to accept the waiting list, you can't possibly take on any bigger loads.'" [ID359, NFP; SV remit]

Waiting lists could also make staff feel that they were not working hard enough, with one service describing its staff feeling "*despair… that we're holding the hope for a lot of these clients*". Some told us that staff members working in triage or taking initial calls might be especially at risk of being adversely impacted, as they were the ones engaging with people on the waiting list first-hand:

> "Your knee-jerk reaction is, 'Oh gosh, give them a slot somewhere. Just get them seen now,' because the level of horrificness we see in these referrals is unbelievable and it's getting worse." [ID369, NFP; wider remit]

8. How are services funded?

This chapter looks at how services supporting victims/survivors of child sexual abuse, and their family members, were funded.

It also considers the influence that these services felt their funders and commissioners had on their service provision, and how confident they felt about maintaining service provision moving into the next financial year.

Key findings and reflections

1. Nearly three-quarters of services were receiving income through delivering commissioned services, while three-fifths received grants from charitable trusts, foundations and statutory sources. In addition, over a third said they received income from donations and fundraising by the general public. Most not-for-profit services derived their income from multiple sources, whereas statutory services were funded solely through commissioning.
2. Some services receiving income through commissioning felt that commissioners imposed criteria that undermined their ability to respond flexibly to need, or that the often short-term nature of funding for not-for-profit services made it difficult to provide a consistent level of service. Funders/commissioners were felt by some to lack understanding around the provision of services for those affected by child sexual abuse, but others said their funders/commissioners were supportive and took an active interest in their work, with a shift towards longer-term funding cycles being welcomed.
3. Many services had also received uplift funding during 2021/2022; this was often associated with the COVID-19 pandemic, although for some it was a recurrent funding pattern. While services welcomed the additional funding which had allowed them to extend their service provision, many noted that the short timescales of allocation and spending created insecurity.
4. Services, and particularly those in the not-for-profit sector, described an uncertain, often competitive funding environment, with increased competition and less funding available. They said they found it especially difficult to find funding for core costs. It was thought that some funders' requirements for 'innovation' could make successful services unsustainable. This is nothing new: Allnock et al (2015:44) described the "high anxiety expressed by service providers about the current funding landscape", and many services in our research indicated that the challenges associated with their funding had increased over the last few years.
5. Two-thirds of services did not feel fully confident that they could sustain their service provision at current levels; this was particularly an issue for the not-for-profit services. Some felt that funding priorities were shifting towards other forms of harm, such as knife crime and criminal exploitation. Funding uncertainties were said to be affecting staff, some of whom were leaving the sector; services were also having to make staff redundant, or were unable to employ new staff.
6. Some services described the challenge of having to accept referrals from statutory services without a corresponding rise in statutory funding. This reflects the findings from other research into the funding of services for child sexual abuse victims/survivors (Hughes, 2023), which found that NHS commissioners failed to appreciate the role that not-for-profit services can play in meeting the needs of victims/survivors, while NHS mental health services were often not equipped to meet those needs.

Implications

Once again, our findings underline the need for funders and commissioners to work together to provide sufficient funding to allow services to sustain and expand the support they provide. This should be long-term funding that does not require services to be 'innovative' yet allows scope for expansion of service provision whenever possible. Uplift funding should be awarded over longer timeframes.

Services' experiences of working with funders and commissioners highlight the need for funders and commissioners to work closely with services to provide funding that allows services to respond to the needs that they are seeing in the most appropriate ways.

8.1 Services' main types of funding

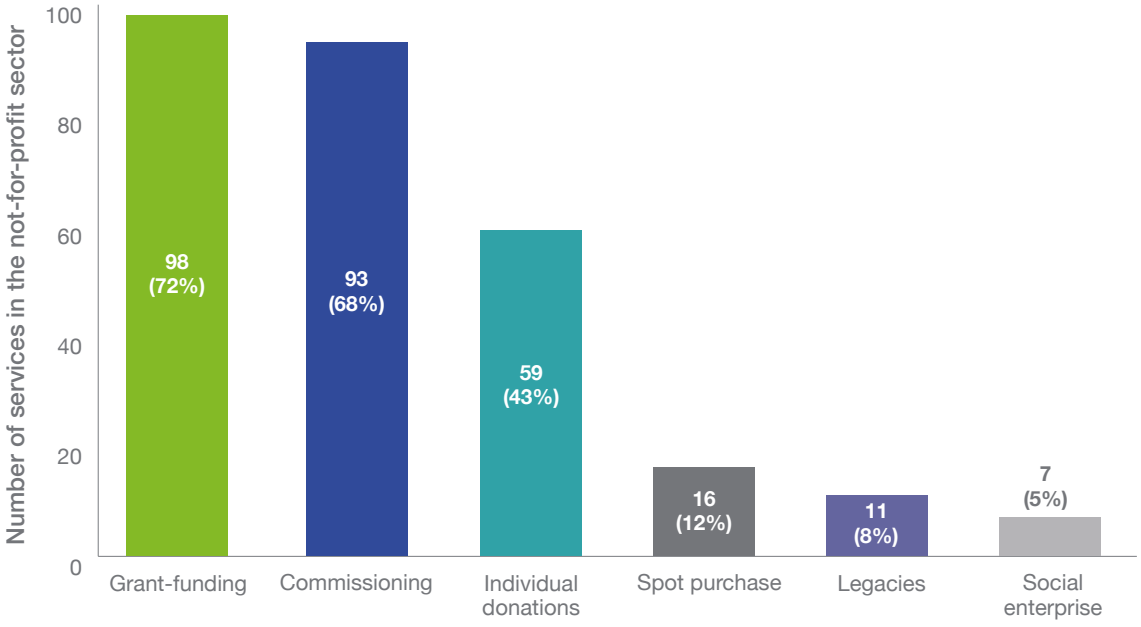
Nearly three-quarters (n=121, 73%) of the 166 services we interviewed received income through providing commissioned services. All 25 services in the statutory sector were funded *solely* through commissioning, as were the two statutory/not-for-profit partnerships.

The three interviewed services in the private sector each had a single source of funding: one was funded through commissioning, another through grant-funding, and the third through individual donations.

As Figure 49 shows, the 136 services in the not-for-profit sector derived their income from a variety of sources. Almost three-quarters received grant-funding from charitable trusts, foundations or statutory sources; two-thirds provided commissioned services; and more than two-fifths received income through the general public's donations and fundraising. A few also received income from spot purchase, legacies and social enterprise activities.

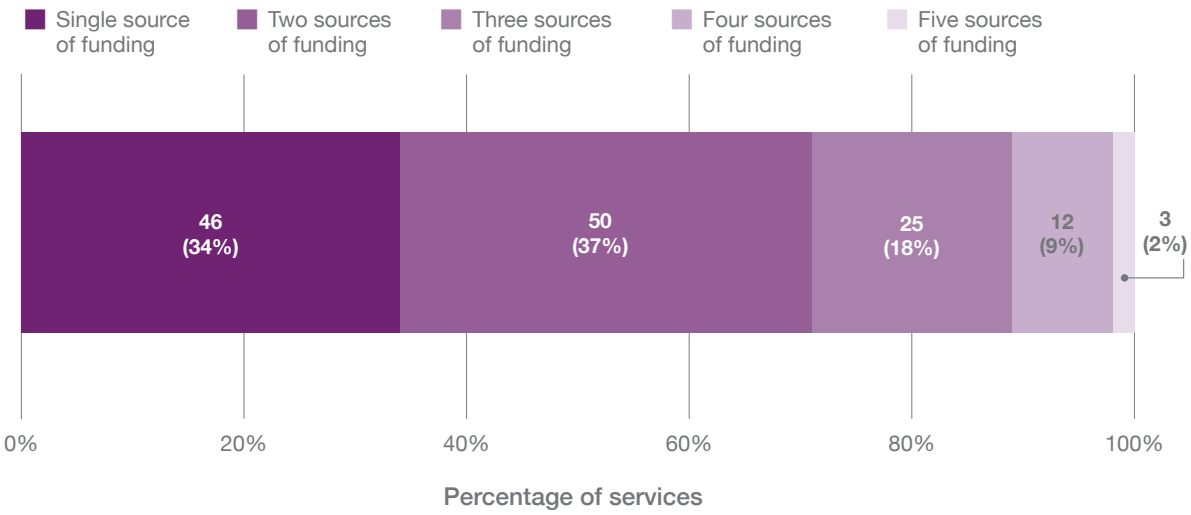
As Figure 50 shows, two thirds (n=90, 66%) of not-for-profit services had more than one funding source. In contrast, every one of the statutory- and private-sector services had derived its funding from a single source.

Figure 49. Main types of funding for services in the not-for-profit sector



n=136.

Figure 50. Number of funding sources for services in the not-for-profit sector

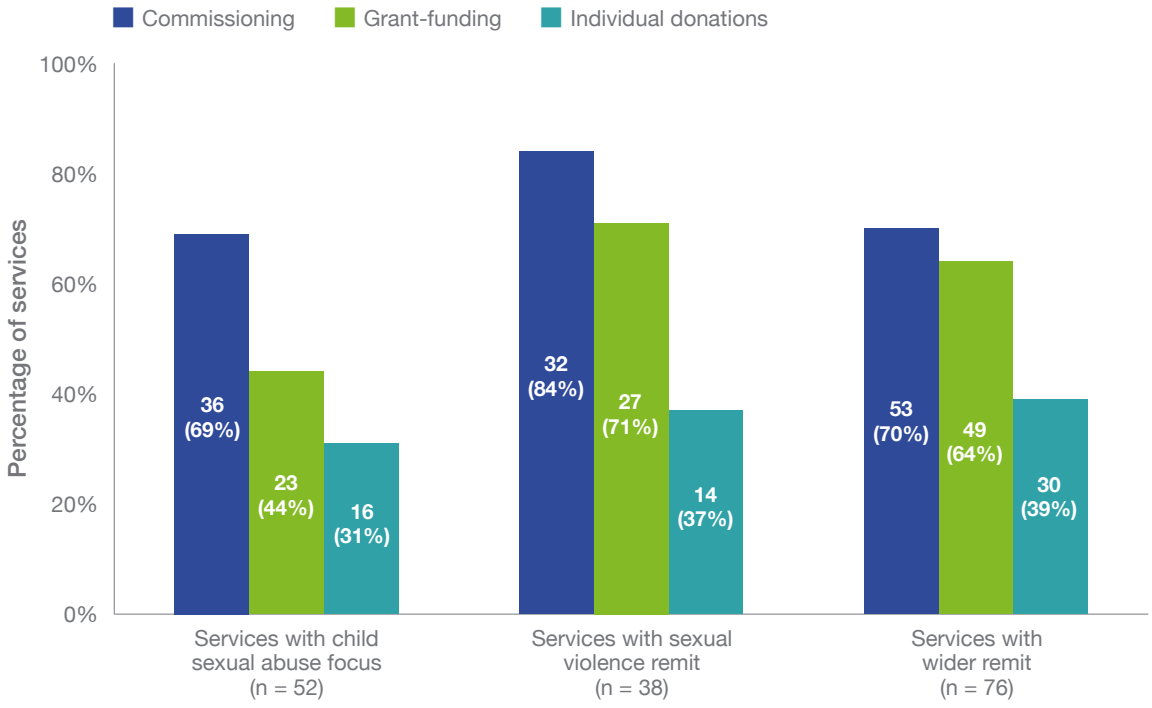


n=136.

Of the 46 not-for-profit services with a single source of funding, half (n=23) were funded solely through commissioning while a third (n=15) received grant-funding. Another six relied solely on individual donations, and two on spot-purchase.

There were also notable differences in funding sources when looking at services by their service remit. As Figure 51 shows, fewer than half of services focused solely on child sexual abuse were receiving grant-funding, compared with around two-thirds of services with a sexual violence focus or a wider remit.

Figure 51. Main types of funding, by services' remit



n=166.

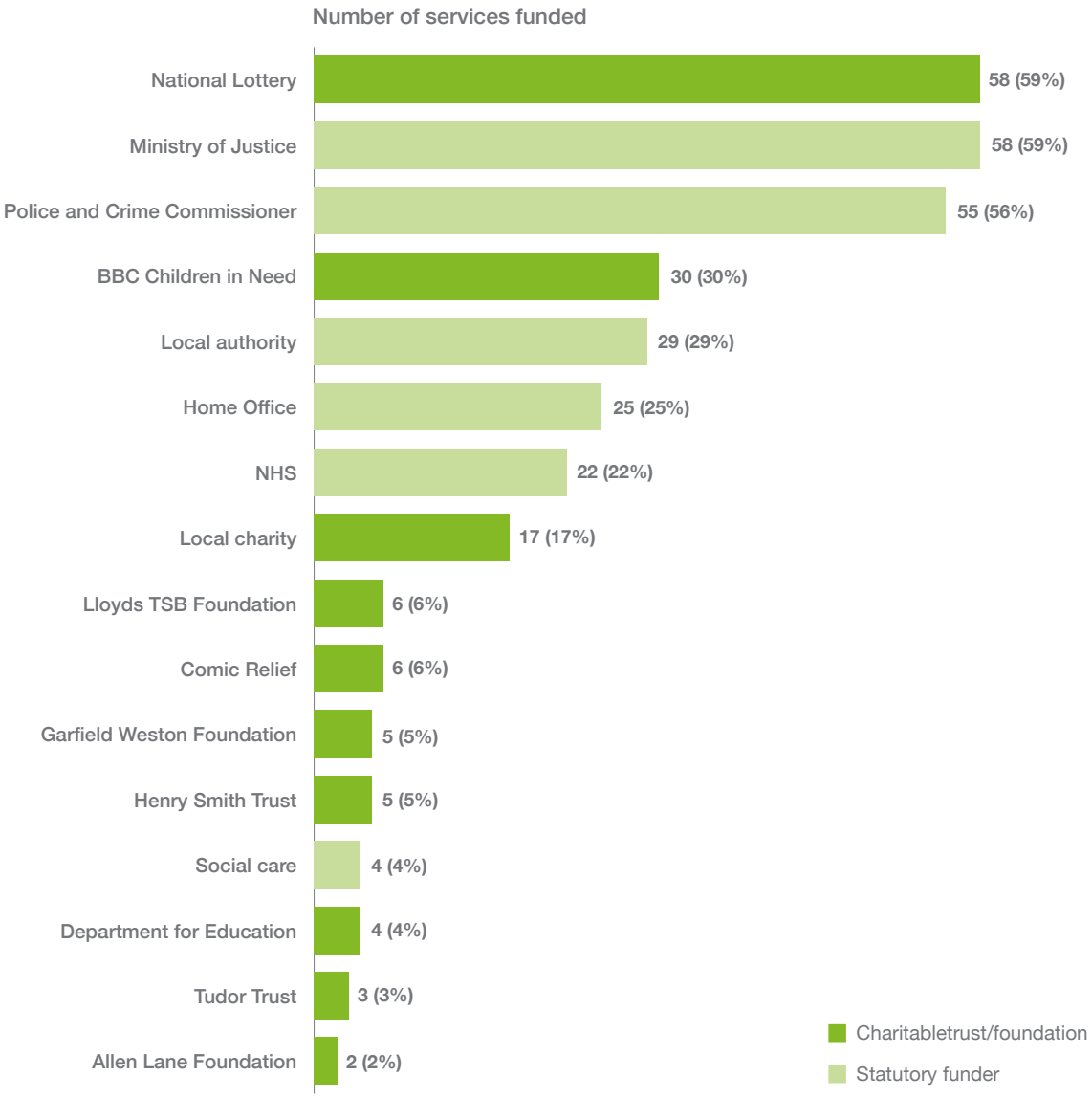
8.2.1 Grant-funding

As Figure 52 shows, the National Lottery, the Ministry of Justice and local Police and Crime Commissioners each awarded grants to more than half of the 99 services receiving grant-funding. Local authorities, BBC Children in Need, the Home Office and the NHS each awarded provided funding to between a fifth and a third of these services. Smaller numbers of services had received or were receiving grants from charitable trusts and foundations, such as the Lloyds TSB foundation, Comic Relief or local charities.

8.2.2 Commissioning

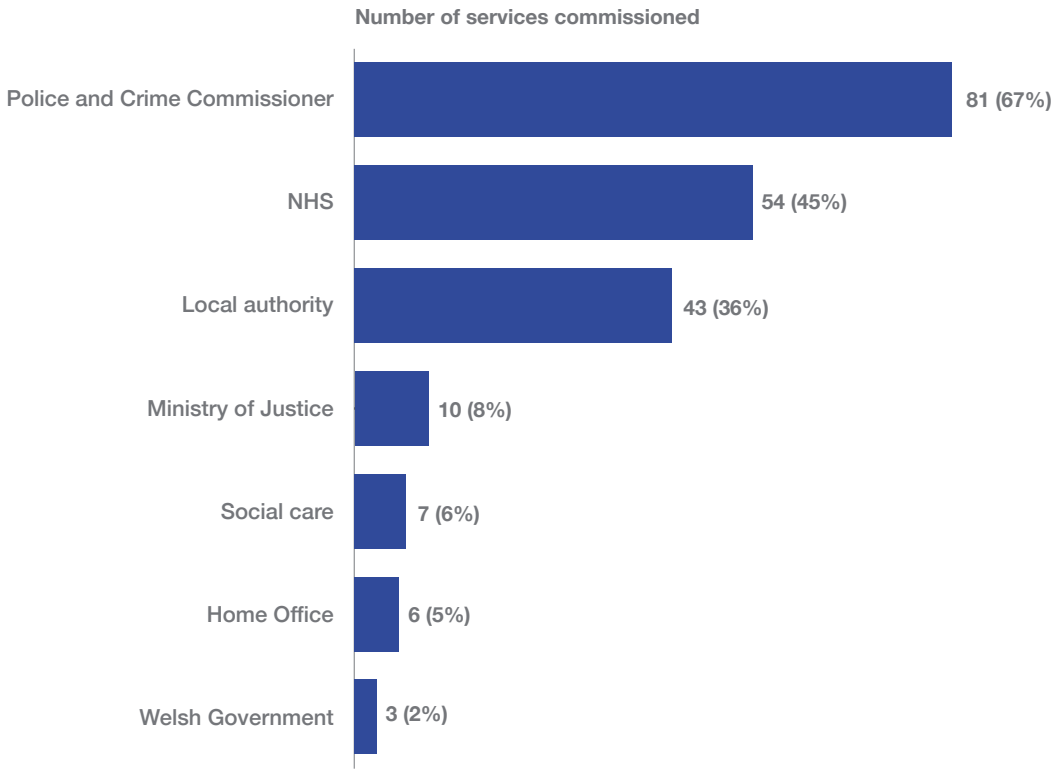
As Figure 53 shows, over two-thirds of the 121 services providing commissioned services said these were commissioned by their local Police and Crime Commissioner. Almost half had services commissioned by the NHS (through Integrated Care Boards), and local authorities commissioned services from a third of services (through Social Care or Violence Reduction Units, for example).

Figure 52. Sources of grant-funding



n=99.

Figure 53. Sources of commissioning



n=121.

8.2 Uplift funding

Services were also asked whether they had received any uplift funding – an additional sum awarded during the year by a funder/commissioner to augment existing funding – in the previous year. Of the 147 services that answered, more than half (n=84, 57%) said they had received a funding boost in 2021/2022. For most of them (n=50, 60%), this had been a one-off payment, often associated with the COVID-19 pandemic, while another fifth had received such payments in previous years (n=16, 19%); others were unsure or described a more complicated situation.

Many services described how valuable this money had been. Some had used it to tackle their waiting lists:

> "We were able to translate that money into eradicating a waiting list, which for morale was massive, because nobody in the organisation ever thought we would be without a waiting list. It was an entrenched waiting list of six to eight months." [ID483, NFP; wider remit]

Others had been able to offer additional counselling sessions or extend the therapeutic support they provided:

> "We have been able to spend it [on] introducing EMDR therapy as a pilot." [ID168, NFP; SV remit]

> "It's given us the opportunity to look at other types of service provision. We are now funded to provide our lotus programme, a residential monthly programme for child sexual abuse survivors." [ID392, NFP; SV remit]

This could present a challenge, however, as services were left ill-equipped to cope with increased levels of demand when the uplift funding came to an end:

> "We put more into the counselling service so that we can provide more clinical hours. But actually that's going to come to an end in March, but the demand is still there." [ID308, NFP; SV remit]

Other significant challenges were associated with the short timescales in which uplift funding was received and had to be spent:

> "The Ministry of Justice tend to give it very last-minute. So we haven't got the money in the bank yet and they're saying we've got to spend it by the end of March." [ID219, NFP; wider remit]

Short timescales were particularly problematic in terms of recruiting and retaining staff:

> "There's a huge amount of effort that goes into recruiting and inducting people, especially when those people have moved out of area to come and work with us. And those people come with a hope and a prayer that maybe the funding will continue next year… because they love our service and they love being part of the work… And then when that funding ends, all of those people leave. And [this creates] huge instabilities within our team." [ID467, NFP; CSA focus]

Because of these challenges, some services told us they had to consider carefully the impact of accepting uplift funding:

> "It's very tempting to jump when a funder offers you a bit of additional money but we're always interested in looking at how sustainable that is. And whether that's going to be replicated in the following year. Sometimes they have an answer to that, sometimes they don't." [ID446, NFP; CSA focus]

8.3 Funders' influence on service provision

We asked services how much influence they felt their grant-funders and commissioners had on their service provision. As Figure 54 shows, half of grant-funded services reporting that their grant-funders influenced their service provision to some extent or a significant extent – but, as would be expected, three-quarters of services funded through commissioning said their commissioners had that influence. This was particularly the case for statutory sector services; nearly half of whom (n=10,43%) said that their commissioners had a significant influence on their service provision.

Among services which felt their grant-funders or commissioners had an influence on their service provision, many said their funders/ commissioners determined who they worked with or how they worked:

> "They decide how much funding they're going to give, how many sessions we offer, how many children and young people we're seeing." [ID654, NFP; CSA focus]

Others noted the funding/commissioning criteria which they had to keep within when providing their services:

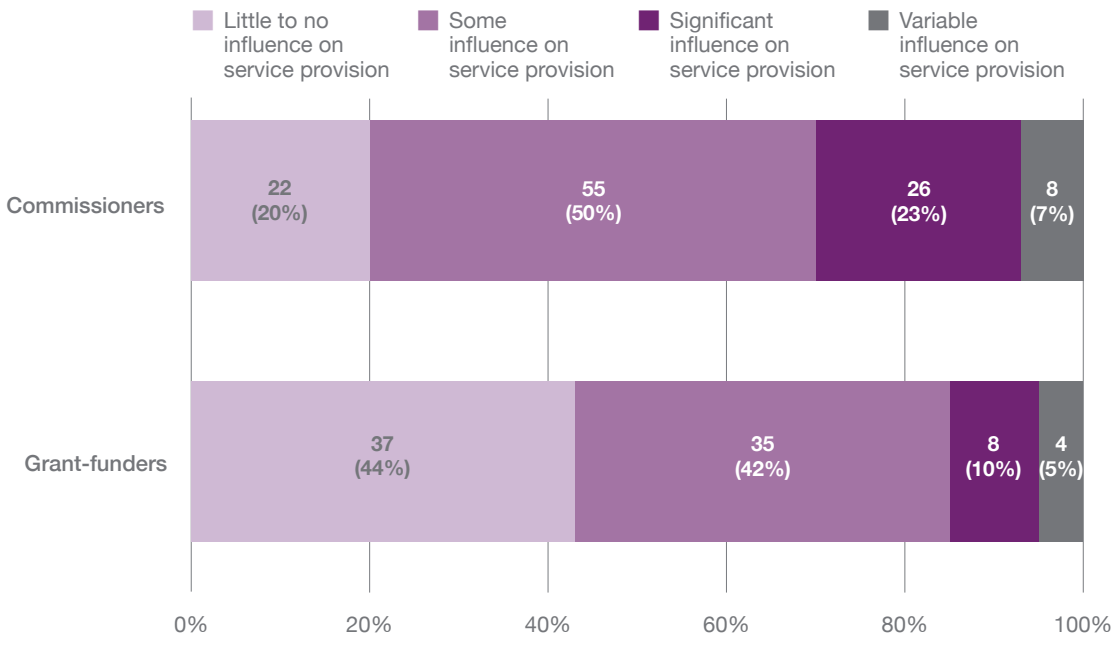
> "We have to be held accountable and prove that we are delivering a good service that meets criteria." [ID75, NFP; SV remit]

Some identified limitations that this imposed on them, in terms of both how long they could provide support and whether they could provide support to parents and to young people moving into adulthood:

> "It doesn't feel like it acknowledges the complexity of the work that we need to provide… There's no funding for the parents within the contract, even though you might work with a four-year-old, when you clearly have to spend time with the parents." [ID198, NFP; CSA focus]

> "It's a challenge with Children in Need because they are up to 18 only, so this doesn't allow for transition which is a massive issue." [ID68, NFP; wider remit]

Figure 54. Level of influence thought to be held by grant-funders and commissioners



n=84 services receiving grant funding; n=111 services funded through commissioning.

