Centre of expertise on child sexual abuse