Nevertheless, many services described their funders/commissioners as supportive and taking an active and positive interest in their work:

> "They have been really supportive to us. They know the impact we are having at a local level. They know that every project we have done, we have done it very well. Hugely they understand what we provide. They've been very supportive." [ID394, NFP; wider remit]

> "They can be really good champions and partners, so they can be really positive on what we're doing, helping us to promote what we're doing, linking us in with other people that are doing similar work." [ID615, NFP; CSA focus]

One highlighted the positive impact of receiving long-term funding from their commissioner:

> "We had our first five-year contract from the PCC last year… I think probably it's the first time we can feel confident really in the funding." [ID349, NFP; SV remit]

Some identified ways in which their funders/commissioners supported them:

> "We have very good relationships with our commissioners and negotiate quite well and tell them what our ideas are." [ID60, NFP; CSA focus]

> "We meet really regularly with the Home Office and they very much listened to us in terms of what we're seeing, what we're doing, how we improve." [ID34, NFP sector; wider remit]

> "The commissioners are very, very supportive and wanting the hospital ISVA project to develop and be innovative and be a bit of a model for other areas to follow." [ID295, stat.; SV remit]

Others were content that they were left to get on with their work without interference:

> "They are very trusting that we are delivering the service and we report quarterly for them and obviously we have an annual review and they're quite hands off. They just sort of let us get on with things." [ID99, NFP; CSA focus]

A few described their funders/commissioners' positive influence in driving them forward in the delivery or development of services:

> "Children in Need expected us to have highest standards in place… You step up to that as an organisation. In that way, it does influence the quality and delivery of services, but I see it as a positive thing." [ID492, NFP; CSA focus]

> "We've recently been given a grant to develop a new service which will probably involve running groups. This is something we wouldn't or couldn't have done otherwise." [ID573, NFP; wider remit]

However, some services felt their funders/commissioners lacked understanding around the provision of services for those affected by child sexual abuse:

> "It's a constant educational battle with them to say if you're working with the most traumatised, these are the people that are going to need longer services. They're going to have issues around engagement, there's going to be more crises that go on [in their lives]. They are going to be the more complex people because of what that is. And of course, really what [the commissioners] want is someone to come in, have 12 sessions and be fixed." [ID378, NFP; wider remit]

Others felt that their funders/commissioners imposed onerous reporting requirements:

> "The reporting is extensive and forever changing. Agendas change and then we need to retrain everybody on what paperwork people need to do, so that we can meet whatever agenda. It's extremely time-consuming and bureaucratic." [ID347, NFP; SV remit]

Some explained that they only applied for funding which allowed them to remain in control of their service provision:

> "We're very selective about who we apply to. If we feel someone wants to remain in control of the service and undermine what we're doing well, then, well, that's not really going to be of much benefit." [ID83, NFP; wider remit]

> "What we don't do is change our values or commitment to how we deliver services because of a contract or a grant. I'd rather not have it." [ID371, NFP; CSA focus]

8.4 Services' confidence in their ability to sustain service provision

Asked how confident they were that they would be able to sustain their service provision at its current level in the next financial year, 159 of the 166 services (96%) gave an answer. As Figure 55 shows, more than a third of these felt extremely confident, but half felt only 'somewhat confident' and one in seven 14% (n=22) were 'not very' or 'not at all' confident. Some of those who were confident in their ability to sustain their services explained that this was based on having reserves they could fall back on:

> "We've still got a big shortfall for the coming financial year, but we have got reserves at this stage that we could draw on in order to sustain the current level." [ID89, NFP; SV remit]

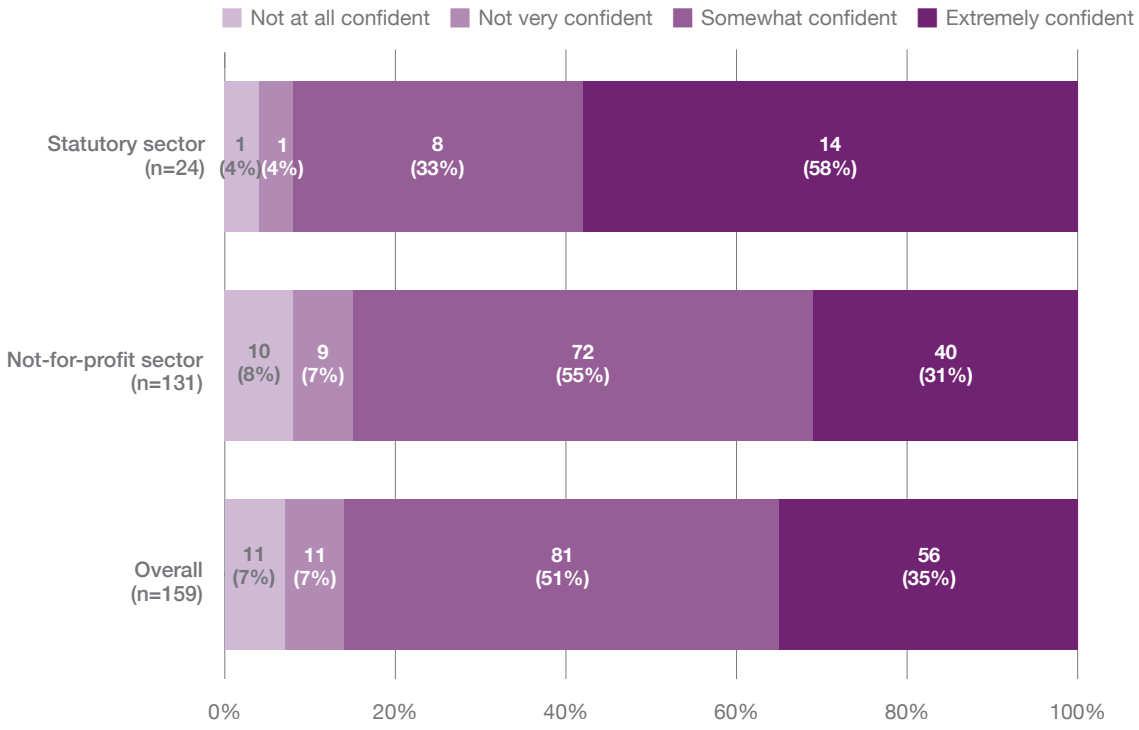
Services in different sectors had very different levels of confidence. three-fifths of statutory services were extremely confident in their ability to sustain their service provision at current levels, but fewer than a third of those in the not-for-profit sector felt the same – and not-for-profit services were more likely to have little or no confidence.

Among the 65 not-for-profit services that explained why they were not confident that they could sustain their service provision, nearly a quarter attributed this to the uncertain, often competitive environment they felt they were now operating in:

> "There is very much an uncertainty at the moment with the [Ministry of Justice] Rape Support Fund going out to tender this month. That is our biggest funder. And although we've been reassured that it's been ring-fenced with specialist organisations, we all know that there's organisations there who are just money-grabbers and will try and source funding without the expertise to back them up." [ID344, NFP; SV remit]

> "Three of our funders – Ministry of Justice, Home Office and the local authority – are all recommissioning this month. So, as it stands, we have nothing for 2023 to 2024." [ID237, NFP; CSA focus]

Figure 55. Services' confidence in their ability to sustain service provision



n=159.

Some highlighted the challenge of finding funding for existing rather than new services:

> "You have to be innovative. So when things are working really well, they tend not to be happy to fund that. They always want something innovative. So you're constantly reinventing the wheel." [ID456, NFP; wider remit]

Six services told us they were not confident that they could replace funding which was coming to an end:

> "[We are losing the funding from] our three main funders all at once, so it's a very scary time." [ID237, NFP; CSA focus]

Five services already expected to be losing staff:

> "We have short-term money coming to an end. Six counselling posts coming to an end and I'm not confident we will get that money again." [ID24, NFP; wider remit]

> "We're casting our net out quite wide to try to bring in funding, but I'm looking at three contracts on the young people service ending unless we get more funding." [ID68, NFP; wider remit]

Others said they would be struggling to meet demand:

> "We're going to have to reduce delivery. It's going to be really tricky for people trying to access support. It means they're going to be having to wait for months on end before they can access counselling, which is going to be really difficult." [ID578, NFP; wider remit]

8.5 Funding challenges

We asked the 166 interviewed services whether they faced any challenges around their funding, and 160 responded: four-fifths (n=128, 80%) of them said they did.

Almost nine in ten (n=112, 88%) not-for-profit services were experiencing challenges; as were two-thirds of statutory services (n=14, 67%), and two of the five services in the private sector.

Many services linked funding challenges to the short-term nature of many grants and contracts:

> "Everything is cliff-edge, lurching from one fund ending and trying to find another fund for every piece of work. Constantly looking for money, tendering, bidding, all short-term." [ID460, NFP; wider remit]

> "When you're taking money from commissioners, you put in the application for 12 months, you get it seven months in and you've got four months to spend it all." [ID83, NFP; wider remit]

They described how financial uncertainty affected their ability to sustain their provision and plan for the future, especially where funders made decisions at short notice:

> "I shouldn't be finding out in February what's happening in April, and I certainly shouldn't be finding out in March what's happening in April. And I certainly shouldn't be finding out in July what's happening for the previous April." [ID483, NFP; wider remit]

One service said it had been commissioned by its Police and Crime Commissioner for the last three years but had recently learnt that it was not being recommissioned, resulting in a loss in income of nearly £300,000:

> "We are going to find it difficult now to sustain what we already have. We can't address waiting lists, we need more counsellors. At the moment, we're going to have a struggle this year to get funding to sustain us beyond the end of 2023. We've got a year left, basically." [ID359, NFP; SV remit]

Funding uncertainties were said to have led workers to leave the sector.

> "Every year by January all staff are feeling a little bit anxious about their role. Even more with this current situation, so we tend to lose a lot of staff who jump ship." [ID308, NFP; SV remit]

They had also left services with the prospect of having to make staff redundant or unable to employ new staff.

> "At one point we had seven posts that were facing being unfunded out of 20 posts… We had seven people who were in theory facing redundancy." [ID428, NFP; wider remit]

> "We can't hire new people. We don't make changes that we might want to make because we need confirmation of the funding before we could do those things [ID598, NFP; wider remit]

> "There is only so much cutting to the bone that we can do." [ID575, NFP; SV remit]

Some services considered that funders did not understand their work or had other priorities:

> "Our commissioners want us to be focusing on other [early help] work." [ID26, NFP; wider remit]

> "Commissioning is out of date and out of touch with the current complexity and need for complex child sexual abuse work, particularly in regard to intra-familial, intra-generational abuse." [ID297, stat.; CSA focus]

Competition for limited funding was said to create stress and reduce the funding available to individual services:

> "We are in the process of rebidding for the Rape Support Fund and the amount that is available across the area is going to mean that we have a reduction in funding." [ID24, NFP; wider remit]

> "It's open to the market and the actual process of competing is epic… it is a full-time job for someone for several months and it's quite stressful as well because you are competing and trying to deliver the service as well… All the staff know that we're actively competing for our service, and we might not get it. We might not be the provider in March." [ID464, stat.; SV remit]

A lack of funding from local authorities was a particular issue for some, especially where a change in local commissioning arrangements had resulted in an influx of referrals:

> "And so we were getting a lot of phone calls from adults looking for where they could access counselling. And when I spoke to the commissioner, I said, 'What have you got in place? What's happening for adult survivors of childhood sexual abuse?' They said, 'Well, we've got [name of service]' and I said, 'You haven't got us. You're not funding us.'" [ID19, NFP; SV remit]

A similar picture was seen in relation to NHS services:

> "We're disappointed there is no funding from the NHS when they are referring to us and not offering any support themselves. We find that not acceptable. We have to go along with it, otherwise the guys don't get any support." [ID248, NFP; CSA focus]

As touched on above, finding enough capacity to support fundraising was another challenge for many services:

> "Because we are so small, we often don't fit the criteria for places that offer grants. We also don't have anyone who has time to research funding options." [ID573, NFP; wider remit]

The challenge of being required to evidence need was also highlighted:

> "We're not able to devote the resource that we would like to... And the research is lacking as well. I know some pieces of work have been done this year about the voices of survivors from minority ethnic communities… Because that's one of the things funders want, don't they? They want the evidence of need." [ID724, NFP; wider remit]

8.5.1 Changes in funding challenges

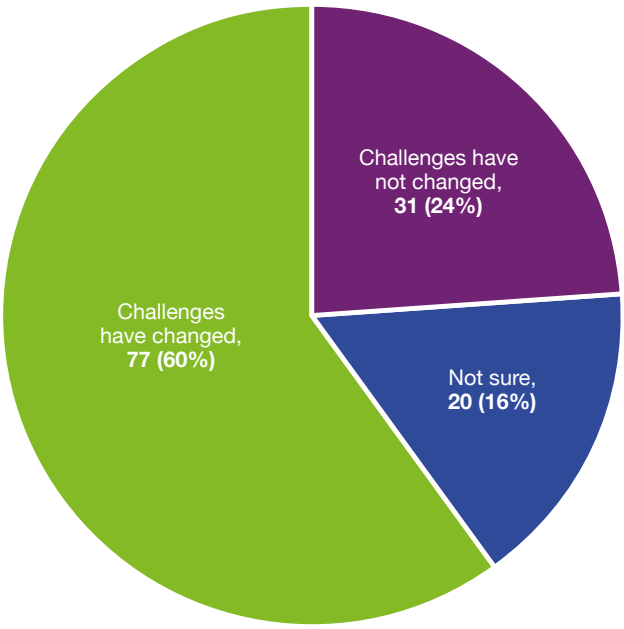
The 128 services that said they faced funding challenges were also asked whether these challenges had changed over the last few years. As Figure 56 shows, three-fifths of them felt that funding challenges *had* changed, with almost all indicating that things had worsened.

Again, services talked about less funding being available to support their work:

> "The local authority seem to have had their funding slashed in the last decade or so and so the less money they have, the less commissioning they will be doing." [ID680, NFP; wider remit]

> "During COVID, funders were very generous and gave a lot of money to spend on whatever we needed to keep going; after COVID, [there was a] loss of funders and trust funds so what's available is going down whilst our demand is going up. [Also there's the] cost-of-living crisis so there is pressure on salary and living wage." [ID443, NFP; wider remit]

Figure 56. Did services feel that funding challenges had changed?



n=128.

Many felt that the environment had become more competitive over the last few years:

> "There are more private companies as opposed to charities that are setting up as counsellors/therapists, and they will compete for tenders. Last time we were competing with large national providers and new emerging small regional providers, so we could lose our whole service to something that has only been open a year and isn't specialist." [ID390, NFP; SV remit]

Furthermore, they felt that funding had not kept up with recent increases in both the volume and the complexity of demand, which had putting services under greater pressure:

> "This is the problem, that demand has gone up. So actually, if funding doesn't keep going up, we're in a far worse position than we were before." [ID483, NFP; wider remit]

> "We have, I would say, double the number of referrals we're able to see with the provision that we have… and the challenges related to the complexity of client referral presentation have increased, impacting on service provision and waiting times." [ID574, NFP; wider remit]

For some, it had become more difficult to sustain services which had expanded in recent years, often as a result of additional funding linked to the COVID-19 pandemic:

> "We have grown a lot in the last few years and we offer a full range of services that we didn't offer five years ago… It would be heartbreaking at this stage to lose those services that we've built. So I think sustaining that level of growth is the new challenge that we're facing." [ID89, NFP; SV remit]

A shift in their funding base towards commissioning had left some services more financially vulnerable than they had been previously:

> "We've become a service now that is heavily dependent on the Ministry of Justice and the PCC. The majority of our funds come from there. So in the past, we would have various different funders which would be quite big funds. But now everything is gone to this kind of, like, one-stop commissioning pot. It's a fear if the government decided, 'We're no longer funding sexual violence services', or the PCC decide [not to], then we will really, really be struggling." [ID349, NFP; SV remit]

Some felt that there had been a decrease in the priority given to funding services supporting victims/survivors of child sexual abuse:

> "I think that's a really big challenge, that the professional lens just isn't on child sexual abuse and child sexual exploitation because the harm is more hidden in a lot of ways… They're often not wielding a machete or ending up with a stab wound in A&E. They're experiencing trauma and it's the impact into later life." [ID68, NFP; wider remit]

> Services said funding had not kept up with increases in the volume and complexity of demand for support

9. How are services staffed?

This chapter looks at how services are staffed as well as the challenges they face in maintaining their workforce.

It also considers what training staff and volunteers have received and what further training would be useful.

Key findings and reflections

1. Many of the services we interviewed had a small staff team providing direct support around child sexual abuse, with more than half telling us they had fewer than 10 full-time-equivalent staff.
2. Most said that recruiting and retaining staff was proving challenging. In part they attributed this to the specialist nature of the work and the skills required, but the inability to offer competitive salaries was a particular issue for not-for-profit services.
3. Almost nine out of ten not-for-profit services used volunteers to support their service delivery, in roles including befriending, providing administrative or technical support, and promotion. Many services were offering placements or volunteering opportunities to trainee social workers, counsellors or psychologists. However, some said they were struggling to recruit volunteers, particularly as a result of the COVID-19 pandemic and the cost-of-living crisis, or they lacked the resources to manage volunteers.
4. Services described how short-term funding and the impact of their work affected their ability to retain staff; this highlights the need for services to be proactive in taking care of staff wellbeing.
5. Most services had given their staff and volunteers specific training around child sexual abuse. Those who had not done so said their staff had joined with existing expertise, and/or provided training focused on other topics such as sexual violence and trauma. Many services said they would value more training for their staff and volunteers; given the complexities of this work, greater access to training specifically around child sexual abuse would clearly be of immense benefit to services working in this area.

Implications

Our research suggests that services are facing a crisis in maintaining sufficient resources – particularly in terms of skilled staff – to support victims/survivors and family members affected by child sexual abuse. Funders, commissioners and policymakers can help by:

- offering long-term funding/commissioning that gives services sufficient time to recruit staff and offer contracts of reasonable length
- providing funding that allows services to proactively support staff wellbeing
- providing funding to support the recruitment, support and management of volunteers, for services who would benefit from volunteer support
- providing funding to support skill-sharing and training specifically around child sexual abuse across the sector.

9.1 Paid staff

Of the 166 services we interviewed, 153 provided information about the number of staff who were directly providing support around child sexual abuse. As Figure 57 shows, more than half had fewer than 10 full-time-equivalent staff doing this work. This included six services which had no paid staff, as they used sessional workers or volunteers to provide support.

As Figure 58 shows, services with a sexual violence remit were much more likely to have at least 10 staff than those focused solely on child sexual abuse or with a wider remit.

Many services highlighted their staff team's strengths. For some, diversity of skills was key:

> "Our staffing team is a real mix: social workers, therapists, youth workers, ex-teaching staff, counsellors." [ID61, NFP; CSA focus]

Others described the value of having staff with lived experience of child sexual abuse:

> "We're really fortunate to have… staff with lived experience working within the team, which really supports us when we're looking at reaching young people and families." [ID72, stat./NFP partnership; wider remit]

Section 13.1 contains more detail about the importance services attached to their staff members' experience, knowledge and commitment.

9.2 Volunteers

A total of 161 services told us how many volunteers they were using to support their service provision. As Figure 59 shows, more than half of them made use of volunteers – including almost nine out of ten services in the not-for-profit sector (n=96, 88%) but fewer than a third in the statutory-sector (n=5, 31%).

Services described a range of volunteer roles.

> "We have volunteers that deliver befriending for adult survivors of sexual violence, including child sexual abuse. And we also have volunteers who work on our helpline and web chat service that also provides support to survivors of child sexual abuse." [ID578, NFP; wider remit]

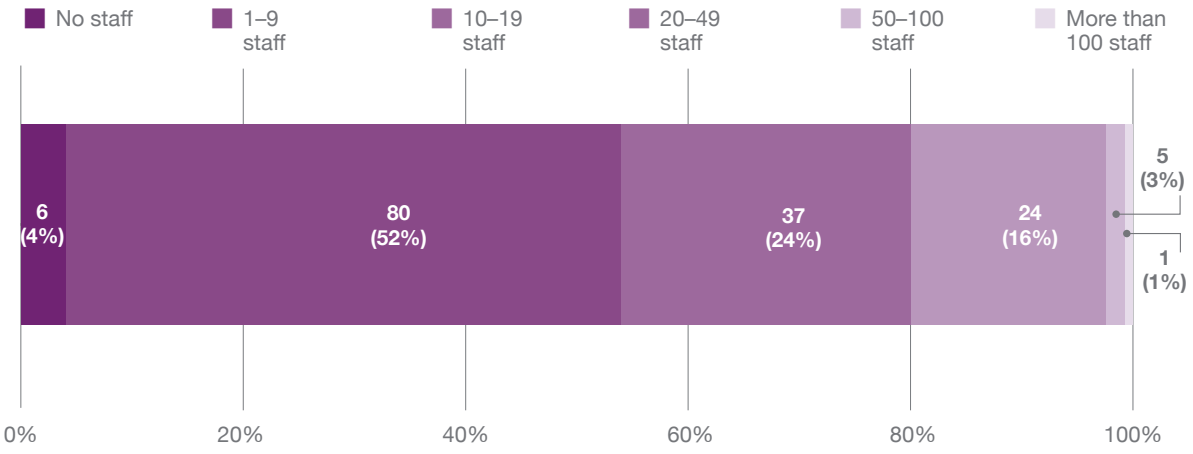
> "We have one lady supports the admin side of things and then we have a guy that helps with music production and editing, as we can offer music as part of the therapy." [ID59, NFP; CSA focus]

> "We have 10 former service users who support our work through volunteering and promotion." [ID363, NFP; CSA focus]

Some offered placements or volunteering opportunities to people training as social workers, counsellors or psychologists:

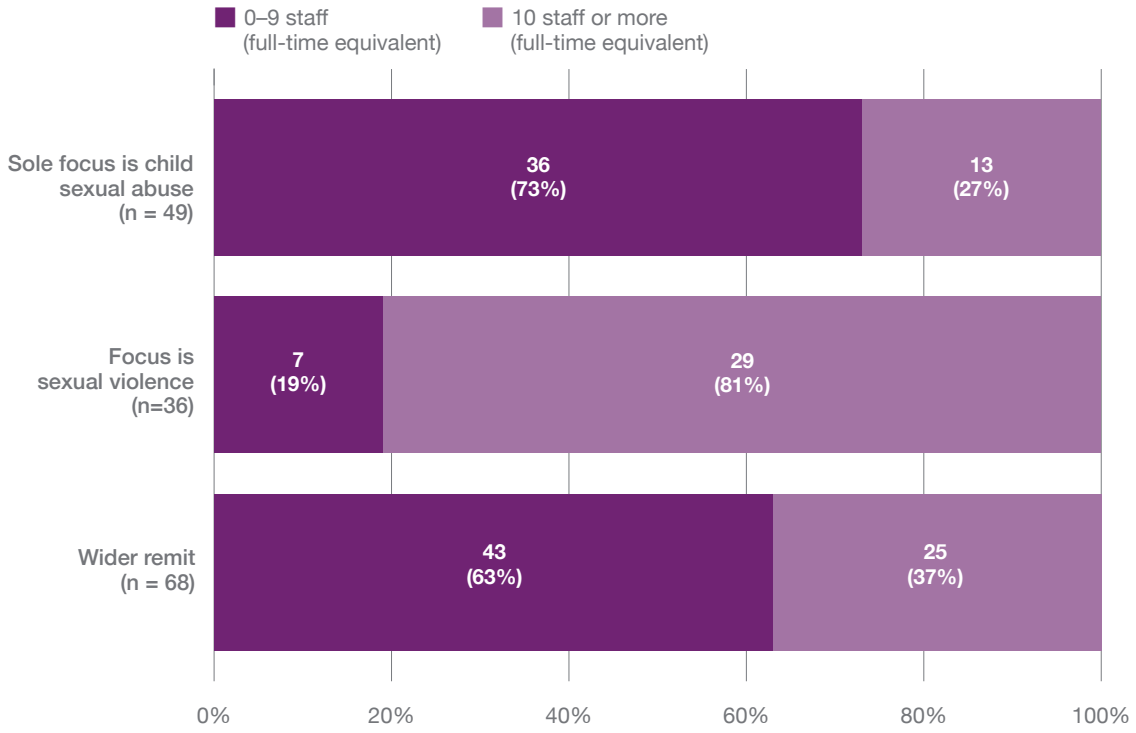
> "The majority of volunteers are in the adult counselling service because we're a placement provider. So people who are training to become counsellors will volunteer for us as well." [ID359, NFP; SV remit]

Figure 57. Staff numbers (full-time equivalent)



n=153.

Figure 58. Staffing levels, by service remit



n=153.

However, many services were struggling to recruit volunteers, and suggested a variety of reasons for this:

> "Women just still seem to have more demands on them post-COVID, and so they haven't necessarily got the time to do unpaid work." [ID483, NFP; wider remit]

> "The cost-of-living crisis affects peoples decision to volunteer." [ID460, NFP; wider remit]

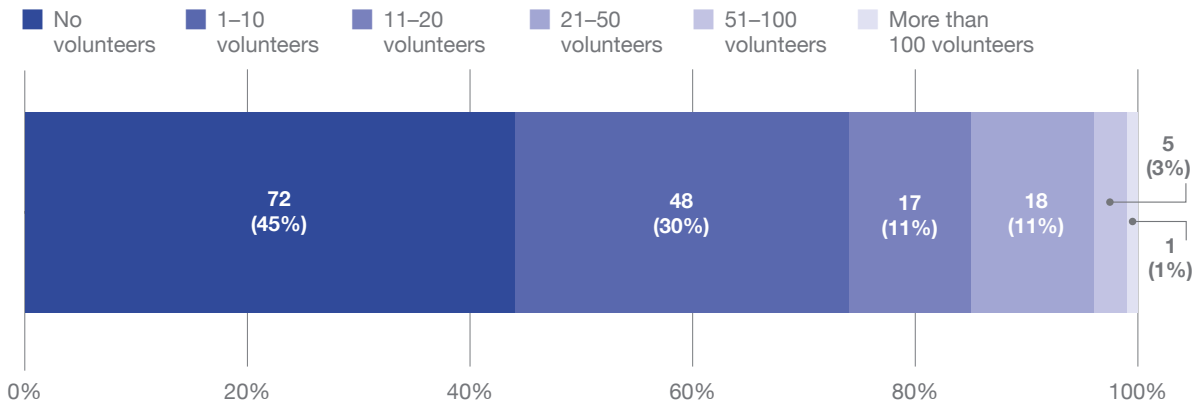
A lack of resources to manage volunteers was also a barrier:

> "We used to [have volunteers] but lost the funding for the worker who coordinated the volunteers." [ID617, NFP; CSA focus]

Other services had decided not to use volunteers because of the nature of their work:

> "Volunteers have the choice whether to turn up, and in terms of accountability you can only expect paid staff to be accountable." [ID680, NFP; wider remit]

Figure 59. Services' use of volunteers



n=161.

9.3 Recruiting and retaining staff

Of the 120 services that answered a question around recruiting and retaining staff, the vast majority (n=115, 96%) said that this was proving challenging.

Many identified recruitment as a particular challenge, and felt that the nature of the work and the skills required were factors in this:

> "It's partly because it's a niche area – so finding people with the right level of expertise in trauma-informed, safeguarding and working in the world of child sexual exploitation. We don't want people learning on the job." [ID61, NFP; CSA focus]

Services in the not-for-profit sector highlighted the challenge of being able to offer competitive salaries, when other types of service could offer more attractive rates of pay:

> "Being voluntary-sector, we can't compete with NHS or private sector pay." [ID118, NFP; SV remit]

The challenge of offering adequate salaries was also reported to be a barrier in terms of *retaining* staff.

> "Times are much tougher for people. People are telling us that they're starting to consider looking for new roles purely for financial reasons." [ID349, NFP; SV remit]

Some services reported losing staff because of the toll that the work placed on them, particularly since the COVID-19 pandemic:

> "I would say recruitment in our sector is in a real crisis at the moment. And it's not always about money. I think it's just people are worn out. They are burnt out. They are frustrated. And because people have learnt to work from home or people wanting more of a work life balance, you know, just all of those factors mean it's really quite difficult to get people to do face-to-face work." [ID99, NFP; CSA focus]

Others highlighted the challenge of retaining staff when their funding only allowed them to offer short-term contracts:

> "The funding for that service is year-on-year. So every year, it's very stressful trying to keep staff to the last minute while we're still waiting to find out whether or not we're going to have funding for the following year. And if I do lose anyone along the way… I can't just get someone in for three months… because they need to be specialist in that area." [ID615, NFP; CSA focus]

Many recognised staff wellbeing as a challenge to retention:

> "Vicarious trauma for staff is an issue – and burnout. We work diligently to look after all our staff, but vicarious trauma is a big one." [ID167, NFP; wider remit]

> "Burnout is a huge, huge thing and I often see it happening. We do provide support. We provide counselling and everything else. It doesn't matter how much you tell people beforehand that it is a specialist service, you will come across things that you might not have ever heard before and understand the reality for them is always a bit different. There's only so much people can take on." [ID434, NFP; SV remit]

> "For therapy, no. Our clinical team … are all at burnout stage because of the numbers coming through and we are short-staffed. We are currently holding vacancies and people are handing in their notices." [ID531, stat.; SV remit]

"Services highlighted the challenge of retaining staff when their funding allowed them to offer only short-term contracts"

While highlighting the quality and strength of its staff team, one service put this in the context of under-resourcing across the sector:

> "They are really loyal, and I think that, for the work that they do, and the money that they're paid, they're all amazing. The whole sector really is relying on that, which is not really good enough. We need specialists. We need to pay them for the job that they're doing year on year. Funding for specialist workers is not sustainable. We can't carry on doing it. We need to look at the sector and properly recognise staff members and make sure that they are being rewarded, even if it's just with job security." [ID615, NFP; CSA focus]

9.4 Training for staff and volunteers

9.4.1 Training received

A question about specific training around child sexual abuse was answered by 163 services, three-quarters (n=120, 74%) of which said their staff and volunteers had received such training:

- 47 services had used training provided by an external organisation – this included training from their local Safeguarding Children's Partnership, or from the AIM Project, the CSA Centre, LimeCulture, PACE, NOTA, NSPCC, the Survivors Trust, Survivors Network, Survivors UK, Survivors Manchester, Male Survivors Partnership, Women and Girls Network, Greenhouse, New Pathways, Into the Light, Safe Lives and St Mary's SARC.
- 53 services had organised in-house training led by their own staff.
- 18 services had used training provided by an external expert consultant, frequently Carolyn Spring, but others such as Jessica Taylor, Zoe Lodrick and Christine Sanderson were also mentioned.

Forty of these services also told us what this training had covered, with 21 of them reporting that it had focused on child sexual exploitation while nine referred to ISVA/ChISVA training.

> Most services said their staff and volunteers had received specific training around child sexual abuse

Some said they expected staff to have acquired relevant expertise before they joined.

> "Generally we're recruiting on the basis that people have specialist knowledge and skills in the area of support, and experience in supporting children who've been sexually abused." [ID304, stat./NFP partnership; CSA focus]

Others said that that their staff members' particular expertise had come through lived experience:

> "All three of us are survivors of child sexual abuse as well so we find that helps how we deal with people." [ID367, NFP; CSA focus]

A quarter (n=43, 26%) of the 163 services did not say that their staff or volunteers had undertaken specific training on child sexual abuse, although many of them told us they had provided training around sexual violence and/or working with trauma:

> "We provide our own training. All of our staff, when they start, get training on sexual violence and awareness. And they also have specific training on working with trauma." [ID118, NFP; SV remit]

9.4.2 Training needs

Asked what support they would like from the CSA Centre, three-quarters (n=124, 75%) of the 166 interviewed services said they would like training to support them in working with people affected by child sexual abuse. Some were interested in learning more about specific forms of child sexual abuse:

> "It would be interesting to have training on specific types of child sexual abuse so that we have a better understanding of each area… To have it broken down, a training on each area, that would be fantastic." [ID308, NFP; SV remit]

Others said they would welcome training that enabled them and their staff to keep up to date:

> "We're always looking at training opportunities. Just more information to kind of keep up to speed on how the world of child sexual abuse and trauma is moving." [ID353, NFP; wider remit]

> "Training on new legislation, compensation, anything new coming up, new research could be disseminated, also that link with other services to share knowledge and understanding." [ID442, NFP; wider remit]

Training for new staff was also suggested.

> "Training for new therapists… In my therapy course, child sexual abuse didn't even come up... Loads of services are using people straight out of counselling college… and are giving them clients that are really far too traumatised to be working with someone with that experience." [ID237, NFP; CSA focus]

A number of services were interested in learning more about ways to support children:

> "Training in creative interventions with young children." [ID118, NFP; SV remit]

> "Training and resources particularly for problematic sexualised behaviour and how to support non-verbal children and young people." [ID142, NFP; SV remit]

> "Being trained to work even more with young people experiencing these types of trauma would be ideal really." [ID598, NFP; wider remit]

10. How well-connected are services?

This chapter looks at whether services felt connected to other services and agencies, exploring referral pathways and membership of networks and partnerships.

Key findings and reflections

1. The vast majority of services accept referrals from a wide range of other services/ agencies, although some supporting adult victims/survivors only accept self-referrals.
2. Nearly two-thirds of services felt negatively, mixed, or neutral about how their incoming referral systems were working. Having effective multi-agency and partnership working and comprehensive triage systems appeared to facilitate incoming referrals, while challenges arose from demand exceeding capacity, a lack of effective multi-agency working, agencies taking different approaches when making referrals, and a lack of awareness of services' existence. As also noted in a study by Allnock et al (2009), not-for-profit services told us of incidents of children being referred to them by statutory agencies which then closed the case before the referral was accepted.
3. When services referred people on to other services, this was often to mental health services, therapeutic and counselling services, and social care. Services working with adults highlighted that referrals for housing and homelessness support were common, although the wide range of other support services that adult victims/survivors were being referred onto reflects the long-lasting impacts that child sexual abuse can have (Vera-Gray, 2023).
4. Nearly three-quarters of services felt negatively, mixed, or neutral about how their onward referral systems were working. Other services/agencies' lack of capacity, restrictive eligibility criteria and high thresholds were all highlighted as posing challenges to effective onward referral systems, echoing other studies which have highlighted referral eligibility criteria as a barrier for victims/survivors accessing support (Allnock et al, 2015; Butterworth et al, 2020; Jay et al, 2022). Statutory agencies, particularly CAMHS and other mental health services, were most frequently described as being difficult to refer service users onto.
5. The vast majority of services were part of local networks, partnerships or consortia, although only a quarter of these were focused specifically on child sexual abuse or exploitation. Nearly two-thirds of services supporting children were linked into their Local Safeguarding Children Partnership/Board (LSCP/B), which they felt was beneficial in sharing understanding of risk and developing strategies to safeguard children. Being part of the LSCP/B could also be challenging, owing to a lack of opportunity to raise concerns, and ineffective communication at meetings; it could also place demands on the time of services working across multiple local authorities.
6. Services generally felt well-connected to other services and agencies, although not necessarily to those also responding to child sexual abuse. Many said they wanted more opportunities to connect with others working in this sector.

Implications

These findings reflect the challenges that services are facing because the demand for their support exceeds their capacity. Funders, commissioners and policymakers should consider how services can be enabled to sustain and strengthen their incoming referral systems, so that service users can access timely support that meets their needs. Statutory services, in particular, should not close cases before support from services has commenced, to avoid victims/survivors being left unsupported.

Services should be able to refer service users on for support with other needs, and not be expected to be a 'one-stop shop' covering all the support needs that service users may have. They should therefore be included in local networks and partnerships, especially Local Safeguarding Children Partnerships/Boards.

10.1 Receiving referrals

10.1.1 How are children and adults referred to services?

All 166 interviewed services told us about the ways in which service users could access their support. As Figure 60 shows, the vast majority accepted referrals from other services/agencies, and six out of seven accepted self-referrals; referrals from parents of children affected by child sexual abuse were accepted by more than half of services. A fifth of services *only* accepted referrals from other services/agencies, and a small number *only* accepted self-referrals.

Of the 31 services that only accepted referrals from other services/agencies:

- 20 only accepted referrals from statutory-sector organisation(s)/pathways
- five only accepted referrals if children's social care, police, or youth offending teams were involved in a child's case
- four only accepted referrals from specific agencies/services in the statutory and not-for-profit sectors
- two services in the not-for-profit sector only accepted referrals from other not-for-profit services.

Figure 60. Referral pathways into services

n=166. Lightly shaded areas show the number of services for which this was the sole *referral pathway.*

As Figure 61 shows, all services which only supported children accepted referrals from other organisations – but among the 36 services which only supported adults, more than a quarter (n=10, 28%) accepted self-referrals only.

For services accepting referrals from other services/agencies, these most commonly came from children's social care, services in the not-for-profit sector, health services (including GPs, CAMHS, sexual health services, community mental health teams and substance misuse services), the police and schools – see Figure 62.

A few services said they received referrals from local authority services other than children's social care, criminal justice services (youth offending teams/services and probation), or other agencies such as professional sporting bodies and universities.

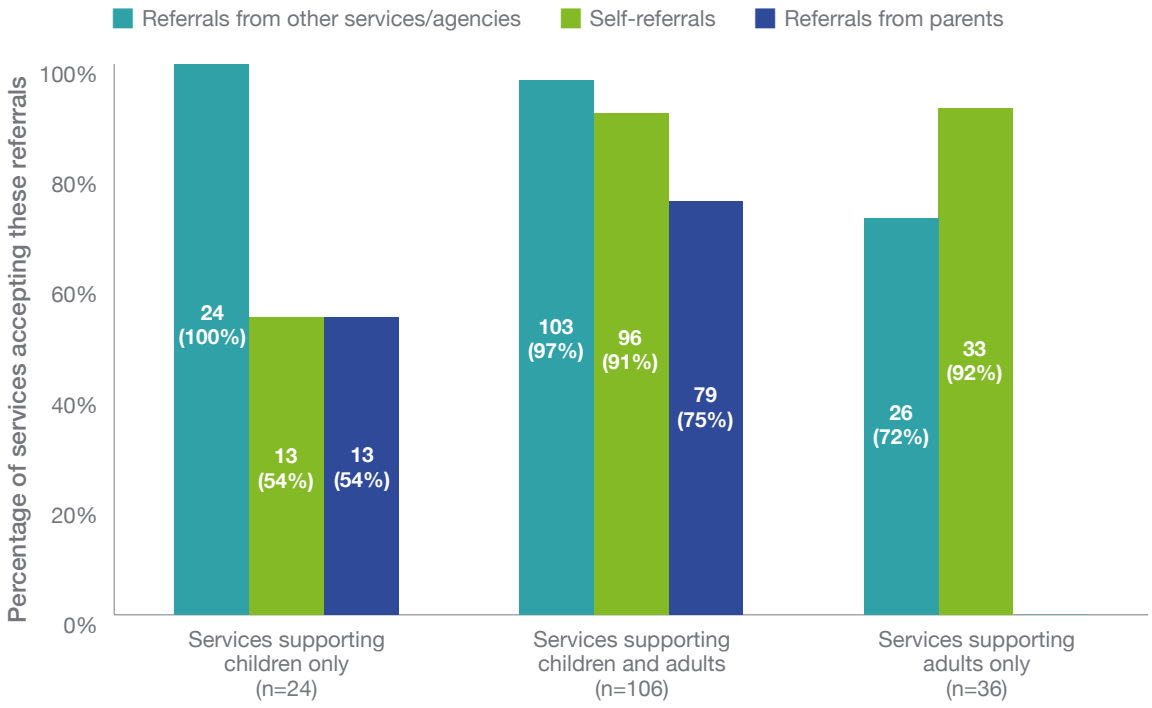
10.1.2 How well do incoming referral pathways work?

Of the 125 services offering an opinion, two-fifths (n=47, 38%) felt their systems for incoming referrals were working well, but one in eight (n=16, 13%) felt they were not effective. The remainder answered neutrally (n=20, 16%) or gave a mixed response (n=42, 34%).

What makes incoming referral pathways work well?

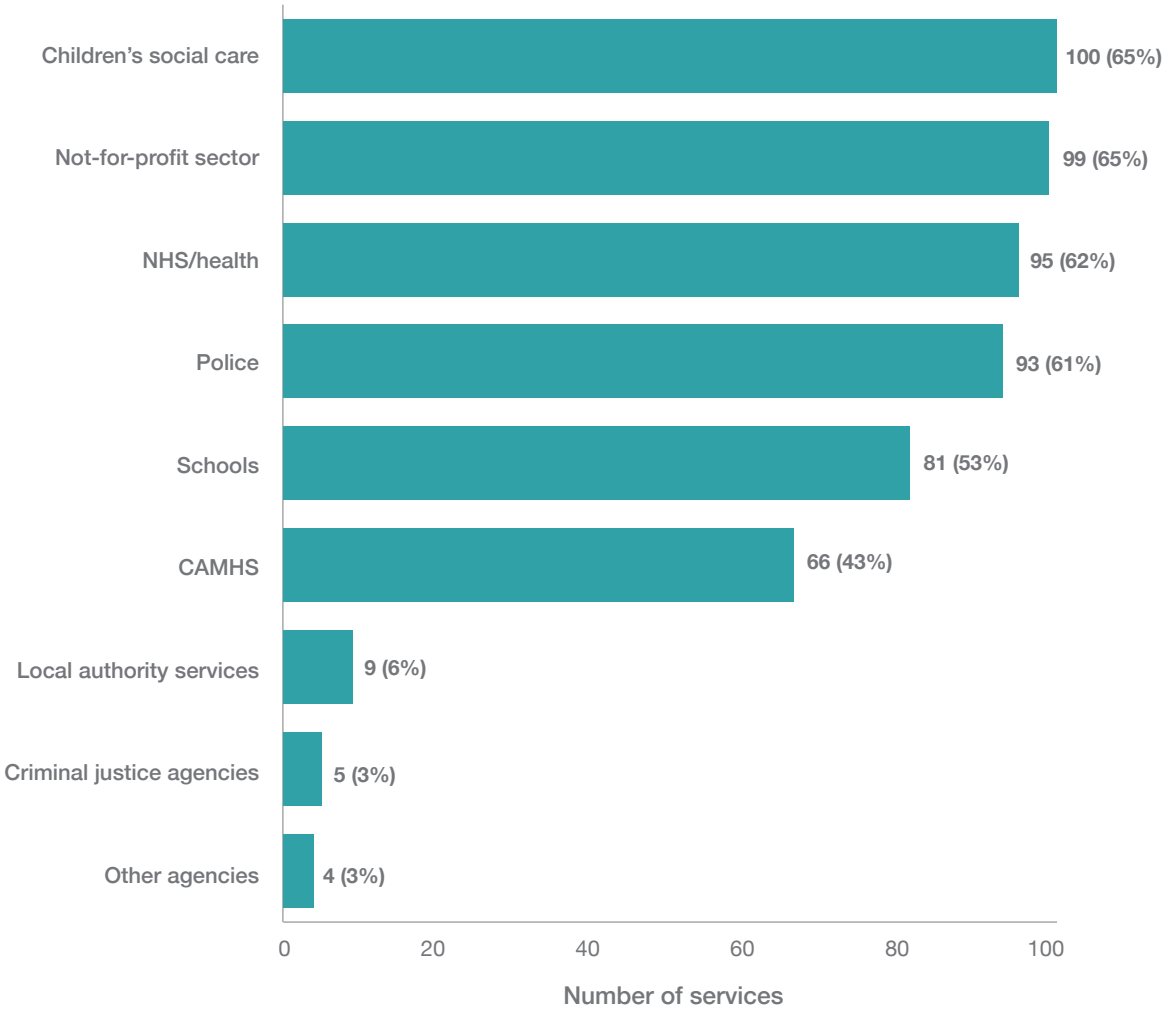
Effective **multi-agency working** and **partnership working** were most frequently identified as contributing to good incoming referral systems. For example, services felt that regular meetings with partner agencies facilitated good communication and provided a space to discuss concerns with other professionals.

Figure 61. Referral pathways by type of service user



n=166.

Figure 62. Sources of referrals from other services/agencies



n=153.

Some also highlighted the value of having a comprehensive **triage system** to support incoming referrals; others described how their incoming referral systems had benefited from improvements they had made, such as implementing a new database or creating new roles to support referral and triage systems.

Having **clear, simple**, and **easy-to-access** referral systems, often online, was felt to be beneficial for both professionals and victims/survivors seeking support – and made it easier to manage incoming referrals.

Other services considered that having **multiple referral channels**, so that referrals could be made online, by telephone or by email, made their systems work well.

What are the challenges?

Managing excess demand was the challenge that services most frequently associated with incoming referrals. Services described receiving "*more referrals than we can possibly cope with*", and feeling "*inundated*" with "*non-stop*" referrals, which left them feeling overwhelmed. Services' capacity to meet demand was also linked to the funding they received, as one service highlighted:

> "We receive 17 billion more [referrals] than we can deal with, and people think they can refer without thinking [about] funding." [ID363, NFP; CSA focus]

Services also described how ineffective multi-agency working resulted in an unsystematic, ad hoc or "*scattergun*" approach to referrals, which could lead to inconsistency in access to service provision. Others felt their referral pathways were overly complicated. One explained that different local authorities all used different referral forms to refer individuals to them for support.

Some services identified the challenges of receiving inappropriate referrals, owing to professionals/agencies not using the correct referral pathway, providing insufficient information or making referrals for people who did not meet eligibility criteria:

> "People aren't always very thorough, so that can just mean that there's a little bit of going back and forth for us to actually find out some more information before we can triage it and risk-assess it effectively." [ID584, NFP; CSA focus]

This was a particular problem when referring agencies closed the case once they had made the referral, which left people without support if the referral did not meet eligibility criteria:

> "They will close a case and leave the child or the parent with us and then deny all knowledge of it." [ID575, NFP; SV remit]

Some services felt that mental health professionals/agencies were more likely than other professionals to make inappropriate referrals:

> "We have a huge number of referrals from mental health. They're not always appropriate. It's mental health who are referring someone because they've mentioned sexual abuse history in their assessment, but it's not what the client is necessarily looking for." [ID89, NFP; SV remit]

> "Mental health [services] are very over capacity, so they hear sexual abuse and they refer on." [ID483, NFP; wider remit]

In addition, services told us that a lack of time and capacity to engage in outreach and awareness-raising activities could result in a decrease in referrals. For example, one service had seen a decrease in referrals from schools after it reduced its outreach work with schools.

10.2 Referring service users to other agencies

10.2.1 How are service users referred on to other services?

A large majority (n=150, 90%) of the services we interviewed told us that they referred service users onto other agencies. As Figure 63 shows, the agencies that most services made onward referrals to were mental health services, therapeutic and counselling services, and social care.

Services working with children typically made onward referrals to children's social care, CAMHS, therapy/counselling services and substance misuse services. Less commonly, they referred children on to ChISVAs, eating disorder clinics, education/youth groups and LGBTQ+ services.

Among services working with adults, referrals for housing and homelessness support were common:

> "[We refer for] housing – social h ousing and private landlords." [ID519, stat.; wider remit]

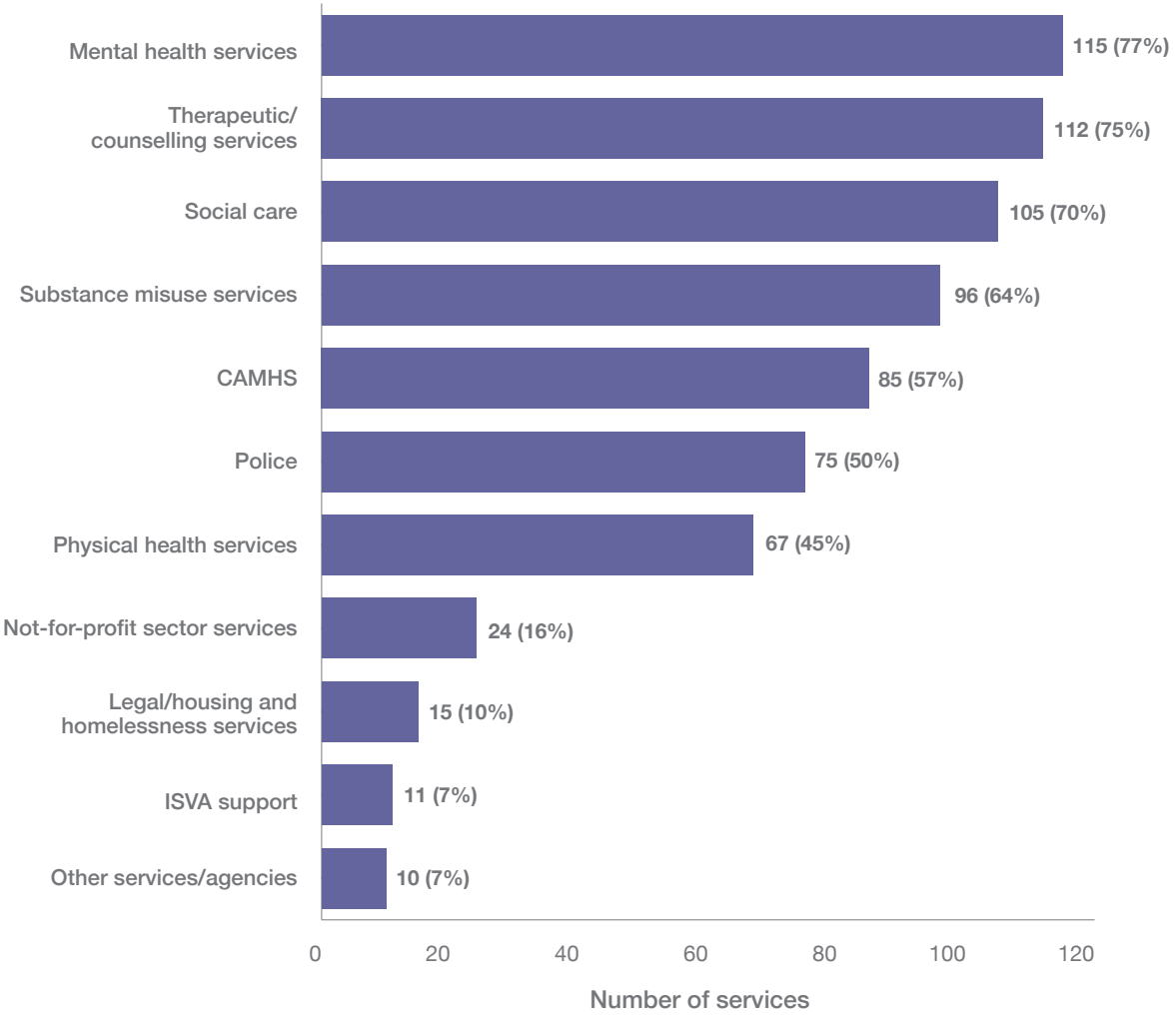
Onward referrals and 'signposting' for further support with adults were also made to Age UK, Citizens Advice, debt advice services, domestic abuse services, refuge support, and SARCs.

10.2.2 How well do onward referral systems work?

A quarter of services felt their onward referrals systems were working well (n=30, 25%), but more (n=36, 30%) felt these were not effective. Almost half either answered neutrally (n=23, 19%) or gave a mixed response (n=32, 26%).

> A quarter of services felt their onward referral systems worked well, but slightly more felt they were not effective

Figure 63. Onward referral destinations



n=150.

What makes onward referral systems work well?

Collaborative **partnership working** and strong **multi-agency relationships** were most frequently identified as contributing to effective onward referral systems. For example, services reported having close links with partner organisations and relevant local services, which facilitated good communication and positive working relationships.

Having a list of agencies and providers that services could refer service users to was described as helpful in managing outward referrals. Another service explained that implementing a thorough **risk and needs assessment**, prior to referring on, ensured that service users were referred to services that could meet their needs.

What are the challenges?

Other agencies' lack of capacity to accept referrals and provide support was the challenge most frequently associated with onward referrals. Services described other agencies as being overstretched and lacking funding to meet high demand:

> "I think everyone is feeling the same way. The demands are higher and resources [are] lower." [ID308, NFP; SV remit]

Services told us that it felt inappropriate to refer people to services with long waiting lists, as it left those people with unmet needs:

> "Everybody is waiting on a long waiting list for other services. People come back to us in a worse way than they went in." [ID354, NFP; CSA focus]

Services also reported long waits for statutory agencies to respond to their referrals, or having to 'chase' referrals or 'make noise' with agencies from which they did not receive responses:

> "Parents often come to us struggling to find services. For example. CAMHS [have an] 18-week waiting list. We just got a response for support a year after a young person was abused. [We] have had to make noise…. So to give you an example, a child who accessed some incredibly disturbing images on the dark web and was showing quite a lot of distress after seeing those… the social worker in that area wasn't picking them up… it was three years without support." [ID238, NFP; CSA focus]

> "It's very difficult to engage with CAMHS services… because they have a very, very long waiting list. They don't come back to us unless we chase them." [ID58, NFP; CSA focus]

Another challenge was other agencies refusing referrals on the basis that they did not 'see' certain types of risk:

> "The system we have for safeguarding is focused on harm within the home, and so that can be a big challenge to get referrals taken up or to be understood that a child can be at risk of significant harm outside the home and needs a safeguarding response in the same way." [ID68, NFP; wider remit]

One service highlighted that some agencies would not accept referrals for children living in unsafe situations:

> "Other services are really restricted in terms of the referral criteria so often they'll say, 'We won't work with the young person unless things are really stable in their family.' But what we know is that kids who are actually abused often come from families where things are really chaotic." [ID297, stat.; CSA focus]

Referrals to CAMHS were described as particularly problematic, owing to CAMHS having high referral eligibility thresholds or rejecting referrals on the basis that service users already had support:

> "CAMHS threshold is so high… [We] will often refer on and it will bounce back that they won't take that referral… because [the child's] presenting symptoms are too complicated." [ID198, NFP; CSA focus]

> "CAMHS will say they don't meet the threshold. It depends on what the child sexual abuse is and when it happened." [ID206, NFP; wider remit]

> "[CAMHS] [will] reject referrals because they say we've already got in-house support." [ID24, NFP; wider remit]

Agencies' high referral eligibility thresholds were thought to be linked to limited capacity:

> "The NHS thresholds are too high because they don't have capacity, so we would refer someone that we would consider at very high risk of suicide, for example, and their thresholds have got higher and higher and higher as time has gone on and their capacity is so low that they would say basically that they're at the point now where if someone hasn't made an active attempt in the last week then they don't count." [ID237, NFP; CSA focus]

"Services reported long waits for statutory agencies to respond to their referrals, or having to 'chase' referrals"

This meant that agencies – particularly those in the statutory sector – sometimes simply rejected the referrals made to them:

> "We refer people and then they don't have capacity to work with them. So then they refer them back, so people to-and-fro for years sometimes." [ID237, NFP; CSA focus]

> "There's so much gatekeeping going on. Most professionals in the statutory sector try to find a reason not to provide a service." [ID428, NFP; wider remit]

> "For the NHS, it's hard to refer people back in. It seems to be one-way traffic." [ID443, NFP; wider remit]

Agencies were said to close cases or refer people back if experience of child sexual abuse emerged:

> "The mental health services will signpost nearly anyone who mentions sexual abuse to them to us. They don't deal with it, apparently." [ID434, NFP; SV remit]

Services said that some agencies were unwilling to develop partnership working and multi-agency working. A more holistic approach was called for:

> "There could be more multi-disciplinary working. The sector tends to be siloed. Having more multi-disciplinary partnerships would be beneficial." [ID415, NFP; wider remit]

> "I think generally [there is] a wider system problem working around child sexual abuse, which is that there are multiple agencies doing different things and the referral pathways between services is really patchy because the funding is so fragmented." [ID467, NFP; CSA focus]

10.3 Networks and partnerships

We also asked services whether they were part of any networks, partnerships or consortia in relation to support provided to people affected by child sexual abuse – and 114 services (69%) said they were.

As Figure 64 shows, more than half reported that their network, partnership or consortium had sexual violence as its focus, while a quarter said it focused on child sexual abuse and exploitation.

We also asked services whether they were formally linked into their Local Safeguarding Children Partnership/Board (LSCP/B). Of the 103 services supporting children that answered, nearly two-thirds (n=65, 63%) told us they *were* linked into their LCSP/B; this included four-fifths of statutory-sector services (n=15, 79%), but fewer than three-fifths of those in the not-for-profit sector (n=47, 58%). Seven services were not sure.

Services said being formally linked into their LSCP/B helped them to understand the risks and types of harm that children in their area were facing. It also gave them an opportunity to raise issues and feed into local strategies to safeguard children, and it facilitated positive working relationships and information-sharing.

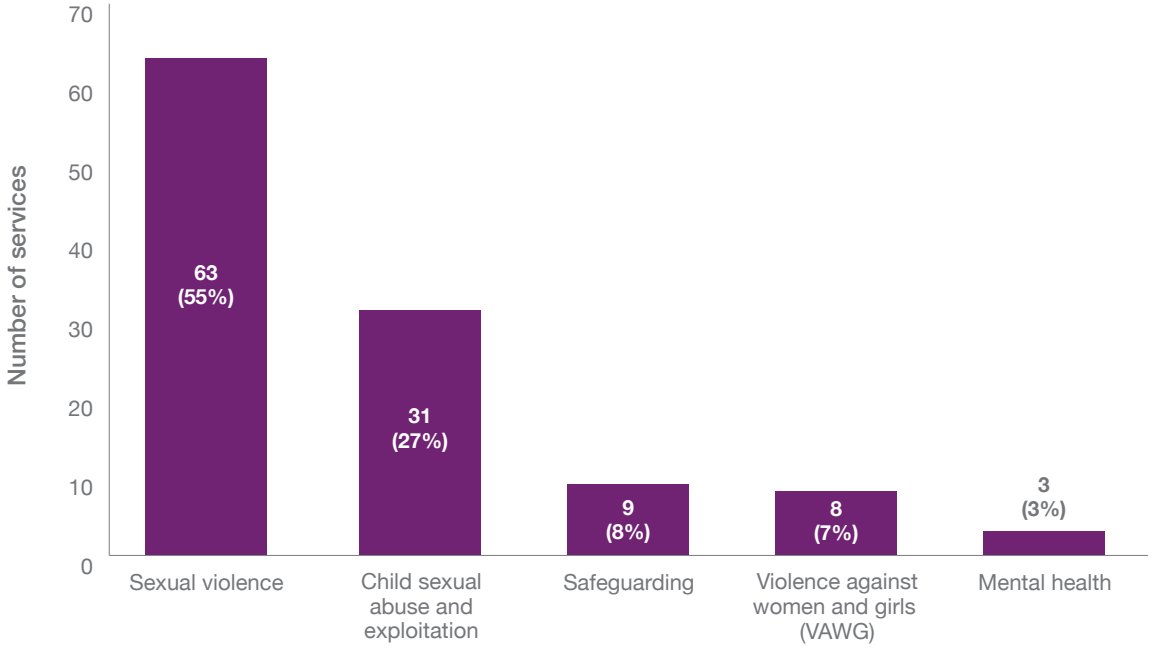
Challenges associated with being formally linked into an LSCP/B included being unable to attend meetings owing to limited staff capacity, or not being regularly invited to meetings:

> "It's sporadic. They get in touch when they need something from us generally. But we go through patches when we're heavily involved and then we might just fall off. I seem to be constantly reminding them that we're around and would like to be better engaged with them." [ID446, NFP; CSA focus]

Another service providing support across multiple local authorities highlighted the amount of work that this involved:

> "Everything we do is replicated four times most of the time… because we deal with four local authorities. So that's a massive time commitment for us, going to multiple meetings about the same but slightly different things." [ID531, stat.; SV remit]

Figure 64. Focus of networks, partnerships and consortia that services were part of



n=114 services saying they belonged to a network, partnership or consortium. A further 19 services said they were not part of any network, and 33 services did not answer this question.

Some services felt there was a lack of opportunity to discuss concerns, or ineffective communication at meetings:

> "We've had some unclear decisions made around why things aren't moving forward. And sometimes hostile responses to us trying to put forward concerns and even asking for support around it. And so it's not always been the most collaborative process from their end." [ID378, NFP; wider remit]

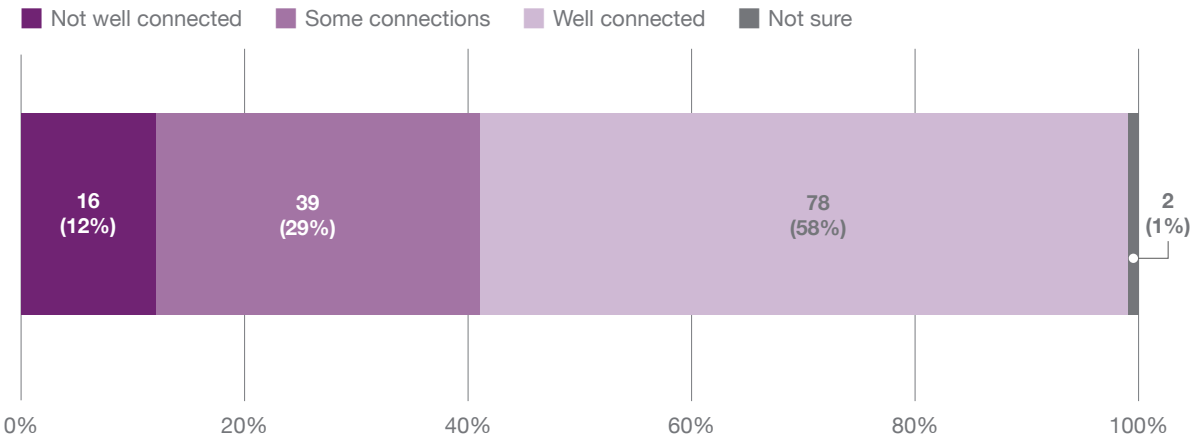
A lack of focus on child sexual abuse within some LSCP/Bs' meetings was identified:

> "They find it really difficult to include child sexual abuse in their thinking and it's not in their strategy. They only talk about child sexual exploitation." [ID390, NFP; SV remit]

10.4 Perceived 'connectedness'

Finally, we asked services how well connected they felt to other services and agencies responding to child sexual abuse. As Figure 65 shows, three-fifths of the 135 services answering the question felt well connected to others, and only one in eight felt they were not well connected. We did notice, however, that some services spoke about their connections to *all* other services locally, rather than specifically to services providing support around child sexual abuse. It is, therefore, possible that services felt more isolated from other *similar* services than their answers would suggest.

Figure 65. How connected services felt to other services



n=135.

Unsurprisingly, the services that felt the least connected were typically not well linked into effectively functioning networks, partnerships or consortia – and a lack of funding and resources exacerbated the situation, particularly for not-for-profit services:

> "We don't really connect with any of the local providers and I think some of that's to do with just how busy other services are. It's hard to develop those relationships or get in contact with anyone." [ID497, private; wider remit]

> "It's a lack of time and staff to build those connections." [ID573, NFP; wider remit]

Many services said they wanted more connections – for example, by having access to information on services supporting people affected by child sexual abuse:

> "[I'd like there to be] a network so services can be on a framework to enable us offer services to children or adults." [ID635, private; wider remit]

> "I think it'd be really valuable… to look at what people are doing and is there duplication or isn't there? And really are there enough of these services, and are there enough specialist services? There's all of these very generic services, but are there specialised services doing this work and could that be a gap?" [ID398, NFP; SV remit]

> "A directory is really helpful, because often agencies, especially smaller agencies, really struggle to advertise their services because of funds. Advertising and campaigning is always at the bottom of the pile." [ID349, NFP; SV remit]

Other suggestions included events and networking opportunities:

> "Events where agencies can attend and display the work that they do to help them reach wider communities [would be] helpful." [ID349, NFP; SV remit]

> "Networking events are just so important for meeting people, learning more about different services, and there's just not enough of it, especially since COVID." [ID584, NFP; CSA focus]

Services wanted to be part of a network of services offering similar support, to combat a sense of isolation and create a 'community' at local, regional and national levels:

> "We are in a part of the country where most people don't think [child sexual abuse] exists. Organisations like ours run the risk of being isolated. Great to be able to link to other networks that can provide support or stimulation or input. [ID321, NFP; CSA focus]

> "A network where you wouldn't feel that you're doing this work on your own." [ID105, NFP; wider remit]

11. How do services support other professionals?

This chapter provides an overview of the types of support provided by services to other professionals, to whom and how.

It also discusses whether services feel the amount of support they provide to other professionals has changed in recent years, and the demands of providing this support.

Key findings and reflections

1. Services were providing a considerable amount of support (mostly training, advice or case consultancy) to other professionals working with children and families – they estimated that, in 2021/22, they had supported more than 70,000 professionals:
2. Most services offered this support, most commonly to professionals in the not-for-profit sector, schools, policing and children's social care. It enabled professionals to enhance their confidence and knowledge around supporting victims/survivors, so that children could sometimes continue to be supported by a professional they already knew rather than being referred to other professionals/services.
3. Other support included contributing expertise to multi-agency meetings and helping other services to strengthen their organisational approach.
4. Two-thirds of services provided support that focused on all forms of child sexual abuse; other support (including the training provided by a quarter of services) focused on specific forms such as abuse in online contexts and child sexual exploitation.
5. Services said the numbers of professionals accessing their support had risen in recent years. While some linked this to their own awareness-raising activities, others felt that it reflected a greater awareness among professionals of child sexual abuse.
6. More than half of services said they would sometimes or always charge for the support they provided, but most charged only for specific types of support, such as training, or only charged certain professions/sectors. We do not know the extent to which services are moving towards supporting other professionals as a means of income generation, nor whether this is something that is beneficial for services in the long run.
7. While services identified many positive impacts of providing support to professionals, they also described challenges, particularly in managing limited resources and finding a balance between directly supporting victims/survivors and supporting professionals.

Implications

Services working with children and adults affected by child sexual abuse have developed an expertise which is of immense value and can help to strengthen other professionals' response to child sexual abuse and other forms of trauma. At the same time, providing this support requires time and resources that takes away from direct service provision.

Funders, commissioners and policymakers should therefore ensure that services can offer their expertise to other professionals without reducing the support they provide to victims/survivors and family members.

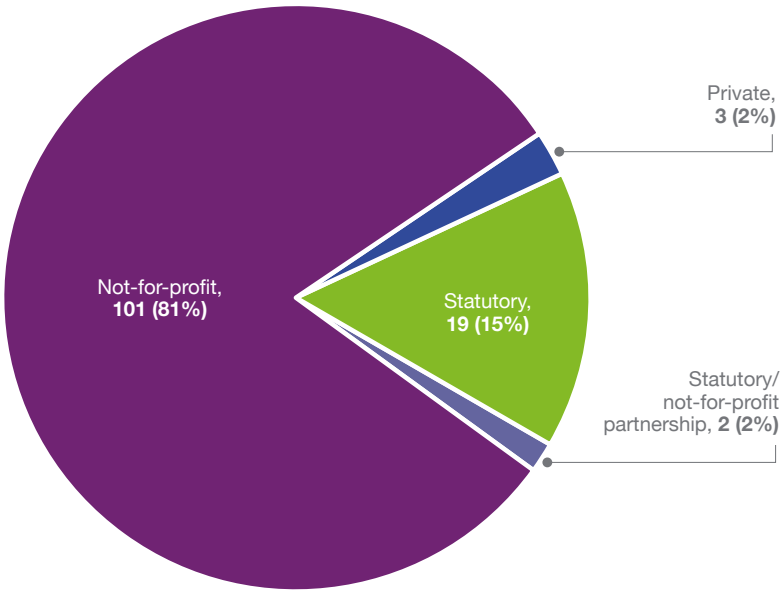
11.1 Which services support other professionals?

Three-quarters (n=125, 75%) of the 166 services we interviewed said they offered some form of support to other professionals, and three-fifths (n=96, 58%) provided multiple types of support.

Figure 66 shows that – as with services overall (see section 3.2) – four-fifths of these services were in the not-for-profit sector, and one in seven was in the statutory sector.

Compared with services overall (see section 3.1), those providing support for other professionals were more likely to have child sexual abuse as their sole focus: services with that focus accounted for more than a quarter of services supporting other professionals, slightly fewer were sexual violence support services, but fewer than half had a wider remit (see Figure 67).

Figure 66. Services providing support to other professionals, by sector



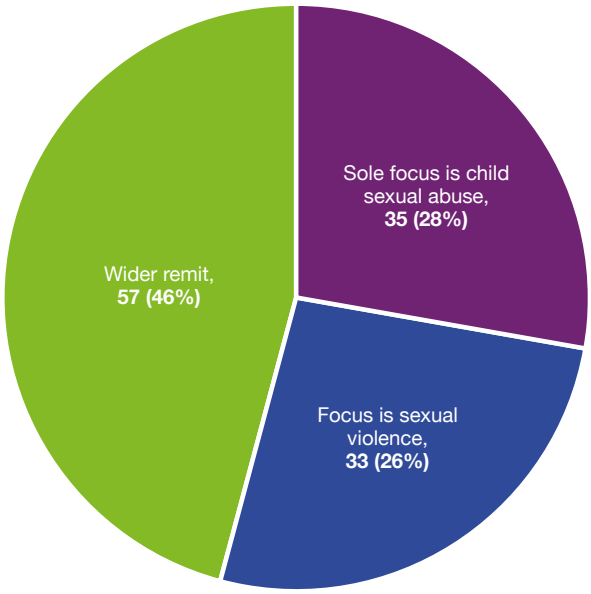
n= 125.

11.2 Types of support provided to professionals

As Figure 68 shows, **training** was the type of support most commonly provided to other professionals; five-sixths of the 125 services provided this, while almost three-quarters offered advice/guidance, and nearly half offered **case consultations**. One in seven provided **assessment services**, with smaller numbers delivering **awareness-raising talks, speaking at conferences** or providing **supervision** for other professionals. Other support included providing access to an online forum, organising a national working group and carrying out safeguarding reviews.

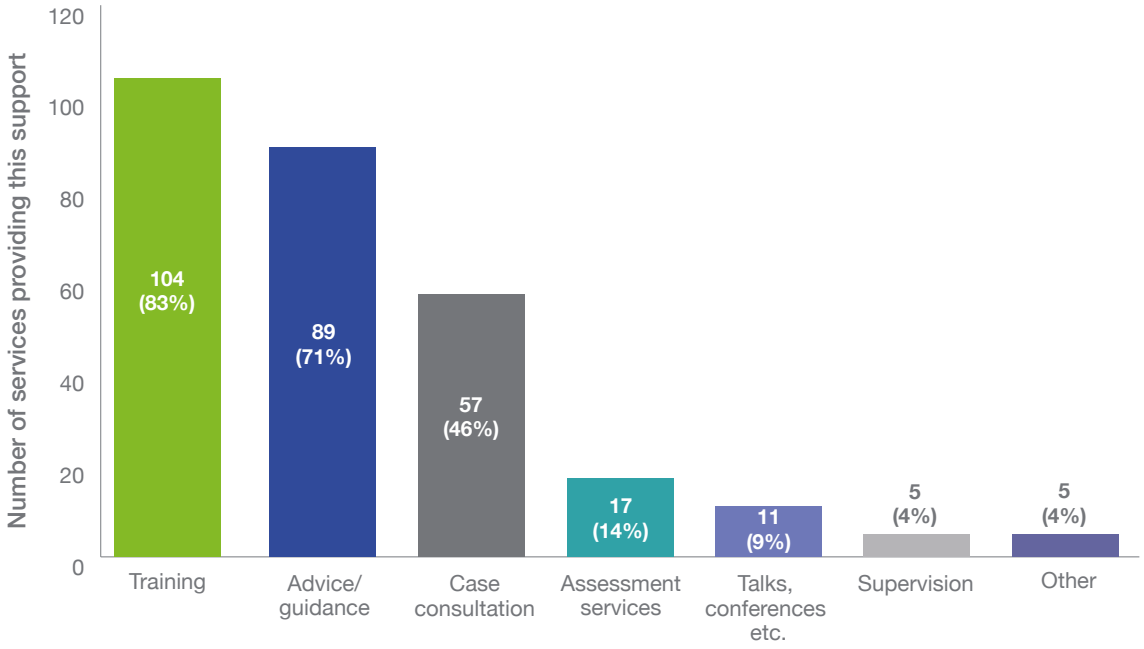
Table 1 shows how services in different sectors varied in the support they offered. All types of support were provided by a greater proportion of statutory and private-sector services than not-for-profit services, with the difference particularly marked for case consultations and assessments.

Figure 67. Proportion of services providing support to other professionals, by service remit



n=125.

Figure 68. Types of support provided to other professionals



n=125. Services could select multiple answers.

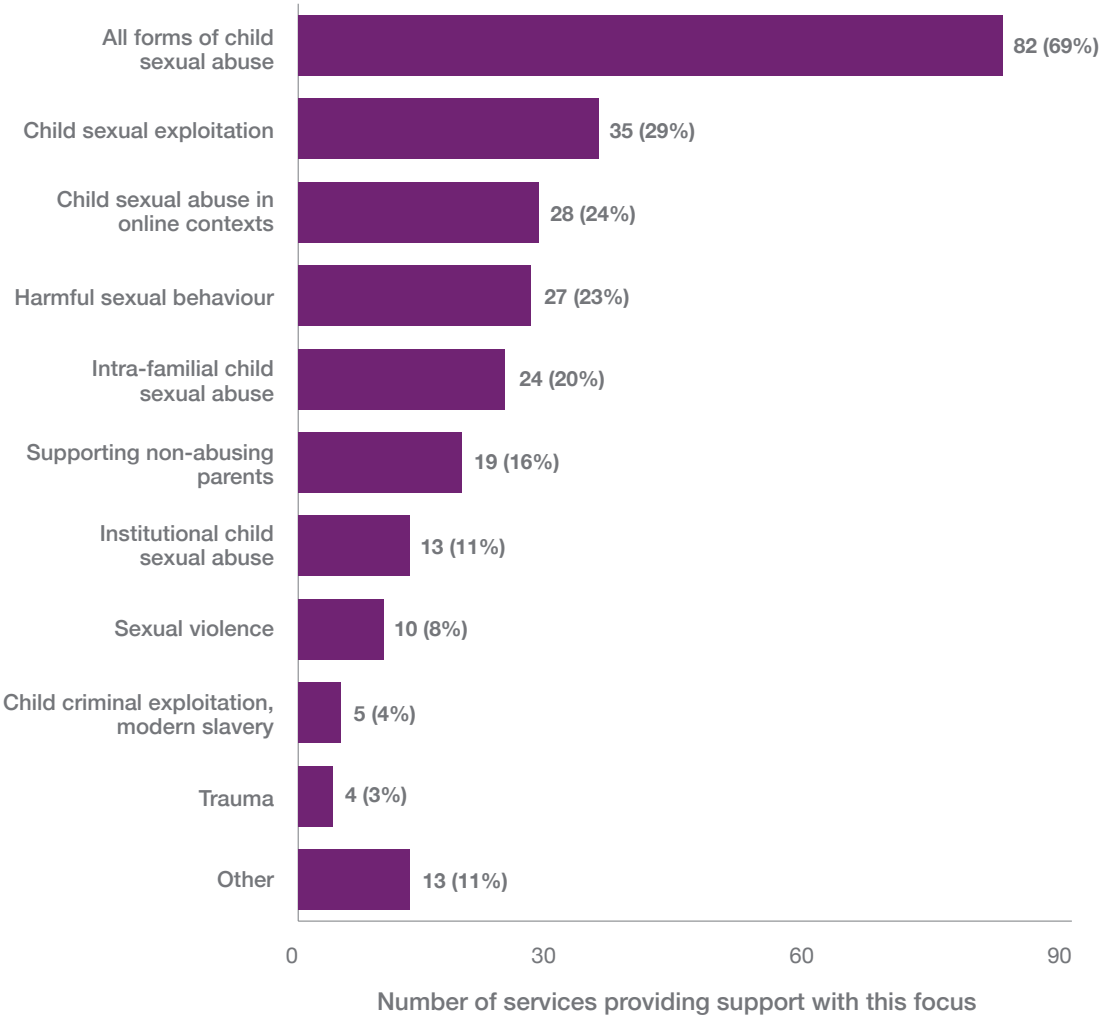
Table 1. Types of support provided to other professionals, by sector

Sector	No. offering support to other professionals	Providing training	Providing advice/ guidance	Providing case consultations	Providing assessment services
Not-for-profit	101	83 (82%)	71 (70%)	40 (40%)	10 (10%)
Statutory	19	17 (89%)	14 (74%)	13 (68%)	6 (32%)
Private	3	3 (100%)	3 (100%)	2 (67%)	1 (33%)
Statutory/not-for-profit partnerships	2	1 (50%)	1 (50%)	2 (100%)	0 (0%)
Total	**125**	**104 (83%)**	**89 (71%)**	**57 (46%)**	**17 (14%)**

A total of 119 services described the focus of the support they provided to other professionals. Figure 69 shows that, while more than two-thirds of support covered all forms of sexual abuse, it was common for services to provide support around specific forms of child sexual abuse (primarily child sexual exploitation and abuse in online contexts); one in seven said they provided support around supporting non-abusing parents. Half of services (n=61, 51%) said they were providing support around at least one specific form of child sexual abuse.

> it was common for services to give other professionals support around specific forms of child sexual abuse

Figure 69. Focus of support provided to professionals



n=119. Services could select multiple answers.

11.2.1 Training

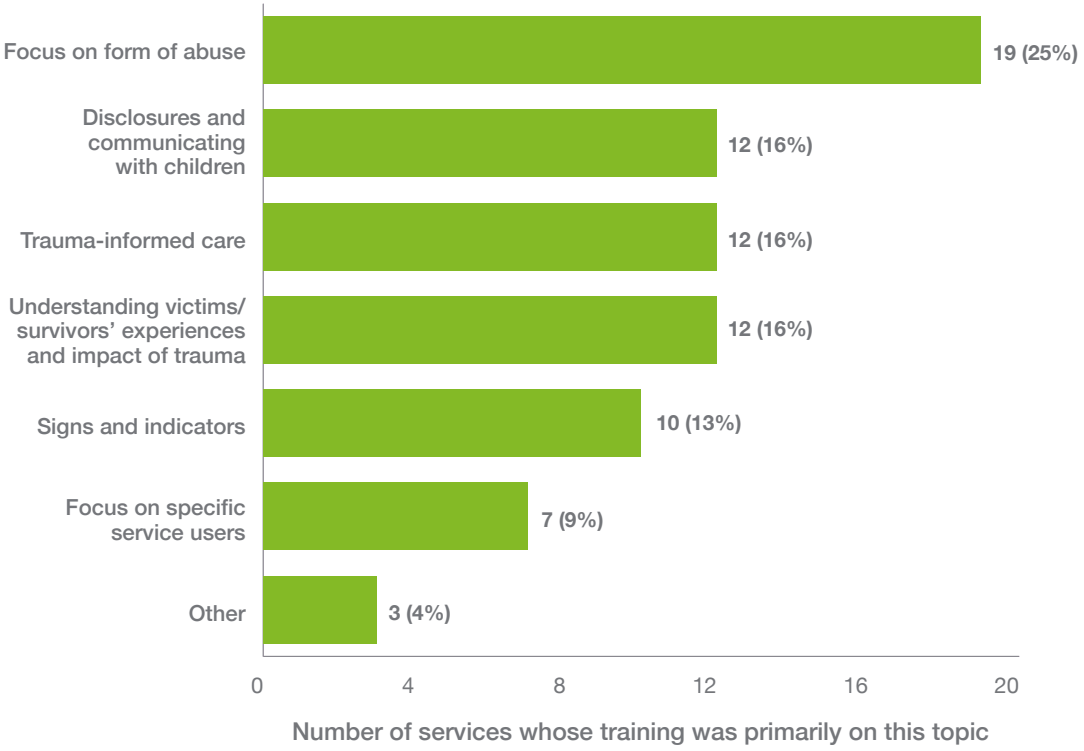
Seventy-five services provided more information about the nature of the training they provided. As Figure 70 shows, a quarter said they provided training focused on a specific form of abuse, while smaller numbers said their training covered topics including managing disclosures of child sexual abuse, trauma-informed ways of working, the impact of trauma on victims/survivors of child sexual abuse, and the signs and indicators of child sexual abuse. Almost one in ten provided training on supporting specific service users, including people with learning disabilities/ difficulties, women with multiple and complex disadvantages, female and male victims/ survivors, South Asian women and girls, and LGBTQ+ young people.

Other training offered by services included workshops on completing a child sexual exploitation assessment, a reflective practice programme for social workers, and a course for police officers working on sexual abuse investigations.

One service told us that it involved victims/ survivors of child sexual abuse in its training for professionals:

> "[It is] heavily about their own experiences and they talk about their own stories and their own experiences in school. They talk about what was missed because neither of them were picked up as abused children and didn't disclose until they were in their thirties. So, the red flag indicators that they clearly displayed to school but weren't picked up on… we look at what did happen versus what could have happened. And we put it to the staff in schools particularly, 'What would you have done with social work?'" [ID689, NFP; wider remit]

Figure 70. Topics principally covered in training for professionals



n=75.

11.2.2 Advice/guidance

Asked about the nature of the advice and guidance they gave other professionals, 53 services responded. As Figure 71 shows, two-thirds said they advised other professionals on specific cases; other topics included supporting victims/survivors, responding to disclosures, and safety planning:

> "[We offer] advice and guidance around care-planning for social workers through a trauma lens as well as general advice and guidance to professionals around child sexual abuse." [ID173, stat.; wider remit]

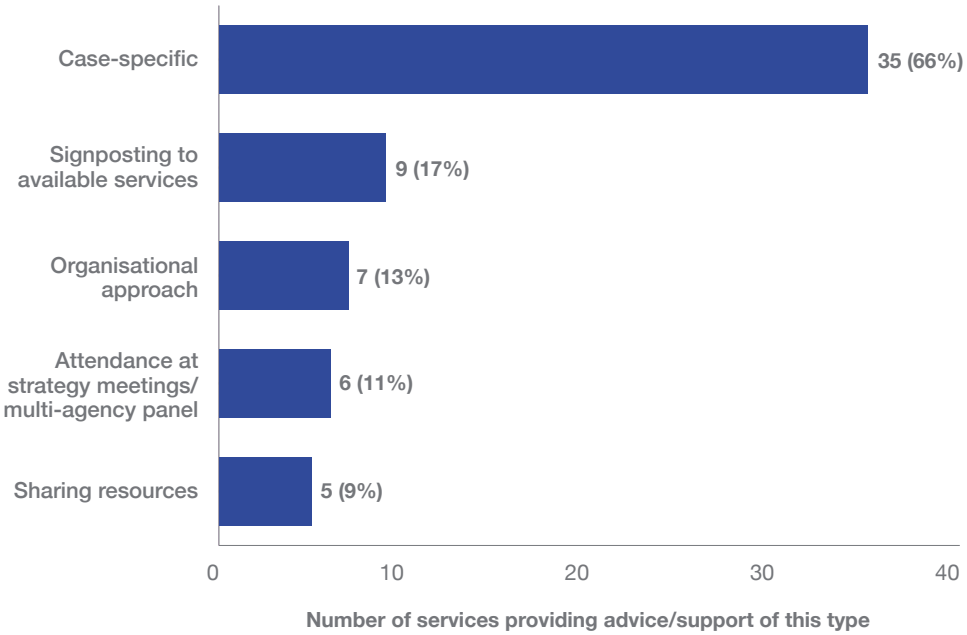
Less commonly, advice and guidance covered signposting people to appropriate services, and organisational topics (such as strengthening existing safeguarding policies and setting up sexual violence support services or peer support groups). A small number of services said they offered advice and guidance by attending strategy meetings and multi-agency panels where their expertise on child sexual abuse was required, and/or by sharing resources, best practice guidelines, and relevant research studies.

11.2.3 Case consultations

As with the case-specific advice and guidance that services told us they provided, case consultations were described as guiding other professionals on how to support victims/survivors, advising on next steps of treatment/intervention, and recommending how best to respond to disclosures. However, services identified case consultations as being more holistic and systematic. They said case consultations typically started with seeking to understand the service users' experiences:

> "[We] do a really deep background read on the young person to think about not only the abuse experience, but also any other adverse experiences they maybe have or what's happening with them currently. Then we will meet with the case holder, and we will think about the impact of their life experiences on the young person, how that's showing will formulate their needs and then we'll think with them about what might help that young person." [ID205, stat.; CSA focus]

Figure 71. Nature of advice/guidance provided to professionals



n=53.

> "We'll look at who's in the family? What's the history? What's the current worries? What are the strengths? Then we'll look at why the person came to the consultation. What did he want to gain from it? We'll then have quite a detailed section around reflections, hypothesis on what's going on. And we'll use a lot of social work theories and models and interventions to really unpick that." [ID106, stat.; wider remit]

Services felt that case consultations were sometimes more appropriate than directly supporting a victim/survivor. Partly, they allowed the professional who had an existing relationship with the victim/survivor to provide support, rather than bringing in other professionals. They also enabled service users to continue receiving support rather than having to wait to access support through a different service:

> "So, we offer consultation for those children and young people who have already got a professional working alongside them. We spend time consulting with them, showing them the recovery work programme or giving them all the materials and then supporting them to deliver that with that young person, so that we can increase our outreach. It means that the young person gets the work quicker than if they had done the waiting list and they also get the context of a caring and actual relationship that they've already made rather than having to make another one." [ID57, NFP; CSA focus]

11.2.4 Assessment services

Five services explained that they offered other professionals a holistic assessment of a client's needs, advising on what interventions or treatments would be beneficial to address these needs:

> "We often do multi-agency assessments where we talk to the social worker or school, parents or third sector or whoever might be involved with the young person, as well as the young person themselves, to bring together a full assessment and make recommendations of what we think might be useful." [ID94, stat.; CSA focus]

One service told us that it provided AIM (Assessment, Intervention and Moving On) assessments to professionals supporting children who had engaged in harmful sexual behaviour; another explained that they provided assessment services to other services seeking to strengthen their use of trauma-informed care and service-user involvement.

11.3 Charging for support

A question on charging for support provided to other professionals was answered by 123 services. As Figure 72 shows, half of them sometimes charged for this support, but very few *always* charged.

Some services said they would charge for certain types of support but not others. For example, many would charge for training, but not for advice, guidance or case consultations:

> "The training we would [charge a fee for]. But where we've been providing support and speaking in forum or conferences, we haven't been charging for that. If it was specific training, they wanted us to do with 20 people or so on, then there would be a charge for that, but any of the other stuff, no." [ID398, NFP; SV remit]

> "We don't charge for consultations, information, advice or guidance. We would charge for training, however. Even if that's a donation. I would rather upskill and train staff and not take money, but we are a charity at the end of the day, and we're not funded to facilitate training, so it is trying to get what we can." [ID584, NFP; CSA focus]

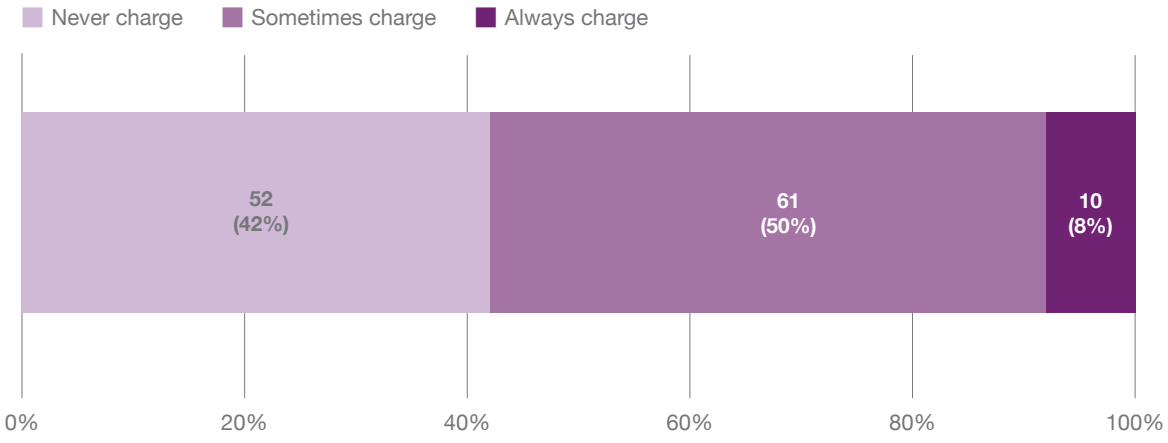
A number told us they would only charge certain services, agencies or sectors for support. For example, some would not charge services that they were commissioned to work with as part of a contract, while others would charge statutory-sector services but not those in the not-for-profit sector. A decision to charge a fee might also depend on the size of the service/agency accessing the support.

One service said it did not charge professionals accessing support, as it considered support provision to be a way of building networks:

> "It's a part of our networking at the minute, like giving sample sessions of the training and talking about our service with the aim to generate an interest, to let people sign up for the service and then pay for the training." [ID354, NFP; CSA focus]

> Many services said they would charge for training, but not for advice, guidance or case consultations

Figure 72. Do services charge for the support they provide to professionals?



n=123.

11.4 Which professionals access support?

We asked services whether their support was available to all professionals. Of the 119 services that answered, more than a quarter (n=34, 29%) said it was not – generally because only professionals working/residing in specific areas or boroughs, or from particular sectors or professions, could access it.

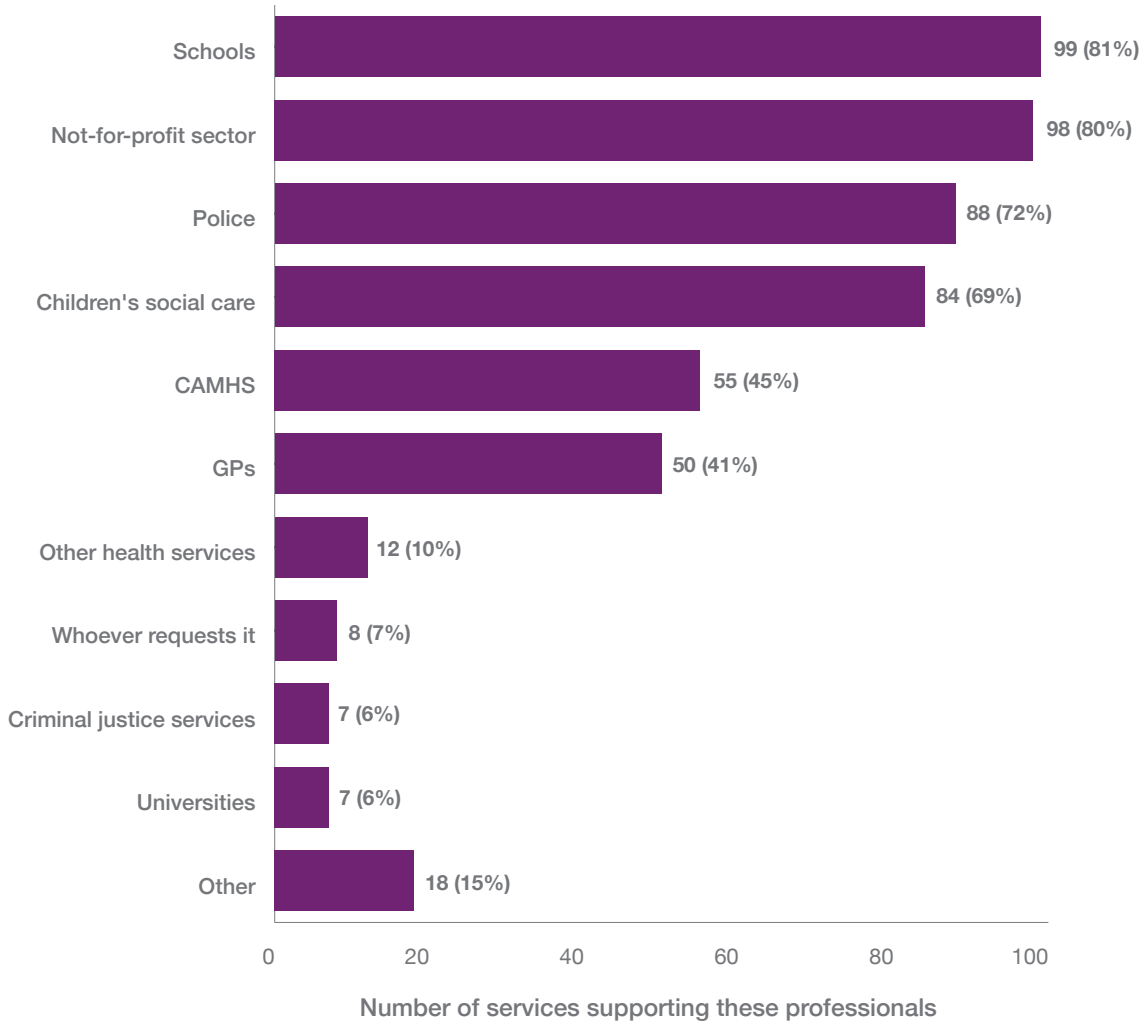
Professionals in schools and in the not-for-profit sector were the most likely to receive support: each was supported by four-fifths of the 122 services providing this information (see Figure 73), with police forces and children's social care also common recipients.

11.4.1 Are more professionals accessing support?

Analysis of the data provided by 73 services suggests that they had supported more than 70,000 professionals in 2021/22. They ranged from services providing in-depth support to fewer than 10 professionals over the year (n=9, 12%) to those delivering online training to thousands of professionals (n=12, 16%).

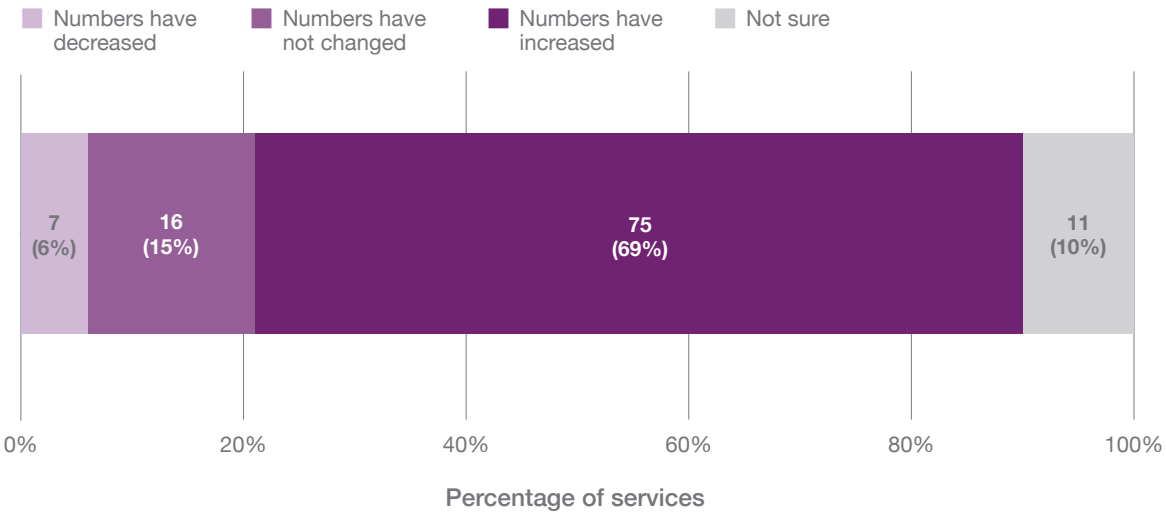
We asked services whether the number of professionals accessing support had changed in recent years; 109 services responded, with two-thirds saying they were supporting more professionals – see Figure 74.

Figure 73. Types of professionals supported



n=122. Services could select multiple answers.

Figure 74. Has the number of professionals accessing support changed in recent years?



n=109.

Of the 75 services saying that more professionals were accessing support, two-fifths (n=30, 40%) felt that this had resulted from efforts to raise awareness of the service, as well as increases in reputation and profile:

> "Greater presence in community; new website and social media." [ID423, NFP; wider remit]

> "We try really hard to advertise and promote our service. We encourage people to come to us if they are concerned about a child or want to have a case consultation. The staff are attending other organisations' team meetings to talk about the service and build up relationships." [ID668, stat.; CSA focus]

Many also attributed it to an increased awareness of child sexual abuse among professionals, a greater willingness to talk about it, and more professionals raising concerns around child sexual abuse:

> "We're really seeing willingness from police forces, certainly some of them, to work with organisations like us and learn from real-life victims' and survivors' experiences." [ID234, NFP; CSA focus]

Others said the COVID-19 pandemic had been a factor, not least because it had increased levels of professional anxiety:

> "COVID heightened schools' awareness of trauma and mental health and not knowing how to deal with it." [ID61, NFP; CSA focus]

> "Lots of new qualified social workers, social workers who qualified in COVID and didn't really get the same social work experience of placements in their first year. And so… managing risk and holding risk is really difficult for social workers." [ID106, stat.; wider remit]

A few services highlighted a lack of other support available to professionals:

> "We're the only specialist provider in [name of region]… Because we're the only provider, there's not as much competition." [ID118, NFP; SV remit]

> "We've identified that nobody else is going to get up and train people. So that's what we decided to do, to be the change we wanted to see." [ID378, NFP; wider remit]

11.4.2 What demand does this place on the services providing support?

We asked services whether providing support to other professionals presented any particular issues or challenges for them. More than a quarter (n=26, 28%) of the 92 services answering the question said it did not, with some highlighting the positive impact and benefits of supporting professionals:

> "It's a much more effective way of working because, prior to doing consultations, we used to have a lot of inappropriate referrals where children weren't ready for therapy."
> [ID205, stat.; CSA focus]

> "The more professionals that we train, the better the awareness. It's a positive change. They've got the knowledge to support victims."
> [ID207, NFP; wider remit]

However, most services *had* experienced challenges, relating this to high demand, limited capacity or a lack of funding. Some told us they had to find a balance between providing direct support to victims/survivors and supporting professionals:

> "I think the challenge is how stretched our team are, really. We really want to do this work. We really see the value of that sort of consultancy and having these sorts of constructive discussions with other agencies about how to support individual children and young people in particular. But it does take our team away from the direct work."
> [ID89, NFP; SV remit]

Others pointed to the need to generate income from supporting professionals:

> "It's a self-funding role. So, in terms of what funding it raises is what continues the role, because of that we don't really like to say no to any work coming in. So she's just incredibly busy."
> [ID59, NFP; CSA focus]

> "We've had lot of enquiries from more formal organisations but they don't want to pay. They want it free of charge."
> [ID105, NFP; wider remit]

> While highlighting the benefits of supporting professionals, services said it had also caused challenges

12. How do services assess, evaluate and develop the support they provide?

This chapter focuses on the ways in which services seek to strengthen the provision of their support.

Key findings and reflections

1. Almost all the services we interviewed were assessing the quality of their service provision in some formal way; more than a third were signed up to, or in the process of signing up to, quality standards such as those provided by Rape Crisis England and Wales, the Survivors Trust and LimeCulture. A wide range of quality assessment standards and frameworks were in use, with some services arguing that a standardised quality assessment for services supporting victims/survivors and their families is needed.
2. Most services had monitoring and evaluation systems in place to assess the impact of their service provision, involving a wide range of different measurement tools and processes. Services stressed the resource implications of this and said they would like support, particularly in developing tools that were appropriate to their work. Such support could build on work already done by the CSA Centre, in exploring the effectiveness of services responding to child sexual abuse (see ***Effectiveness of Services for Sexually Abused Children and Young People: A Knowledge Review***), in funding services to develop their evaluation systems (see ***The CSA Centre's Evaluation Fund: A Reflection***) and in providing guidance to those wishing to improve their evaluation systems (see ***Measuring Your Effectiveness: A Practical Guide for Services Working with Children and Young People Affected by Sexual Abuse***).
3. Two-thirds of services had expanded their support provision in recent years, and four-fifths were considering ways to develop their services in the future. This supports the picture of a vibrant, innovative sector, as described by Hughes (2023). The COVID-19 pandemic appears to have left a largely positive legacy for services, with many saying they could now offer a more flexible, accessible service and/or engage service user groups they had previously been unable to reach. Although the pandemic had resulted in increased levels of complex need and trauma among service users, and had increased delays in the criminal justice system, it had also led to an injection, albeit short-term, of funding into the sector, allowing services to increase in size or scope.
4. The majority of services involved service users in the design and delivery of service provision – for example, by having experts by experience, victim/survivor consultations or advisory groups which contributed to policymaking, staff recruitment, and monitoring and evaluation. Nonetheless, many said they would like support with this.

Implications

Services should be able to evidence the quality and impact of their work in ways that are appropriate to their resources and remit. This means that:

- Funders, commissioners and policymakers should consider what support they can offer to services, individually and/or as a sector, to develop and share quality and impact assessment frameworks and tools.

Services users should be given appropriate opportunities to engage with service design and delivery. This means that:

- Funders, commissioners and policymakers should consider what support they can offer to services, either individually or as a sector, to develop and share learning and practice around service user engagement and consultation.

Services should be supported to develop their services to respond to changing needs and make best use of their resources. This means that:

- Funders, commissioners and policymakers should recognise and address the resource implications for services of designing and piloting new ways of providing support or expanding their existing support to new user groups. However, this must be done in a way that allows services to develop their provision from a base of certainty over their core costs and with enough time and funding to evaluate new services.
- Services would benefit from funding and support to commission external evaluations, which would contribute to the development of an improved evidence base on the effectiveness of various support models or elements of these.

12.1 Assessing quality

We asked services whether they were carrying out any regular assessment of the quality of the support they provided – and, if so, how they were doing this.

Of the 140 services answering these questions, almost all were assessing the quality of their service provision in some formal way (see Figure 75) – and half (n=70, 50%) were using multiple assessment methods:

> "We are members of BACP [British Association for Counselling and Psychotherapy] and Survivors Trust and the Male Survivors Partnership. We are applying for the Allyship programme to show we are a safe space for the LGBTQ+ community." [ID219, NFP; wider remit]

> "We have RCEW [Rape Crisis England and Wales], Survivors Trust and Lime Culture quality standards… We are organisational members of BACP and we follow the Wales safeguarding protocols and guidelines." [ID344, NFP; SV remit]

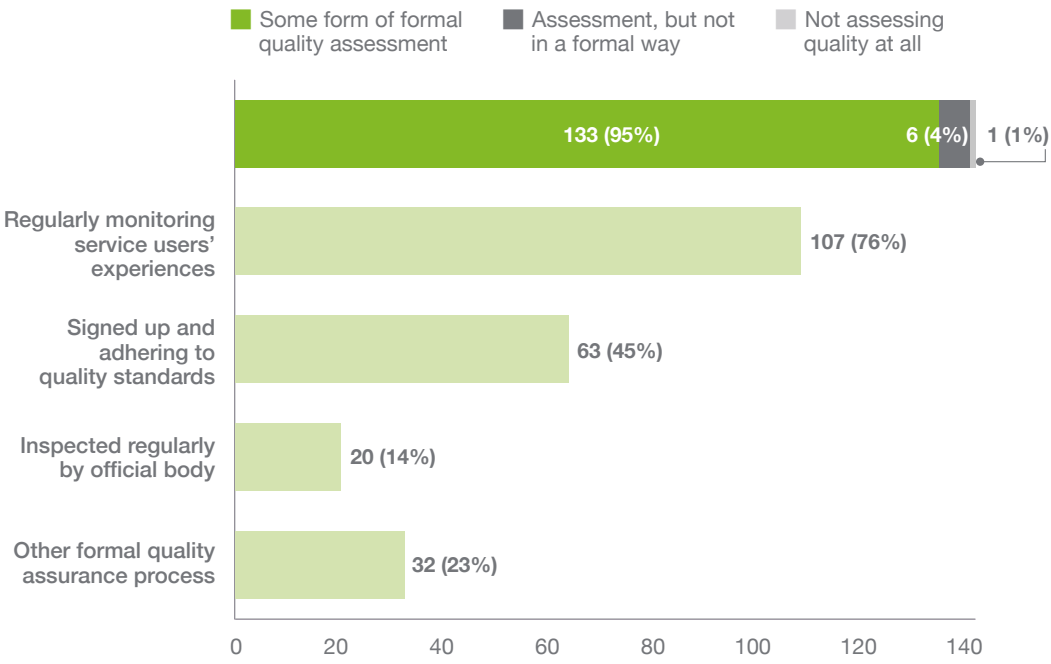
Three-quarters of services said they **regularly monitored service users' experiences** in order to assess the quality of service they were providing. One had sought service users' feedback to understand why people were not accessing therapy for longer:

> "We couldn't understand why some people would drop off therapy so quickly, so we contacted people who had stopped… As a service, we've always thought that childhood sexual abuse and the trauma that comes from that is really complex… so we think people need really long-term support… But some people might just want two or three sessions and off they go. So when we contacted people, they were saying, 'No, I'm fine. You gave me what I needed.'" [ID434, NFP; SV remit]

Another had organised a quarterly 'practice week' to review their service provision:

> "That's where you have leaders in the council, in children's services and service leads going out to different parts of the system… They'll come out on visits, they will meet our young people where appropriate, they'll audit files." [ID106, stat.; wider remit]

Figure 75. How services assessed the quality of their service provision



n=140. Services could select multiple answers.

Almost half were signed up and adhering to **quality standards**. The most frequently referenced of these were:

- Rape Crisis National Service Standards
- The Survivors Trust's National Service Standards
- Lime Culture's Quality Standards for ISVA services
- Male Survivors Partnership's Male Quality Standards
- British Association for Counselling and Psychotherapy's Ethical Framework

Other quality standards or accreditations used by services included those of the Care Quality Commission, Women's Aid and Welsh Women's Aid, Leading Lights, the Helplines Partnership, Assent, the Trusted Charity Mark, the Victims' Quality Mark, Open College Network, Allyship and Barnardo's CSSO (Child-directed, System-focused, Strengths-based, Outcome-informed) framework.

One in seven services said they were subject to **regular inspection**. For the SARCs and other statutory services we interviewed, this generally involved inspections by the Care Quality Commission. Residential services talked about complying with Ofsted, while other services referred to inspections by their Police and Crime Commissioner or local authority commissioners, involving regular monitoring visits as well as expectations around quality standards.

Services that had **other quality assurance processes** typically referred to internal quarterly audits and regular case reviews. Some incorporated case supervision into quality assessment:

> "We provide clinical supervision to support quality." [ID497, private; wider remit]

Some services said they had an independent complaints system for service users, which enabled those services to monitor the quality of their service provision. Another described how it provided feedback to *other* services:

> "We often write a chronology to feed back to other services, with permission." [ID238, NFP; CSA focus]

When asked what support they would like to receive, two-fifths (n=60, 43%) of the 140 services identified support around quality standards. Some stressed the need for standards that would work across the sector:

> "It is really important for us that you get the quality standards that fit the needs of the clients that we work with, that are specific for sexual violence. And we support all genders, all ages and that's been some of the challenges. [Quality standard providers] have either been, 'You can't [use ours] because you support this client group,' or we've looked at [other standards] and [found that] we can't, because actually they're more weighted towards domestic abuse." [ID 257, NFP; SV remit]

> "So many different people now are coming up with a list of quality standards and they all overlap... It would be great if some of the umbrella organisations came together and agreed on one set of standards. Sometimes I think, as small organisations, we can spend a lot of time sort of jumping through hoops trying to meet everybody's quality standards, but it'd be great if there was just one set that was agreed and that organisations were kind of supported to reach them and it looked at more than just, 'Show us what policies you've got' – actually looking at what is the culture within the organisation, how are staff treated and cared for, because that's where the burnout comes." [ID723, NFP; CSA focus]

Others drew attention to the resources required to implement quality standards:

> "Quality standards… put a lot of pressure on organisations. We want to upskill and meet them but that can take away from service delivery, and can be expensive to adhere to, like a membership." [ID198, NFP; CSA focus]

12.2 Evaluating impact

Again, 140 services answered questions about whether and how they evaluated the impact of their service provision – and again, the vast majority said they did evaluate impact in some way (see Figure 76). For one in six, this involved external evaluation.

Many services used pre/post questionnaires to monitor their impact:

> "At assessment of all of our clients, we measure things like self-esteem, general wellbeing, we use PHQ9 [Patient Health Questionnaire-9 depression test], GAD 7 impact of event scale [Generalised Anxiety Disorder Assessment]. We use a wide range of scores and measures to benchmark and track progress across time. Those are repeated. Sometimes we use those as a therapeutic tool if someone is a bit stuck, where we can go back at the scores and try and assess what's going on there. But equally, we can use those to determine distance travelled or an outcome when someone completes an intervention. And those are all monitored across all of our interventions." [ID446, NFP; CSA focus]

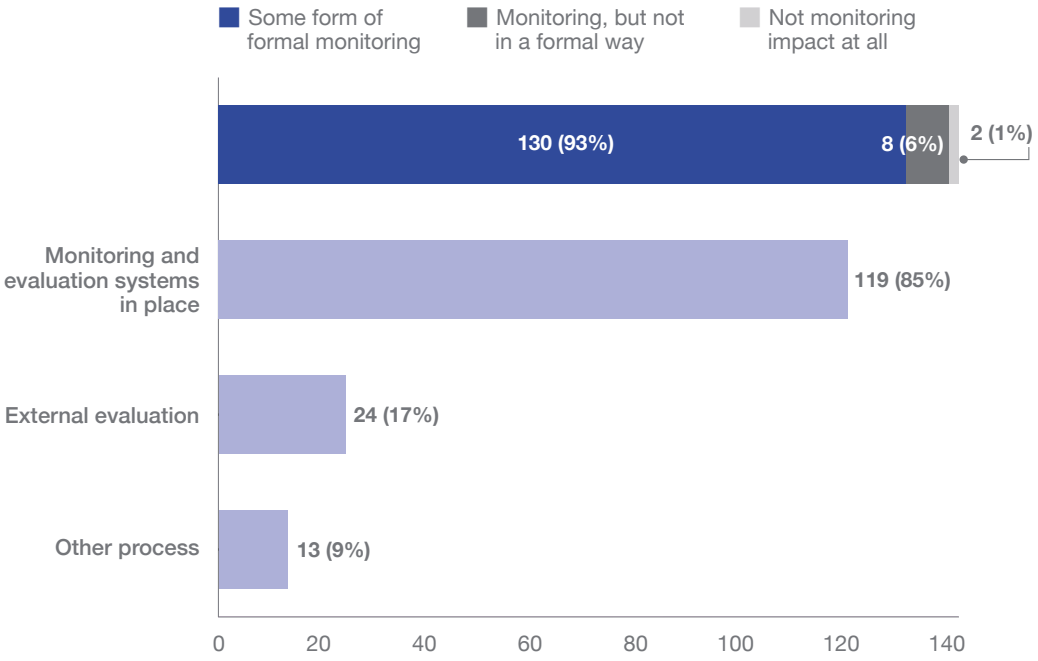
The need to combine pre/post assessment with capturing qualitative data was identified:

> "Every client is assessed on entry, at six, 12 and 30 weeks and at exit for wellbeing, health and carer confidence. We also gather qualitative data about successes, e.g. around education, thriving and employment." [ID363, NFP; CSA focus]

Some described how regular progress assessment could support their interventions:

> "We would use those measures at the beginning in our assessment, they would help us to tailor and structure an intervention plan and then we would use those measures again at point of closure to track whether there are still ongoing needs in any of those areas and we need to continue working with the child and family, or whether actually there's been sufficient improvements and we can look to close." [ID28, NFP; CSA focus]

Figure 76. How services evaluate the impact of their service provision



n=140. Services could select multiple answers.

A number of services mentioned specific impact-measuring tools or frameworks such as the Outcomes Star, the Rape Crisis England and Wales outcomes framework and Barnardo's outcomes monitoring framework; others were using clinical tools such as the Warwick Edinburgh Mental Well-being Scale (WEMWEBS) and CORE measurement tools to chart progress or 'change over time'.

> "We have a very comprehensive evaluation framework – using evidence from WEMWEBS and CORE-YP. Lots of our own questionnaires, qualitative assessment." [ID374, NFP; CSA focus]

Collecting service user feedback was commonly used to support impact assessments:

> "[We use] feedback forms for service users that are anonymous. The feedback goes to corporate, and this is fed back to management to make changes. For the ISVA service we have monthly coffee mornings to get feedback from service users, current and previous. If a client rejects support, they can give feedback as to why they did not want to engage with the service." [ID75, NFP; SV remit]

> "When we take a call on the helpline, we always take feedback. We have surveys that we send out to service users every three months." [ID728, NFP; wider remit]

Some services had carried out or were planning to carry out external evaluations of their work, or had carried out research:

> "We did work with King's [College London] – still to be published – Delphi project on models of therapy." [ID159, NFP; wider remit]

However, the resource implications of developing effective monitoring systems were highlighted:

> "I feel that the level of scrutiny that we are under for monitoring and evaluation generally outstrips the value of the contract; and because some of the monitoring comes from, in our case, the Police and Crime Commissioners and the Ministry of Justice, we just do not have the database to effectively manage what they want." [ID575, NFP; SV remit]

> "We're getting funding for a monitoring, evaluation and learning manager, so once she's in post we'll be overhauling it. We get good data but we're asking women about 50 questions, which is not ideal." [ID483, NFP; wider remit]

One service described a challenge it saw in using external evaluators with its service user group:

> "We do record positive outcomes and positive case studies. But there's no kind of external evaluation of this… because you can't talk to our client group… They don't want to talk to anybody external. So that makes it more problematic than in other sectors." [ID245, NFP; wider remit]

Another noted the large number of forms and processes it used:

> "Counselling feedback forms, review forms, CORE measures for counselling outcomes, case closure reviews, case management reviews, service user focus groups, before and after questionnaires, midway reviews, early exit surveys…" [ID305, NFP; wider remit]

Almost half (n=67, 48%) of the 140 services said they would like some support around monitoring and evaluating impact, particularly in developing tools that were appropriate to their work:

> "We would like to develop a measure that isn't looking for an improvement in symptoms, that would capture what services are managing to do rather than expecting a resolution of mental health difficulties, which is really hard to achieve." [ID297, stat.; CSA focus]

> "I've worked in other sectors like drug and alcohol, they're always talking about evidence-based this and evidence-based that. I think we still struggle as a sector to really demonstrate that. And having a common framework that isn't too 'mental healthy' but is robust would be helpful." [ID483, NFP; wider remit]

> "Evaluation around outcomes can be difficult. People's tangible outcomes are often missing episodes, have they or have they not disclosed? But I think other, softer outcomes could be identified as showing progress… Things like confidence, people being assertive, do they have a network of friends? Those are protective factors that can minimise the risk." [ID621, NFP; CSA focus]

12.3 Involving service users

A question about involving service users in service design and delivery was, once again, answered by 140 of the 166 services we interviewed. More than four-fifths said they did involve service users in some way (see Figure 77), using a range of methods. Most commonly, they had established consultation or service user panels or young people's participation groups.

Many services actively involved their service users in both strategic and operational issues. Some described having experts by experience, victim/survivor consultations or advisory groups which contributed to policymaking, staff recruitment, and monitoring and evaluation:

> "We have a service users' participation group, and they are involved in things like advising on the physical environment, e.g. what do they think of the rooms we use. They might do paintings and pictures for our rooms. Generally, our aim is to have at least one service user on every interview panel to help advise on the recruitment process. And when we're delivering new interventions or programmes, we would often have a focus group afterwards, so do a pilot and then have a focus group and then incorporate their feedback." [ID100, NFP; wider remit]

Others talked about their service users' involvement in wider consultations:

> "We have a young person's partnership board. They meet about once every two months, alternating face-to-face and online to allow those working or in school to participate at least bi-monthly. Children from those groups support us in understanding areas of service development. They also help us to feed into Welsh government consultations, Home Office consultations around responses to child sexual abuse." [ID28, NFP; CSA focus]

A number said they consulted their service users on changes and developments:

> "We have a service user group who we pass everything through to see what they think. So even if it's changing a document, creating a new evaluation form, we put it to them to scrutinise and to share their thoughts and feedback." [ID83, NFP; wider remit]

In some cases, this was embedded in the way the service was set up:

> "Our board is made up of those with lived experience and those without lived experience… Our workforce, other than a tiny number of people, are individuals with lived experience… so they are influencing and involved in the design at every step." [ID103, NFP; CSA focus]

Engagement with service users was sometimes less formal:

> "We put out questions on social media: 'What would you like to see?', 'What did you find helpful?', etc." [ID196, NFP; CSA focus]

> "We have community cafés where we invite service users to come and provide feedback on the service and help us design leaflets or any queries that we've got." [ID521, NFP; wider remit]

Bringing service users together who did not know each other, or who had left the service, was identified as a challenge:

> "It's often difficult to get service users to engage, especially when they have exited [support]. And, following BACP guidance, we don't want to risk retraumatising them by contacting them again." [ID414, NFP; SV remit]

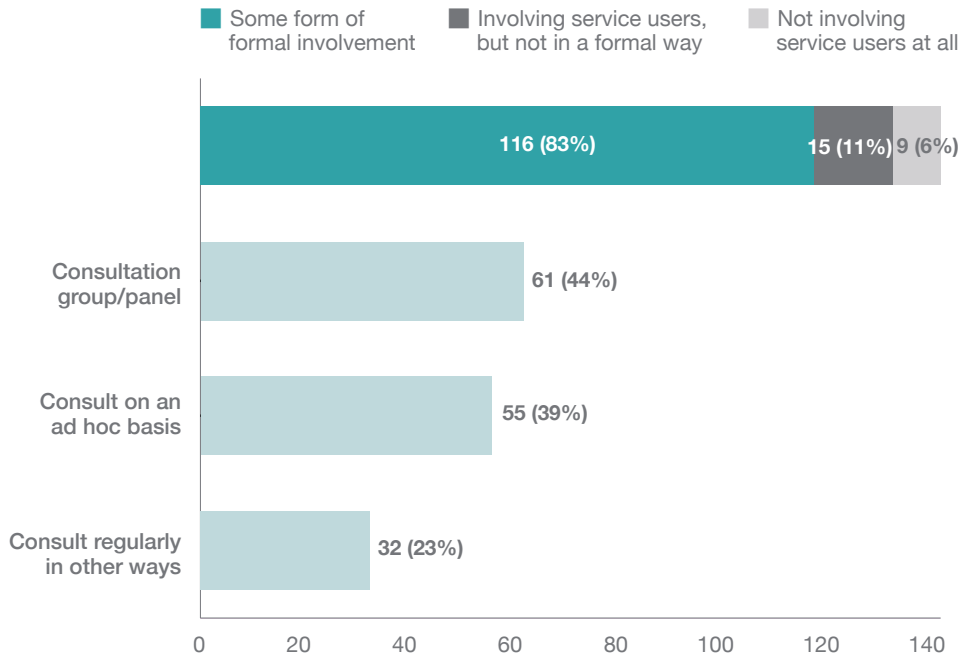
Asked a general question about what support they would like in the future, more than half (n=75, 54%) of the 140 services said they wanted support around service user engagement and consultation:

> "We need to be looking at those with the lived experience and bringing them in to help us understand better what works." [ID180, NFP; wider remit]

> "We've found it challenging to get consistent engagement from our service users. And so I think some support around what works best with that would be beneficial." [ID341, NFP; CSA focus]

> "Service user engagement is super important to me. Youth voice. What do young people want? What do they like about services? What would make them engage [with a] service? What makes them walk away? What do we need to be doing more of as professionals? I think it's really easy, and I've experienced it, to lose touch as a manager when you're not frontline working, of what a child needs, what a young person needs, what a service needs, and I think we need to be doing more of that well." [ID584, NFP; CSA focus]

Figure 77. How service users were involved in service design and delivery



n=140. Services could select multiple answers.

12.4 Developing support provision

Finally, we also asked services how they had developed their support provision during the last few years, both in response to the COVID-19 pandemic and independently of this, as well as what plans they had for future development.

12.4.1 Recent developments

Five-sixths (n=138, 83%) of the 166 interviewed services told us about how their services had developed in recent years.

As Figure 78 shows, two-thirds of them said they now provided more services, and almost one in ten provided *different* services. Nearly a quarter told us their service provision had not changed significantly; only five said they now provided fewer services.

Among the 90 services that had expanded their provision, the commonest expansion was in therapeutic provision:

> "We now provide specialist child counselling, due to the increase in funding during COVID." [ID245, NFP; wider remit]

Many services said they had increased their remote offer, either online or by telephone:

> "More telephone support, not something that was done much before the pandemic but it's now one of the main ways we support people. We can support people in broader areas across [the county]." [ID618, NFP; wider remit]

Others had set up new group programmes or expanded group programmes they were already running:

> "We were able to put on an extra group, as the waiting list was getting large so funding for an extra group secured." [ID663, NFP; wider remit]

Some described an expansion in their services for children or for families:

> "We have opened up the trauma-focused cognitive behaviour therapy for children." [ID531, stat.; SV remit]

> "We're trying to develop family mentalisation-based therapy." [ID4, NFP; CSA focus]

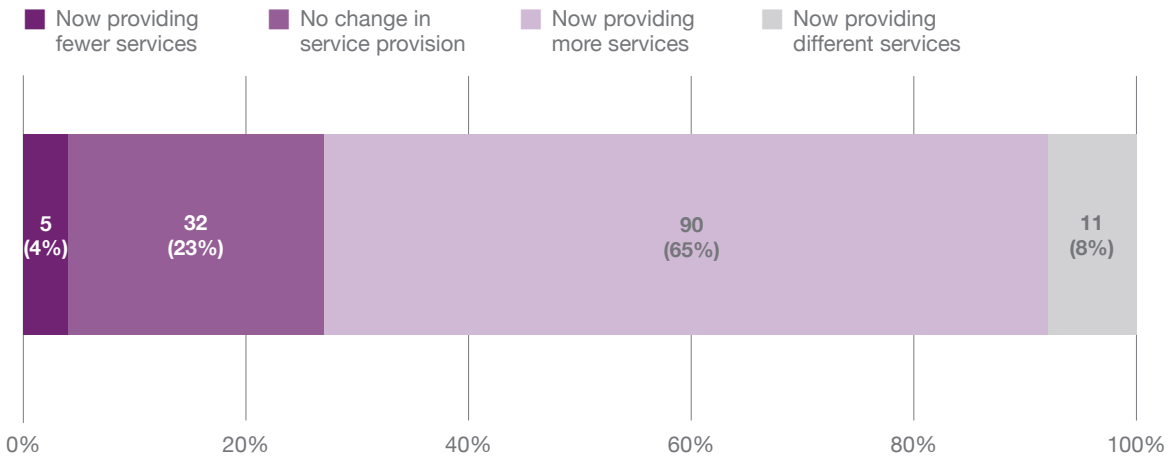
The expansion of advocacy support, such as through ISVAs and ChISVAs, was also commonly reported:

> "Our ISVA service only started working with children under 11 about three years ago, and now we've added a family ISVA." [ID24, NFP; wider remit]

Some services recognised that expansion had been driven by a need to respond to more forms of child sexual abuse:

> "We changed from being just child sexual exploitation to encompassing all forms of child sexual abuse and including post-abuse. Which has been really good but increased demand… But it means that we're able to pick up those people who would fall through the gaps of traditional CSE service." [ID68, NFP; wider remit]

Figure 78. Recent changes in service provision



n=138.

A considerable number said they had modified their approach:

> "We are working with young people and providing more diversionary activities, using young people's interests more as a positive route for them to develop more positive relationships. Different approaches rather than new services." [ID30, NFP; CSA focus]

Sometimes this was in response to changes in the kind of sexual abuse that services were seeing:

> "We are keeping up to date on the cyber aspect of child sexual abuse because people who were trained 10 years ago were not as aware of the reality of how pervasive technology has become in recent child sexual abuse." [ID347, NFP; SV remit]

Five services, all in the not-for-profit sector, said they now provided fewer services. Two were no longer running groups, one was no longer providing an outreach support service, another had stopped providing a helpline as "*no one was using it*", and the fifth explained that it had merged two separate services – one for child sexual exploitation and one for child sexual abuse – into one.

12.4.2 Impact of COVID-19

We asked services to tell us what difference the COVID-19 pandemic had made to their current service provision, and 152 responded. As Figure 79 shows, a quarter of them reported a positive impact, and more than half said the impact had been mixed. One in nine described the impact as negative, and almost as many said there had been no impact.

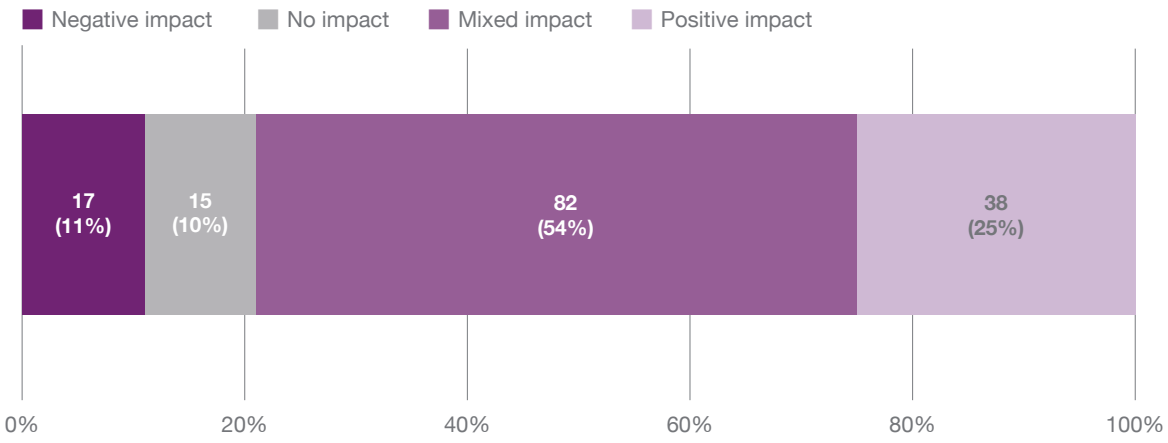
Services reporting a positive impact said they could now offer a more flexible, accessible service having discovered the benefits of remote provision:

> "It kicked us into the digital world overnight… We believed previously that face-to-face was the only way to do our work." [ID492, NFP; CSA focus]

As a result, some felt that their support was more effective and was available to groups they had previously been unable to reach:

> "We've been able to broaden our service offer and reach more people – I think particularly people with disabilities who wouldn't be able to leave the home. And I think many women have benefited from this." [ID578, NFP; wider remit]

Figure 79. Impact of the COVID-19 pandemic on service provision



n=152.

Others talked about the positive impact on their funding:

> "We've had more money to be able to increase both capacity and scope of services. I don't think we'd ever have put [an] app together if COVID hadn't happened." [ID483, NFP; wider remit]

> "People were throwing money at us. We were able to open two satellite bases and have been able to maintain them." [ID414, NFP; SV remit]

Negative impacts included the inability to provide support in person during the pandemic:

> "It was particularly difficult for those people who've experienced child sexual abuse, who were then having to do some of the sessions from their bedroom or from locations where the abuse might have happened." [ID299, stat.; wider remit]

Some services said they were encountering increased levels of complex need and trauma among service users:

> "People are still scared to come out. A lot of young people are feeling left out. Scared to go back to school. Mental health [issues are] huge." [ID394, NFP; wider remit]

Another highlighted the pandemic's impact on the criminal justice system:

> "It's had an impact on court backlogs and pressure on the system, which has a massive impact on [our] team." [ID19, NFP; SV remit]

12.4.3 Services' development plans

Of the 152 services that answered a question about their plans for development, four-fifths (n=123, 81%) said they were interested in or planning to develop their provision further.

Many wanted to develop their therapeutic and/or advocacy support for children:

> "We are looking at the counselling expanding to 5–10-year-olds." [ID24, NFP; wider remit]

> "I can see the need for a ChISVA – we have child safeguarding teams so this is the next progression. Specific for young people." [ID289, stat.; SV remit]

Others were looking to expand their services for adult victims/survivors, either by expanding geographically or by developing new support offers:

> "One of our Home Office bids is to seek out historical child sexual abuse victims from the late nineties and noughties who reported and got ignored and didn't get investigated, and support these victims." [ID460, NFP; wider remit]

Some were hoping to develop their provision for parents:

> "We would love to be able to provide a counselling service for parents and carers who make use of the service." [ID680, NFP; wider remit]

A few wanted more sex-specific provision for victims/survivors:

> "We want to offer male specialist services in more areas because, at the moment, there's only five services in the whole of the UK and we don't think that's fair. We want to do more areas that aren't currently covered." [ID237, NFP; CSA focus]

> "We would like to have a specific live chat and helpline service for young women and girls." [ID305, NFP; wider remit]

The need to respond to service users from under-represented groups was also highlighted:

> "We'd like to have a disability outreach worker because we know that's kind of an untapped thing that we haven't really focused on. Most of our outreach work is around ethnic minority groups." [ID118, NFP; SV remit]

> "Some of the hard-to-reach groups… blind, visually impaired, hearing impaired. Possibly going to be collaborating with the local authority and outreach to street homeless substance users." [ID254, NFP; wider remit]

Other plans included developing outreach, peer support, service user engagement/voice, training for professionals, and providing more support to those on waiting lists.

13. What enables services to provide effective support?

This chapter presents services' responses when asked to describe what they saw as the key strengths or qualities of the support they provided to people affected by child sexual abuse.

Overall, two main themes emerged: the experience and commitment of their staff, and their flexible and individualised approach to support. Services also told us of the importance of accessibility, and described how they had taken action to make themselves more accessible.

Key findings and reflections

1. Services identified many strengths which they considered key to the quality of their support. These included the expertise, skills and experience of their staff, combined with compassion and commitment to providing high-quality support; their accessibility; and their ability to be flexible and deliver tailored needs-based support.
2. Almost all services said they made their services accessible to people with specific needs – for example, by providing access to language interpreters, translators or signers. Some had employed specialist support staff or adapted their service provision to ensure accessibility. In relation to translators and interpreters, funding was highlighted as a particular challenge, as were the sensitive nature of child sexual abuse and issues of confidentiality and safety.

Implications

Funders, commissioners and policymakers should ensure that their support for services takes account of the additional funding implications of meeting all service users' requirements in terms of accessibility and language – for example, by providing funding to cover the costs of using interpreters and translators).

> "Two themes emerged: staff experience and commitment, and a flexible, individualised approach to support"

13.1 Staff experience, knowledge and commitment

Many services said the quality of their support provision was underpinned by their experienced, highly skilled and well-trained staff. They emphasised that staff were highly qualified in different disciplines, were knowledgeable about the impact of trauma, and had extensive experience of supporting people affected by child sexual abuse:

> "The quality of our staff is just phenomenal. And what that translates into is everybody's capable of supporting anybody, really. And they're all trained to the highest possible standards to give the highest possible support. It also means that we can really tailor, for example, counsellors to clients."
> [ID374, NFP; CSA focus]

Having an inter-disciplinary team was seen by some services as a strength, as staff members' different backgrounds, professions and experience added an important element to the support they could offer children and adults.

Services described their staff as passionate and committed to their work, and willing to go out of their way to support victims/survivors:

> "We've got an incredibly passionate team that love their work and just want to make things better and want to make people's journey through this horrendous system better. So they go the extra mile."
> [ID19, NFP; SV remit]

This combination of expertise, experience and commitment enabled staff to engage with victims/survivors in a sensitive and supportive manner:

> "Just the level of expertise within the team. I think it's a huge strength in us. Sometimes we have young people referred to us who've not engaged with anyone else…The team are reachable for those young people. It's their communication skills, their level of expertise, their delivery."
> [ID72, stat./NFP partnership; wider remit]

> "The key strength is our specialism and our team, a highly skilled team. And because our work is uniquely around sexual violence and child sexual abuse, we really do have a strong expertise. We've got a strong understanding of it, and we live and breathe it every day. The whole team is really expert and I think the support we provide is compassionate and outstanding – it's high-quality, compassionate support."
> [ID89, NFP; SV remit]

A few services highlighted the stability of their staff team as a key strength, noting that staff needed a supportive environment, a manageable caseload and regular one-to-one and peer supervision in order to carry out their emotionally challenging work.

> "Our staff retention is strong – we invest in their emotional wellbeing to enable them to better support clients."
> [ID635, private sector; wider remit]

"We look after each other as colleagues and I think that we are a human organisation. We're a very human team, so if people are wobbling, we'll say, 'OK, we're not going to allocate another case. You will hold off. You OK?' Because we need to keep them safe and happy and well for them to be able to do this work."
[ID157, NFP; wider remit]

> Services told us the stability of the staff team was a strength, noting that staff needed a supportive environment

13.2 Flexibility

Being flexible and adaptable in their support provision was perceived as a key quality by many services. A needs-based approach enabled services to tailor their support to each victim/survivor's unique needs and changing circumstances:

> "It's a very person-centred and individualised approach. For us it is very much around getting to know that child and their family individually. Because it's such a broad range of circumstances that encompasses the age of the young person, it could be a 5-year-old or it could be a 17-year-old. The types of abuse they've experienced, the number of them, who it was by – all of those things are going to be important factors. So what we do will be very adapted to the needs of that individual child." [ID100, NFP; wider remit]

Some smaller services suggested that their size increased their flexibility to develop bespoke and individualised support plans; other services pointed to the flexibility of their funders.

A few services said that this flexibility extended to what they could provide beyond individualised support. They felt that their support provision was strengthened by being agile and open to new approaches, different types of support and/or methods of delivery:

> "We are continuing to roll with the challenges and develop services. It's an ongoing thing as opposed to just 'This is what we offer. That's the end of it.' So, if we have increased waiting lists or we see a particular gap where support isn't provided, we can tailor services and provide them quite quickly." [ID423, NFP; wider remit]

13.3 Accessibility

Some services considered that their **accessibility** was a strength, whether this involved being physically accessible (e.g. close to transport links), being available outside office hours, being free of charge, or having no waiting list. Having different types of support (such as therapy and advocacy) available in one place or within one service was also perceived as a strength, as was not being constrained in the range of support available .

> "We are fortunate with our funding, and we are able to go above and beyond for clients [in a way] that other services may not be able to do. We have very few limitations and we are open and accessible. We support all ages, children and adults. We do not have a waiting list and are very accessible." [ID468, stat.; SV remit]

Some services highlighted the provision of support free of charge was a major component of their accessibility:

> "Having a counselling service that is free. It's so expensive to go and get the type of support that we provide." [ID308, NFP; SV remit]

We asked all 166 interviewed services to tell us whether and how they made their services accessible to people with specific needs. Of the 139 services (84%) who responded to the question, all but four told us that they did take steps to make themselves accessible.

> Services highlighted the value of being open to different approaches, types of support and/or methods of delivery

13.3.1 Addressing language and cultural barriers

Two-thirds of these services told us that they provided access to interpreters and translators when supporting children or adults who did not speak English as a first language. Some of these said they used translation services such as Language Line or Clear Voice:

> "We have the Language Line app and you can dial into the interpreter and see their face on the telephone." [ID470, stat. sector; SV remit]

Using an interpreting service meant that services could respond to their service users' specific needs:

> "I don't think there's a limit to the languages they would offer. But often the young people who require interpreting services are from a refugee background. So that's the largest proportion. And they offer a lot of different languages." [ID598, NFP; wider remit]

A number of services employed staff who spoke some of the same languages as their service users:

> "Our staff are Black and minoritised and can speak many different languages. [ID13, NFP; wider remit]

Some had translated resources into different languages:

> "We've had our promotion material translated into 13 languages because we've just added Ukrainian and Russian to that." [ID224, NFP; SV remit]

One service told us that it had several outreach workers, based in different sites, who focused specifically on reaching people from different backgrounds. Others had developed programmes for particular groups of people; these included a project for refugees, a group for people from minority ethnic communities, and another for people from minority ethnic communities who were LGBTQ+.

However, a number of services talked about the challenge of finding and using translators and interpreters, due to either a lack of demographic diversity in their area or a lack of funding to cover the costs:

> "We have access to a language service, which we have used in the past. But it's difficult in terms of funding. A pay-as-you-go service is expensive and so you can't use that for long-term support." [ID618, NFP; wider remit]

Some relied on their local authority, NHS service, police force or clinical commissioning group to cover the costs of translation services, and had to find other solutions when this was not possible:

> "Interpreters are very expensive and, if social care don't provide them, we have to be very resourceful to try and find it. We have had instances where we've communicated with parents and carers… We've used Google Translate quite a lot." [ID680, NFP; wider remit]

Another service said it could not fund translators and interpreters because of the long-term nature of the support it offered. Others described using interpreters and translators as challenging, owing to the sensitivities around discussing child sexual abuse:

> "[There have been] lots of cases where it's been difficult working with the interpreter, [because of] another person in the room sharing very intimate things." [ID198, NFP; CSA focus]

Some highlighted issues of confidentiality and safety when working with local interpreters and translators in a small community, where service users might know the translator/interpreter.

13.3.2 Access for disabled people and those with additional needs

Many services said they used signers for D/deaf or hard of hearing service users, or visual aids with people who were visually impaired, and/or provided accessible buildings and facilities for people with physical disabilities (e.g. allocated parking, wheelchair access to rooms and toilets, ground-floor rooms, and buildings with a lift). A SARC described how its medical suite had been made accessible:

> "The suite is disability-friendly… [and] wheelchair-accessible. The couches go up and down and we can have the loan of a hoist from the hospital if needed." [ID144, stat.; CSA focus]

One service had commissioned counsellors who had experience of working with disabled victims/survivors and understood the social model of disability, while another had provided counselling with interpreters:

> "We also have a specialist counsellor who works with deaf women. She is fluent in British Sign Language. So it's accessible to women who have different language needs." [ID578, NFP; wider remit]

Two services told us that, as they did not have accessible buildings, they had partnered with other services in the community to provide wheelchair-accessible spaces for their service users.

Some services provided different ways for service users with additional needs to access support, such as offering online or telephone support or arranging to meet service users at their home or in a local public building with private space. A number said they tailored their service provision to meet the needs of people with additional needs on an individual basis.

A few services told us they had specialist staff to provide support to particular groups of people, e.g. an additional needs specialist ISVA. Others had developed specific programmes to cater for the needs of service users with learning disabilities/difficulties.

> "We have in-house counsellors that specialise in learning difficulties and counselling people with learning difficulties." [ID344, NFP; SV remit]

13.4 Other qualities

Services that were **led by victims/survivors** or employed staff with **lived experience** of child sexual abuse described this as an important asset, as it provided a depth of knowledge and understanding, as well as a passion and commitment for the work.

> "The value of being victim- and survivor-led [is a] real strength to empower [service users] to make decisions about their own life, instead of telling them what they have to do." [ID207, NFP; wider remit]

Having a **holistic approach** which acknowledged victims/survivors as whole people, often with multiple and interacting strengths and difficulties, was highlighted by a few services as a strength. They also stressed the significance of situating victims/survivors within a wider familial and societal context.

> "[Our support is] holistic – we're not saying we can only see you about the child sexual abuse, or we can only see you about the domestic abuse that happened last Wednesday, or we can only see you about the hate crime that happened last Wednesday. It's just you." [ID428, NFP; wider remit]

> Services employing staff with lived experience of child sexual abuse described this as an important asset

Where services could provide **open-ended support** without time limits, they valued this highly:

> "We're giving those clients a long-term intervention that addresses their trauma. We're not trying to fix it in 12 sessions, 20 sessions – we are giving them the time and the space to develop a really good working relationship with their counsellor." [ID99, NFP; CSA focus]

Similarly, some highlighted the value of being able to offer **follow-up support**:

> "We're about the only service that actually gives long-term support and then has a wraparound service after they come out of counselling." [ID653, NFP; wider remit]

By combining these different elements, services felt able to offer a **safe space** to victims/survivors and their families, where they were cared for in a way that made them feel safe and listened to:

> "We offer them a quality service where they are heard and believed… We've got a stable team, which means they are likely to encounter the same people and that creates safety… We're in a nice physical environment and I think that's really lovely to be able to offer a nurturing space to people that feels looked after and cared for." [ID157, NFP; wider remit]

> "It is about that safe space. It is about the fact that people don't have to tell us where they are. They don't want to be identified and unless we identify that there is a safeguarding concern, they can remain anonymous because what you want is not to scare people off. We offer a kind of relationship that people feel empowered enough to come back and know that they are safe in that space [so they can] tell us what's going on for them." [ID224, NFP; SV remit]

> Services felt able to offer a safe space where victims/survivors and their families felt safe and listened to

14. Conclusions

14.1 What did this research show?

This research project mapped 468 services in England and Wales that provide support to victims/survivors and their families in relation to child sexual abuse. While a fifth of these services focused *solely* on child sexual abuse, many were providing this support as part of a response to sexual violence or other forms of abuse.

We gained insights into the different types of services providing support, how these are accessed, and how many people are receiving support – as well as the length of waiting lists. Services told us how they are funded and staffed, how they oversee their service provision, and how they liaise with other agencies. Crucially, we explored whether current levels of service provision are likely to be meeting the need for support across England and Wales.

We saw that most support is provided by services in the **not-for-profit sector**. While this is both unsurprising and appropriate given that victims/survivors have expressed a preference for support from such services (Adisa et al, 2023; Gekoski et al, 2020), it means that support provision is concentrated in a sector that faces constant funding insecurity and high pressure. In addition, services tend to be **relatively small-scale**: most of those we interviewed had fewer than 10 staff, and around half supported fewer than 100 children or adults in 2021/22.

Our research has also shown **the diversity of support** provided around child sexual abuse. We found services providing a range of different interventions in response to different forms of abuse and different groups of people. Services described their support as flexible, tailored to individual needs, and delivered by highly skilled, compassionate and committed staff.

However, the pressure faced by services in **meeting demand** has intensified. Half the services we interviewed – and two-thirds of those in the not-for-profit sector – said they could not keep up with the number of people presenting for support. As a result, nearly three-quarters of not-for-profit services, and almost half of those in the statutory sector, told us they were operating with **waiting lists** – leading us to estimate that, at the time of our research, more than 55,000 children and adults were on services' waiting lists across England and Wales. The time spent on waiting lists was a little over six months on average (and ranged from a few weeks to several years); it was particularly long in services with a sexual violence remit. Services highlighted the impact of unmet demand on their staff, and expressed great concern for the welfare of people waiting for support.

Furthermore, with half a million children estimated to be sexually abused every year (Karsna and Kelly, 2021), **those who are accessing support represent just the tip of the iceberg**; to meet this need, each of the services we identified would need to support more than 1,000 new victims/survivors per year; in reality, many were able to support fewer than 100 people in 2021/22. We also found a 'postcode lottery' of access to support: depending on the region, there were between 2,500 and 5,000 child victims/survivors, and between 10,000 and 23,000 adult victims/survivors, for every service providing support.

> To keep up with need, each service would have to support over 1,000 new victims/survivors per year

Services faced challenges in sustaining their level of support without appropriate, unrestricted, multi-year **funding**. Ongoing uncertainty around the stability of their funding was forcing many to offer short-term contracts and put staff on notice of redundancy while awaiting funding decisions. It was a struggle to retain staff on reasonable salaries, particularly in the current economic climate, and to recruit new staff with the necessary skills and resilience. Many services, particularly those in the not-for-profit sector, relied on funding from multiple sources; such fragmentation of responsibility for funding and commissioning child sexual abuse support creates challenges around meeting different funders' priorities and monitoring requirements, and forces services to devote valuable resources to seeking funding which is often restricted, short-term and competitive.

We discovered that services were providing considerable support – including training, advice and case consultations – **to other professionals** in a variety of sectors to improve their response to child sexual abuse. Working with limited resources, services had to manage the balance between providing direct support to victims/survivors and enabling other professionals to improve their practice.

Services had a deep commitment and determination to **sustaining and improving** their support provision: they were offering interim support to people on waiting lists, developing new interventions and reaching out to different service user groups. Moving to online working as a result of the COVID-19 pandemic was seen as a positive move, with most continuing to offer it to their service users where feasible. Services were using a wide range of **quality assessment standards and frameworks**; some highlighted the need for quality standards that would work across services supporting victims/survivors and their families. Many also wanted more support with **evaluating the impact** of their work and involving service users in support design and delivery.

14.2 What should the provision of support around child sexual abuse look like?

For the response to people affected by child sexual abuse (including the hundreds of thousands not currently receiving any support) to be effective, the support available has to be sufficient, appropriate and **accessible**. However, our research has shown that these fundamental elements are not currently in place.

Capacity within services to provide sufficient support

Our research highlighted the challenges that services face with their funding and staffing, which make it impossible for many of them to meet demand. It also showed that, across the whole of England and Wales, there are tens of thousands of victims/survivors of child sexual abuse for each service supporting them. This echoes the findings of the final IICSA report, which found a lack of support services both nationally and locally for victims/survivors and their families (Jay et al, 2022).

Child sexual abuse can have significant, long-term impacts on physical and mental health, relationships, education attainment, employment and financial stability (Vera-Gray, 2023) – and being able to access support, whether in childhood or as an adult, is crucial to mitigating those impacts (Truth Project, 2022). Home Office research on contact sexual abuse has estimated that these impacts cost society more than £10 billion through victims/survivors' increased use of and involvement with social services and the criminal justice and healthcare systems (Radakin et al, 2021).

> There is both a humane and an economic case for greater investment to sustain and expand service provision

Clearly there are insufficient services to meet current demand, let alone the true scale of unmet need. **There is, therefore, both a humane and an economic case for greater investment to sustain and support existing service provision, and to enable an expansion in provision** for both child and adult victims/survivors and their families. Alongside this, services need to be able to operate within a **nurturing environment** where training and resources to support their work are readily available, and where they are valued for the unique and highly skilled work they do.

Appropriate support to meet individuals' needs

As well as observing a scarcity of support services overall, we found – as the final IICSA report (Jay et al, 2022) did – that there was a lack of support tailored to particular needs.

There were relatively more services available for sexually abused children than for adult victims/survivors. While safeguarding and supporting children who have been sexually abused is an immediate priority, it is also important to recognise services' crucial role in helping adult victims/survivors address the long-term impact of sexual abuse.

Among the services we interviewed that supported children, nearly two-thirds appeared not to be offering any support to the children's parents. This support is vital in helping parents to manage their own feelings and support their child, so both can heal from the abuse and move forward with their lives. Additionally, while support for teenagers was widespread, many services did not offer support directly to younger children.

Few services were focused primarily on supporting people from minority ethnic backgrounds, or men and boys affected by child sexual abuse. Given that a third of children in England and Wales are from minority ethnic backgrounds (ONS, 2023) and a quarter of child sexual abuse victims/survivors are male (ONS, 2020), these are major gaps. While many more services were providing support for women and girls, sex-specific provision for them was scarce: only 67 services across England and Wales offered this support.

Similarly, there was little specific provision around certain forms of child sexual abuse, particularly intra-familial abuse and abuse in online or institutional contexts.

It is vital that support is available that responds to individual need, in terms of the victim/survivor's characteristics and background *and* the form of sexual abuse they have experienced. This includes ensuring that tailored support is available in response to a wide range of forms of child sexual abuse, not just child sexual exploitation.

Easy access to support

While many victims/survivors and their family members face a long wait for support, many more are likely to struggle to find support in the first place. it is difficult to know what support is available, for whom and where. Existing directories are valuable, but those provided by the **Survivors Trust**, **Rape Crisis England and Wales** or the **Male Survivors Partnership** list only the services that belong to their networks, while others – such as those on the **Survivor Pathway** and **Sexual Violence Support** websites – cover only a specific geographical region.

Services need to actively promote their existence, particularly to groups (such as disabled people) that they currently struggle to reach. However, such promotion requires resources, both in conducting outreach activities and in responding to the resulting increase in demand. Many services told us they avoid such outreach because they lack the capacity to meet the demand that would result, and were concerned at the impact on people encouraged to access support only to find themselves placed on a lengthy waiting list.

> Services need to promote themselves, particularly to groups that they currently struggle to reach

14.3 Implications for policymakers, funders and commissioners

Our research has built on previous mapping studies of support for children who have been sexually abused (Allnock et al, 2009; 2015) and for adult survivors (Coy and Kelly, 2017) – and, like them, it has highlighted the importance of access to timely and appropriate support services. Reflecting on the three fundamental elements and the evidence arising from this research, we have identified six response priorities for policymakers and for funders and commissioners of support services and/or research in this field:

1. **Ensure sufficient funding for services to maintain their current provision and provide timely support.**

   This should include long-term, unrestricted funding for core costs, enabling services to provide support which meets service users' needs at the time they need it; services should not have to be operating with lengthy waiting lists.

   That unrestricted funding would allow services to expand and develop their provision (see below) from a base of financial stability. It would also build resilience across the sector, so that service provision can respond to future demand.

   Funders and commissioners should also consider how they can avoid creating situations where services doing valuable work are required to use scarce resources competing with each other for limited pots of funding.

2. **Working closely with services, provide funding that enables them to expand and develop, so they can meet the diverse needs of their existing service users *and* new user groups.**

   This funding might be used by services to:

   - extend their reach – for example, by promoting their work (either generally or to specific groups) and ensuring they are widely accessible
   - design and develop the provision of new support, with the involvement of their service users – and with the time and resources to evaluate that provision
   - explore different models of support, so they can adapt to service users' individual needs (by, for example, offering flexibility around the type and duration of support provided, and operating an open-door policy so service users can return for further support if needed).

   Funders and commissioners should take account of the additional funding implications of enabling services to respond more fully to service users' requirements, in terms of accessibility and language (e.g. funding to cover costs of using interpreters and translators).

3. **Provide funding and support in relation to services' infrastructure,** enabling them to:

   - improve their data collection systems and analysis
   - offer their professional expertise to other professionals, without reducing the support they provide to victims/survivors and family members
   - develop and share quality and impact assessment frameworks and tools
   - develop and share learning and practice around service user engagement and consultation.

4. **Provide funding to support the appropriate training and upskilling of professionals, whether they work in specialist support services or in the wider professional network.**

   Specialist professionals need training to keep up to date and develop their skills in areas such as different forms of child sexual abuse and ways to support children. Also, given the central role played by non-specialist professionals in statutory agencies when concerns about child sexual abuse arise, training for them is urgently required so there can be an effective, joined-up response to children and adults affected by that abuse. National and local reviews and enquiries consistently highlight that professionals have not been given the knowledge and skills to identify and respond to child sexual abuse confidently.

5. **Commission research into specific groups' support needs and access to services.**

   This research would be particularly beneficial in relation to boys, physically disabled children, and children and adults from minority ethnic backgrounds.

6. **Enhance funders' and commissioners' own expertise in funding child sexual abuse support services effectively.**

   This could include access to information and guidance, training, and resources that enable funders and commissioners to understand and respond to the need for support around child sexual abuse.

14.4 Practical implications for service provision

The research findings also highlight some practical implications for services across all sectors, and for all agencies and partnerships involved in the response to child sexual abuse:

- Statutory agencies in particular should not close cases before support from other services has commenced; this will avoid victims/survivors being left with no support. They should also consider providing funding for not-for-profit services to which they make referrals.
- Services should not be expected to act as a one-stop shop covering *all* the support needs that their service users may have. While providing therapeutic or wellbeing-focused support, services should be able to refer service users on for support with their wider needs, to relevant agencies which recognise their responsibilities in providing that support.
- Services should be included in local networks and partnerships, especially Local Safeguarding Children Partnerships/ Boards, and have opportunities to come together regionally and nationally.
- Every service should be collecting and analysing data on its service users, how they are supported, and what they think of the support they receive. The CSA Centre's ***Improving Your Data on Child Sexual Abuse: A Practical Guide for Organisations*** can help with this.

> Long-term, unrestricted funding for core costs is required, so services can provide support when people need it

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Appendix 1: Research methodology

Aims of the research

The research aimed to establish an up-to-date and accurate picture of the current provision of services supporting people affected by child sexual abuse, and to identify gaps in provision. We also wanted to better understand the nature of the support that services were providing to victims/survivors and their families, the strengths of the support they provided, and the challenges they were encountering.

To address the aims of the research, we formulated the following research questions:

1. What support services currently exist in England and Wales for victims/survivors of child sexual abuse and their families?
2. What are services' strengths, and what challenges are faced by these services?
3. How has provision changed in recent times?
4. Where are the gaps in service provision across England and Wales, and how does this compare with the need for support?

Approach

We employed a mixed-methods approach, bringing together both quantitative and qualitative elements. It involved:

- desk research – internet searches using existing lists and directories, as well as searches on key terms – to map service provision across England and Wales
- online structured interviews with services, to better understand service provision and explore their experiences of delivering support for victims/survivors and their families.

This approach was informed by a review of previous mapping research. In particular, we decided to avoid using an online survey as our main data collection tool, as we were conscious that survey response rates tend to be low and data less reliable than when it is collected directly. However, surveys have advantages over interviews in providing more standardised data and reducing the time needed for transcription. We therefore decided to combine both approaches, carrying out interviews over Teams/Zoom in which participants were taken through an online questionnaire. This meant that interviewers could probe and check participants' responses to the questions, ensuring as much accuracy as possible in the data recorded; it also ensured that the data was collated in a format prescribed by the questionnaire design, facilitating its analysis.

Ethical considerations

Having reviewed the overarching ethical implications of this research, we concluded that we did not need to seek approval from the CSA Centre's Research Ethics Committee. This was because the research would not involve gathering data from vulnerable people or people who lacked capacity to make decisions, nor the covert observation of participants.

Nonetheless, we considered the ethical considerations that might arise, and how we could mitigate them. For example, we recognised that some data (such as information on services' funding arrangements) is sensitive; we therefore made clear to services how we would be using the data they gave us, and what information would be treated as confidential. This was done in the information sheet that we sent services with our request for an interview.

Recognising that some of the services interviewed are run by victims/survivors, who might talk to the interviewer about their abuse, we addressed this possibility in our interviewer guidelines and training so that all interviewers were sensitive to it and knew how to respond appropriately.

We were aware that the interviews might reveal poor practice, raising safeguarding concerns. We decided that, in such instances, we would seek the interviewee's permission to involve one of the CSA Centre's Practice Improvement Advisors, who could support them in addressing the issues identified. If an interview raised significant safeguarding concerns, however, we would follow Barnardo's safeguarding procedures.[17] No concerns about poor practice were identified by interviews, so we did not need to follow this procedure.

We are aware of the potential impact that working in this field can have on researchers. Throughout this project, our team members were supported by their line managers and had access to clinical support from an external therapist. The team also met together during interviews and analysis, to reflect upon what we were hearing and share our feelings.

Identifying services

The first phase of the research began in July 2022 and involved desk research to identify relevant services, applying the inclusion criteria set out in Chapter 2. We compiled a list of services for potential inclusion by:

- identifying and extracting details of relevant services from existing directories and lists (e.g. Directory and Books Services, the Survivors Trust, Rape Crisis England and Wales, Male Survivors Partnership, the National Association For People Abused in Childhood)
- conducting internet searches using specific search terms (e.g. "child sexual abuse" "support")
- advertising the research via networks and mailing lists (e.g. the National Organisation for the Treatment of Abuse, the National Working Group, the Violence Against Women and Girls Research Network, and our own newsletter)
- looking through our own CSA Centre Twitter (now 'X') followers.

As we compiled the list of potential services, we recorded basic details about each service (contact details, location, remit, etc) based on information available on its websites.

A preliminary screening process was then undertaken, involving further checks of services' websites to ensure that each service met the inclusion criteria. If it was unclear whether a service met these criteria, we provisionally included it so that we could check this when we contacted the service.

Additional services were identified through 'snowballing', as we asked services we interviewed whether they were aware of other services that we should include.

17 The CSA Centre, while independent of Barnardo's, was originally set up by Barnardo's and operates within its governance and administrative systems.

Designing data collection tools

We designed two main data collection tools:

- an Excel spreadsheet, stored securely on the CSA Centre shared server, enabling the research team to access and update the list of services identified
- an interview schedule, formatted as an online questionnaire hosted on SurveyMonkey, to collect and store the data from the interviews with services.

The interviews were carried out online via Teams/Zoom; this meant that, subject to participants' consent, we could record the interviews and fill in the answers on the questionnaire in full later.

We also designed an online interview questionnaire for services that were closing down, as we wanted to capture information about the support they had been providing and the reasons for their closure.

We asked volunteers from the CSA Centre's Strengthening Services Programme advisory group to review the draft questionnaire, and received helpful feedback from three members. We also then piloted the questionnaire with members of our own team and another volunteer from the advisory group.

In addition, we set up systems to record when services had been contacted and had consented to take part in an interview.

Undertaking the interviews

Once the online interview schedule/questionnaire and data collection processes had been set up, we set about developing interviewer guidelines and training the team of interviewers. Our team of nine interviewers were drawn from the CSA Centre's Research and Evaluation team and its Practice Improvement Advisor for the voluntary sector.

Each interviewer was allocated a batch of services to contact and given the information sheet and a standard email message to send out; these described the aims of the interview, what it involved, how their information would be managed, how they could withdraw from the research and who to contact if they had any concerns or questions.

Where services agreed to an interview, this was scheduled at a time convenient for them. Interviews were carried out over a five-month period from November 2022 to March 2023.

Services that did not respond to the initial email were sent a further email; those that still did not respond were contacted, as far as we could manage, by telephone.

The interviews lasted between 45 and 90 minutes; some questions were asked of all participants, while others were tailored to the different types of service. After each interview, the interviewer used the transcription to complete the questionnaire, inputting any data that had not been entered during the interview.

After the interviews, participating services were sent an email thanking them for their time, offering them some of the CSA Centre's practice resources, and inviting them to free webinar training sessions that we had developed for them. A total of 229 people attended these sessions, which covered.

- supporting parents of children who have been sexually abused (94 attendees)
- harmful sexual behaviour in children and child sexual abuse in online contexts (79 attendees)
- the scale and nature of child sexual abuse (56 attendees).

Checking the data

The completed questionnaires were sent to participants as a record of their interview, and to give them an opportunity to check for accuracy.

Services which had not been interviewed (because they had declined or not responded to our invitation) were sent individual emails, asking them to check the information we had gathered about them – in terms of their geographical remit, service user group and main types of service provision – through our desk research.

Data analysis

The next step was to bring together the data from our interviews, extracted as another Excel spreadsheet from SurveyMonkey, with the data that we had gathered through our desk research and 'check' emails to services. Once this was completed, the data was cleaned to delete duplicate or empty records.

As we had such a large dataset to work with, the analysis was shared across the research team, which now included an external researcher who was brought into take on some of this work. The team members were briefed and given standardised documents to use, to ensure a common approach. The research lead kept in touch with the team members, to troubleshoot any difficulties and monitor progress. As individual researchers finished analysing their allocated sections, these were checked and edited by the research lead to ensure consistency and accuracy.

The data was largely analysed in Microsoft Excel. We also used Microsoft Power BI to develop visual maps, and qualitative data analysis software (NVivo 10, QSR International) to analyse lengthy qualitative data.

In reporting the qualitative data from the open questions in the interviews, we sought to draw out key themes using a top-down approach driven by our research questions and underpinned by Braun and Clarke's (2006) framework. We have *not* reported the numbers of interviewees expressing a particular view in response to the open questions, as this might lead readers to conclude that others did not share that view (whereas in fact it simply means they did not proactively express it).

Feedback from participants

Some of the services we interviewed said that taking part in the research had been beneficial for them: they appreciated the opportunity to tell us about their work and the challenges they encountered, and thanked us for listening to them.

Services also told us they appreciated the resources we sent them following the interview:

> "Thank you so much for the resources. It's really helpful to have access to these to support our funding bids."

Feedback on the post-interview training webinars was positive too:

> "Thought-provoking, good resources and links to research which will have an impact on practice."

> "It was accessible and very informative. Allowed me to revisit a lot of things I knew but also introduced interesting and helpful research."

> "Person presenting was engaging, and the information and tools that were delivered offered very practical advice to directly apply to practice in working with families."

> "Loads of useful data that we can use to support our work."

> "Really informative and interesting, the trainer was relaxed in her teaching style and really easy to understand. I was pleased that we are being encouraged to share the training materials with other agencies so that the information can be used to the maximum benefit to raise awareness."

> Services appreciated the opportunity to tell us about their work and the challenges they encountered

Appendix 2: Overview of the research sample

Our mapping exercise identified 529 services. Of these, 468 services were providing support to victims/survivors and family members affected by child sexual abuse, and 61 services were supporting young people who had engaged in harmful sexual behaviour.

This appendix focuses on the 468 services focused on victims/survivors and their families; for information about the other 61 services, see Appendix 3.

Sector

Sector	All identified	Interviewed	Responded to check email	Identified but did not respond
Not-for-profit	379 (81%)	136 (82%)	70 (79%)	173 (81%)
Statutory	64 (14%)	25 (15%)	15 (17%)	24 (11%)
Private	23 (5%)	3 (2%)	4 (4%)	16 (8%)
Statutory/not-for-profit partnerships	2 (0%)	2 (1%)	0 (0%)	0 (0%)
Total	**468**	**166**	**89**	**213**

Service focus

Service focus	All identified	Interviewed	Responded to check email	Identified but did not respond
Child sexual abuse only	93 (20%)	51 (31%)	15 (17%)	27 (13%)
Sexual violence, including child sexual abuse	108 (23%)	39 (23%)	18 (20%)	51 (24%)
Wider remit, including child sexual abuse	267 (57%)	76 (46%)	56 (63%)	135 (63%)
Total	**468**	**166**	**89**	**213**

Geographical coverage

Geographical coverage	All identified	Interviewed	Responded to check email	Identified but did not respond
Local (within one local authority)	105 (22%)	28 (17%)	20 (22%)	56 (26%)
Small regional (2–10 local authorities)	159 (34%)	70 (42%)	30 (34%)	60 (28%)
Large regional (>10 local authorities)	98 (21%)	34 (20%)	17 (19%)	47 (22%)
Multi-regional (across more than one region of England and Wales)	15 (3%)	5 (3%)	1 (1%)	9 (4%)
Across England or across Wales	30 (6%)	5 (3%)	8 (9%)	17 (8%)
Across England and Wales	60 (13%)	24 (14%)	13 (15%)	24 (11%)
Total	**468**	**166**	**89**	**213**

We mapped services according to all types of local authority, including district councils. In total there are 339 local authorities in England and Wales: 317 in England and 22 in Wales.

Age groups supported

Age groups supported	All identified	Interviewed	Responded to check email	Identified but did not respond
Adults only	97 (21%)	36 (22%)	16 (18%)	45 (21%)
Children and adults	267 (57%)	107 (64%)	55 (62%)	105 (49%)
Children only	104 (22%)	23 (14%)	18 (20%)	63 (30%)
Total	**468**	**166**	**89**	**213**

Services supporting children and young people up to the age of 25 were categorised as services supporting children, not as services supporting adults, unless they also supported adults over the age of 25. This is because some services continue to support children through their transition into early adulthood, and others extend the age limit of their support for children with learning difficulties/disabilities.

Appendix 3: Services for children who have engaged in harmful sexual behaviour

A3.1 Characteristics of services

Across England and Wales, our mapping exercise identified 61 services whose support around child sexual abuse was focused on children who had engaged in harmful sexual behaviour:

- Nearly half of these services (n=29, 46%) were *solely* supporting these children.
- The others had a wider remit which included harmful sexual behaviour; some of them supported children with a range of behaviours that presented a risk to others, while others supported children who had been sexually abused *and* engaged in harmful sexual behaviour.

We were able to conduct interviews with 12 of these services. Compared with the wider 61 services, the interviewed services were more likely to be in the statutory sector.

Range of service users

A large majority of the 61 services (n=55, 89%) were providing support solely to children, while the other six were providing support to both children and their non-abusing parent. Five services specifically supported boys who had engaged in harmful sexual behaviour.

Private, public and/or not-for-profit sector?

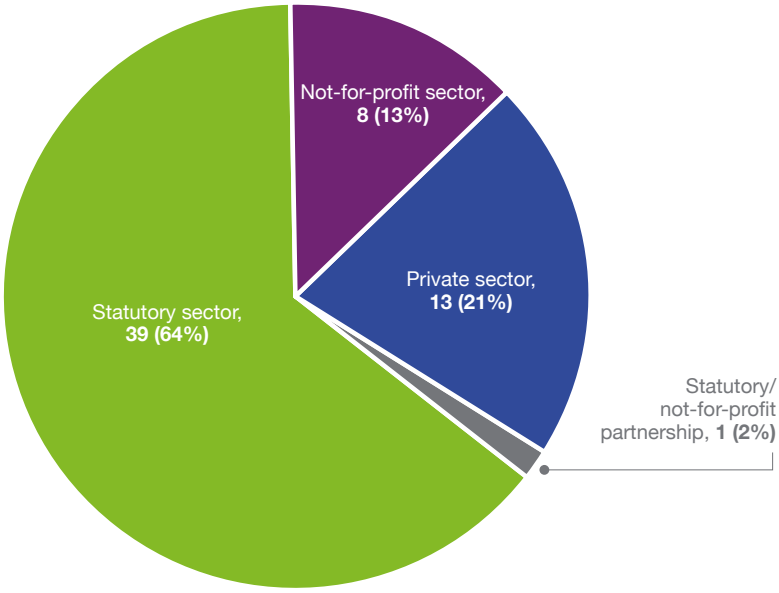
As Figure A1 shows, two-thirds of the 61 services were in the statutory sector.

- Most of these were NHS services (n=25), while nearly a quarter (n=9) were local authority services. Four were criminal justice services, and one service was provided through an NHS and criminal justice partnership.
- Only one statutory-sector service provided support to parents alongside the support provided to children.

A fifth were private-sector services:

- Ten of these services were therapeutic residential care homes, eight of which focused specifically on supporting children who had engaged in harmful sexual behaviour; the other two had a wider remit of supporting children with a wider range of harmful behaviours or presenting a risk of harm to others. Four residential care homes were providing support solely to boys.
- The remaining three services in the private sector provided assessment and therapeutic intervention support for children who had engaged in harmful sexual behaviour.
- Only one private-sector service provided support to parents as well as children.

Figure A1. Type of sector of harmful sexual behaviour support services



n=61.

One-eighth of services were in the not-for-profit sector:

- Seven of these (four of which were run by Barnardo's) provided therapeutic one-to-one interventions; one of them also provided group-based support. The other service provided group-based support only.
- Three not-for-profit-sector services provided support to parents/carers as well as children.

One service was delivered through a statutory/not-for-profit partnership, which provided support to both parents and children.

Geographical coverage

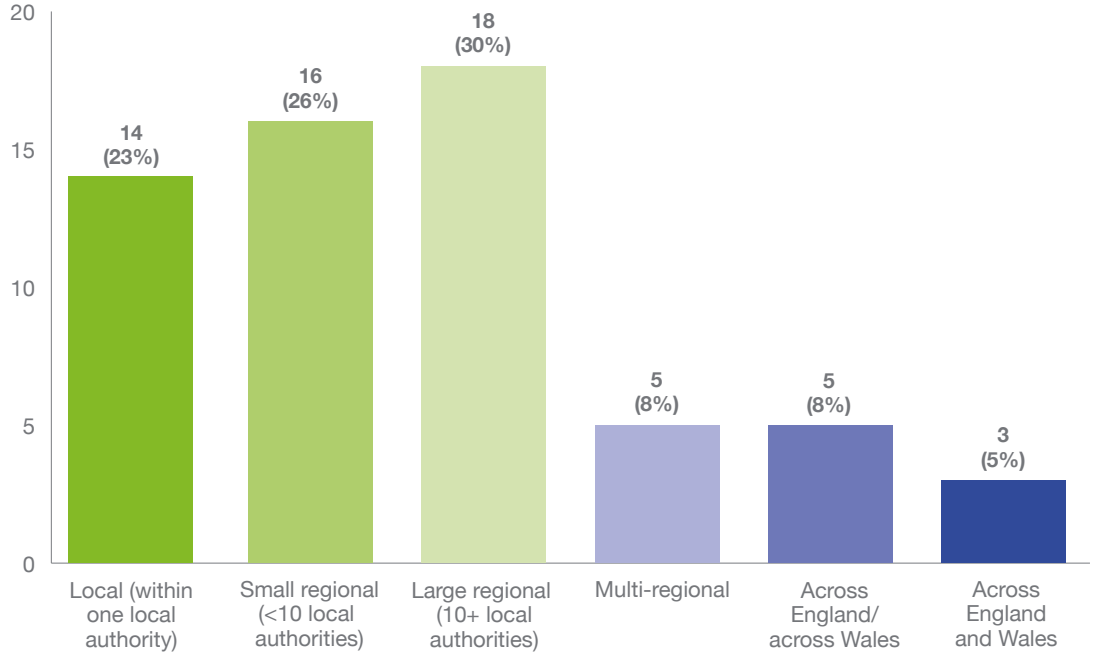
As Figure A2 shows, four-fifths of harmful sexual behaviour support services were operating at a local or single-region level. At the other end of the scale, one-eighth operated across the whole of England and/or Wales.

Local and regional services were mainly in the not-for-profit or statutory sectors, while national services were mainly in the private sector.

As Figure A3 shows, local, regional and multi-regional support services for children who had engaged in harmful sexual behaviour were identified in all regions of England and Wales.

In the absence of any accurate prevalence statistics for the full spectrum of harmful sexual behaviour, it is impossible to assess how well services for children who have engaged in that behaviour are meeting need. However, available data suggests that under-18s are responsible for a significant proportion of child sexual abuse (McNeish and Scott, 2023), so current support provision is likely to be inadequate.

Figure A2. Harmful sexual behaviour support services' geographical coverage



n=61.

A3.2 Types of support provided

As Figure A4 shows, the vast majority of the 61 services offered one-to-one therapy, counselling or emotional support to children or their family members. Other relatively common types of support were group-based interventions, one-to-one support through advocacy or casework, and residential care. Very few services offered a helpline or chat service, or other types of support such as support to young people in schools.

One-to-one therapeutic support

All of the 12 services we interviewed offered one-to-one therapeutic support, including therapy, counselling and emotional support. Between them, these 12 services provided 19 different therapeutic interventions.

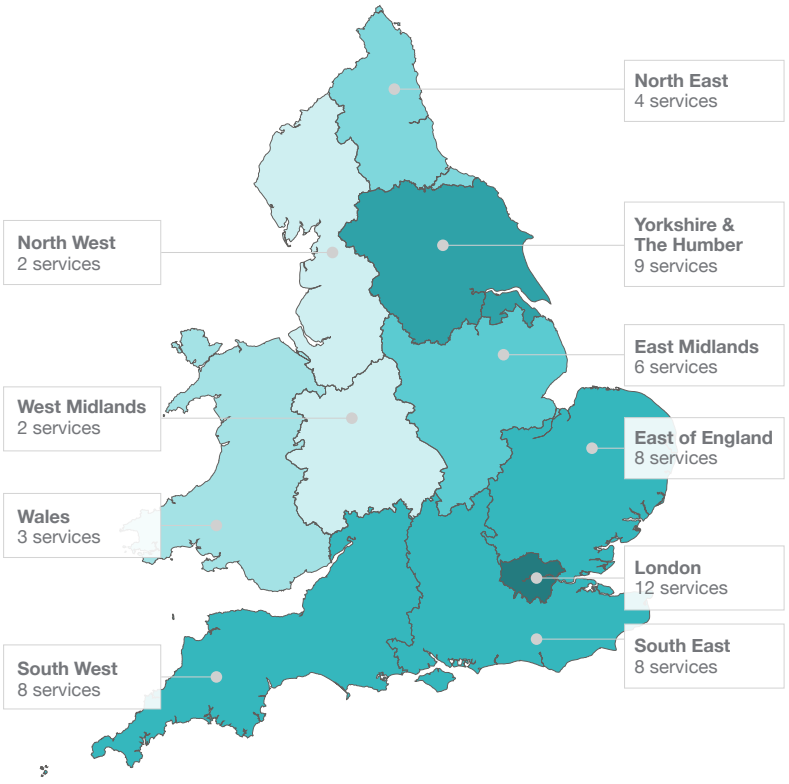
A range of therapies, models and approaches was described by services: the most frequently reported interventions were cognitive behavioural therapy (CBT) and the AIM3 model of assessment, but other psychotherapies and evidence-based approaches included life-story therapies, eye movement desensitisation and reprocessing (EMDR), dialectical behaviour therapy, whole-family models and relationship-based approaches. Services also drew from models developed by other organisations, such as the Lucy Faithfull Foundation and the NSPCC.

Ten of the 19 therapeutic interventions provided support to both children who had engaged in harmful sexual behaviour *and* their parents. Almost all (n=16, 84%) were used with children aged 13–17, while half (n=10, 53%) were used with 5–10-year-olds. Two services said they extended their upper age range for young people who had special educational needs or were care-experienced, supporting these young people until they were 21 or 25 years old.

Three services told us they provided therapeutic support for boys only; none provided it solely to girls. Nearly two-thirds (n=12, 63%) of one-to-one therapeutic interventions were available only to children in specific geographical areas.

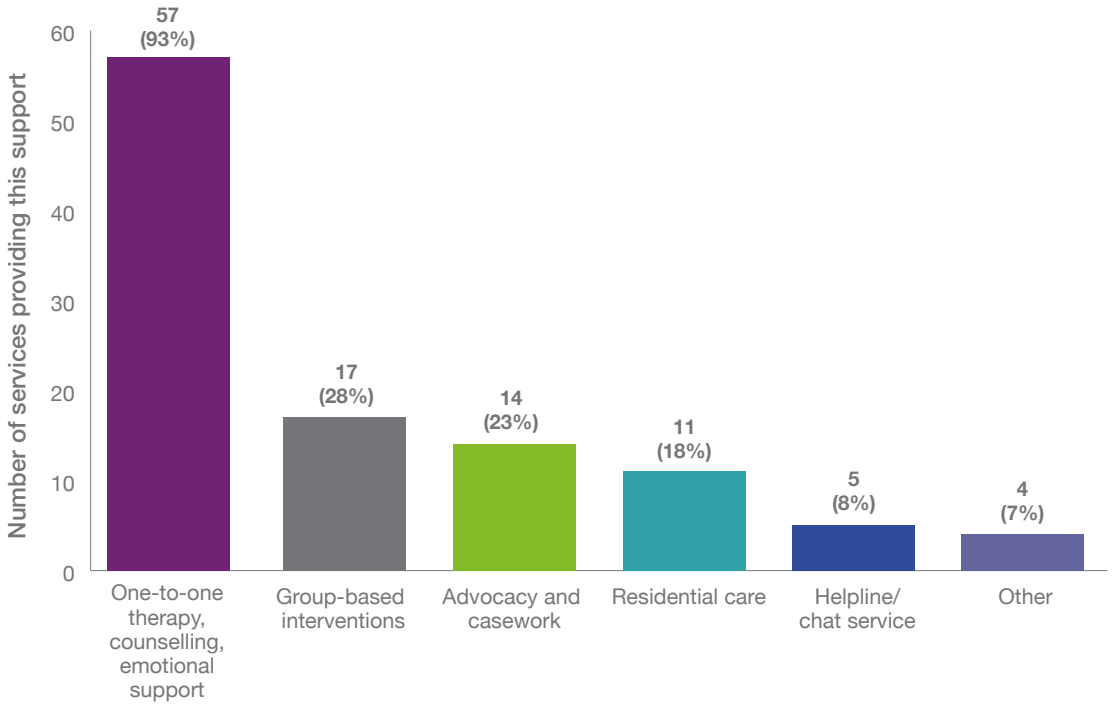
All but one of the 19 therapeutic interventions were delivered in person, but a third were also offered online (n=7, 37%) and two could be delivered by telephone. Seventeen were offered during weekdays only.

Figure A3. Distribution of services supporting children who had engaged in harmful sexual behaviour



n=54 local, regional and multi-regional services; the 7 services working across England, or across England and Wales, are not shown.

Figure A4. Types of support provided by harmful sexual behaviour support services



n=61. Many services provided more than one type of service.

Other types of support

Other interventions were provided by six of the 12 harmful sexual behaviour support services we interviewed:

- Two services provided their therapeutic interventions as part of a **residential care home** for boys aged 11–17; one of them also offered one-to-one advocacy and casework.
- A total of seven **group-based interventions** were provided by four services. Two of these interventions were for children and their parents:

  "Trauma-focused CBT programme for children who have engaged in problematic sexual behaviour and their parents/carers, delivered over 18 sessions." [ID267, stat.; CSA focus]

  Another was provided as an online group for the parents of children accessing the service.

- One service provided a **pre-referral helpline** for professionals and parents, who could contact the service with any safeguarding concerns:

  "They can call our safeguarding leads and just say, 'I'm really worried. This child is presenting with 123,' and then they could talk through their concerns." [ID21, stat.; CSA focus]

> A pre-referral helpline enabled professionals and parents to contact one service with any safeguarding concerns

A3.3 Waiting lists

Six of the 12 services that we interviewed had a waiting list:

- Four of these services were in the statutory sector – three in the NHS, including a specialist CAMHS service, and one provided by a local authority. Another was in the private sector (providing residential care), and one was a not-for-profit service.
- Five of the services held a waiting list for their whole service, while one said its waiting list was specifically for its therapy/ counselling support.
- Five told us how many children were on their waiting lists, with the number ranging from three to nearly 40; a total of around 50 children were on these services' waiting lists. Waiting times ranged from two months to a year, although one service explained that it would not put a child on the list if it thought they would have to wait more than three months for support.

Two services felt that their waiting lists had got longer in the last few years. One said this happened because it could not fill a specialist staff post, while the other pointed to commissioning constraints:

> "We've seen referrals go up steadily over the last few years. And the numbers of cases that we are commissioned to do is far below the actual number of referrals we get in every month. So we're just not able to respond as quickly as we would like." [ID115, stat.; CSA focus]

One service, provided by a not-for-profit organisation with NHS-seconded staff, explained that it did not operate a waiting list but sometimes had to ask people to come back to them after a few months:

> "We're not allowed to keep a waiting list. But we will say, and we have been saying towards the end of 2022, 'We can't accept at the moment, refer back to us in end of January,' for example." [ID320, stat./NFP partnership; CSA focus]

Another four services said their support was available to service users as soon as they needed it; two of these were statutory services, with one each in the not-for-profit and private sectors. However, one of these services explained that they were about to start a waiting list:

> "We haven't had one up until now… but it's a part-time service with one worker… and our capacity is no more than about eight cases… And so we're just about to reach full capacity." [ID65, NFP; CSA focus]

> "Half of the harmful sexual behaviour support services had waiting lists; another was about to start one"

Appendix 4: Therapies, models and approaches used in therapeutic/emotional support

Types of therapy

Acceptance and commitment therapy

Adlerian therapy

Analytic-informed therapy

Art psychotherapy

Art therapy

Attachment intervention

Behavioural-informed therapy

Brain and body-based approaches

Children's Accelerated Trauma Technique (CATT)

Clinical psychology (therapeutic)

Cognitive analytic-informed therapy

Cognitive behavioural therapy (CBT)

Cognitive behavioural-informed therapy

Dance and movement therapy

Dialectical behavioural therapy (DBT)/Dialectical behavioural-informed therapy

Drama therapy

Dyadic developmental informed therapy

Dynamic interpersonal therapy (DIT)

Emotion-focused therapy (EFT)

Experimental counselling

Eye movement desensitisation and reprocessing (EMDR)

Human Givens approach (HG)

Hypnotherapy

Integrative Manual Therapy (IMT)

Music therapy

Narrative therapy

Narrative exposure therapy

Parks Inner Child Therapy (PICT)

Person-centred experimental counselling (PCEC)

Play therapy (including non-directive)

Pre-trial therapy (based on Crown Prosecution Service guidelines)

Psychoeducation

Rewind therapy

Selfcare and compassion focused therapy (third-wave CBT/low-end CBT)

Somatic therapy

Systematic therapy

Talking therapy

Trauma processing

Trauma recovery

Trauma-focused therapy

Walk and talk therapy (outdoors)

Models

Barnardo's '4 As' model (Assertive outreach, Advocacy, Attention, Access) – for child sexual CSE interventions

CSSO model (Child-directed, System-focused, Strengths-based, Outcome-informed) – Barnardo's child-centred therapeutic model

DARTS model (Dissociation, Attachment, Resilience, Trauma, Shame) – devised by Claire Harrison-Breed

Dissociation-informed model

Emotional support model

Empowerment model

Family reparation model (completed pilot)

Finkelhor's Four Preconditions Model

Good Lives Model (GLM)

Improving Access to Psychological Therapy (IAPT) – NHS

Informed model

Integrative model

Internal Family System model

Letting the Future In (LTFI) model – developed by the NSPCC

NSPCC evidence-based therapeutic model

Outreach model

Psychobiological Approach to Couples Therapy

Person-centred model

Phase model

Psychodynamic

Psychological model

Relational model

Safe Home and Change for Good (similar to Letting the Future In)

Safety and Security model (used for crisis management/model to respond to recent trauma)

Sexual abuse model

Therapeutic model

Tiered model

Traditional counselling model

Trauma processing models

Trauma recovery clinical model

Trauma Recovery Focused Model – created by Betsy de Thierry

Triphasic trauma model – devised by Judith Herman

Youth work model

Approaches

Asset-based approach

Brain and body-based approach

Can-do approach

Capacity building approach

Centred approach

Client-led approach

Combined approach

Counsellor approach

Creative therapy approach

Directive/structured counselling (as opposed to non-directive counselling)

Empathetic listening

Empowerment approach

Episodic care approach

Flexible/blended/multiple/eclectic approach

Goal-focused/goal-based approach (short-term)

Healing journey

Helping Mothers Move Forward – book written by Lucy Regan

Humanistic integrative approach/humanistic (person) approach – not an analytical approach

Hybrid model (online and in person)

Informed approach

Integrated approach

Medical approach

Mindfulness approach

Narrative approach

Psychoeducational approach

RPR approach (risk, protect, resilience)

Single-point of contact approach

Staged approach (e.g. three-stage programme)

Systematic approach

Tailored approach

The REACH approach (Resilience, Education, Acceptance, Child Centred and Holistic) – used in Birmingham

Trauma Informed Growth and Empowered Recovery (TIGER/TIGER Light) – Barnardo's approach to support following child sexual exploitation

Trauma-informed approach

Two practitioners work on one case (with parent/carer and with child) -HSB?

Whole family approach

Youth work approach

Other work (not described as therapy)

Behavioural work

Deep trauma work/depth work

Disruption work

Explorative work

Grounding techniques

Healing work

Mindfulness neuroscience (cognitive neuroscience)

Non-talking therapies, e.g. trauma release exercise, trauma-focused yoga, managing flashbacks

Recovery work

Reiki (a natural healing technique, delivered by a counsellor)

Release exercises

Restorative justice interventions

Sleep work

Stabilisation work (coping strategies in the here-and-now)

Therapeutic Life Story Work

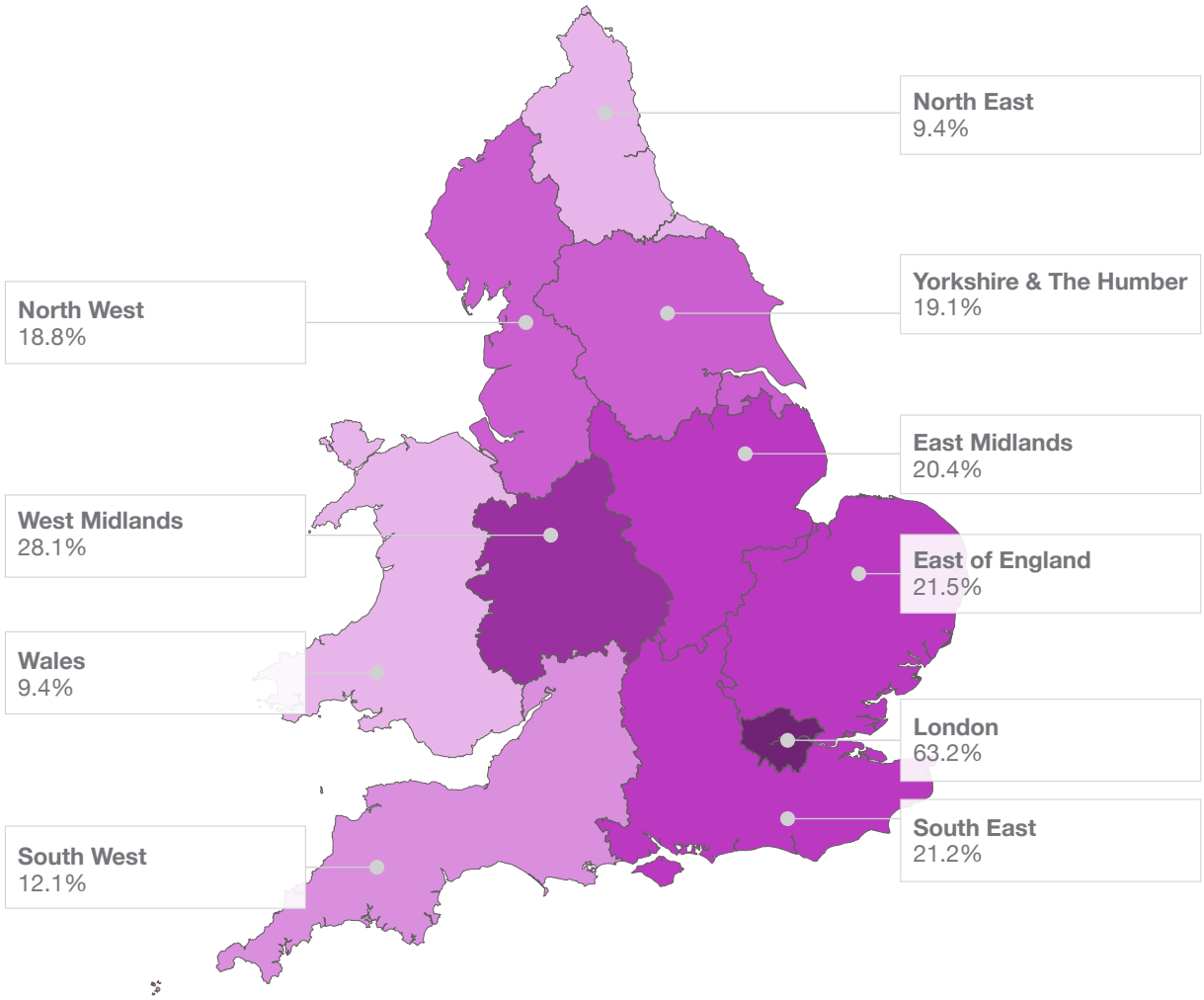
Trauma management techniques

Trauma responses

Wellbeing Wheel

Youth work

Appendix 5: Population of England and Wales from minority ethnic backgrounds, by region



Source: Office for National Statistics (2023a).

Centre of expertise on child sexual abuse

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The photograph on the cover was taken using actors and does not depict an actual situation.

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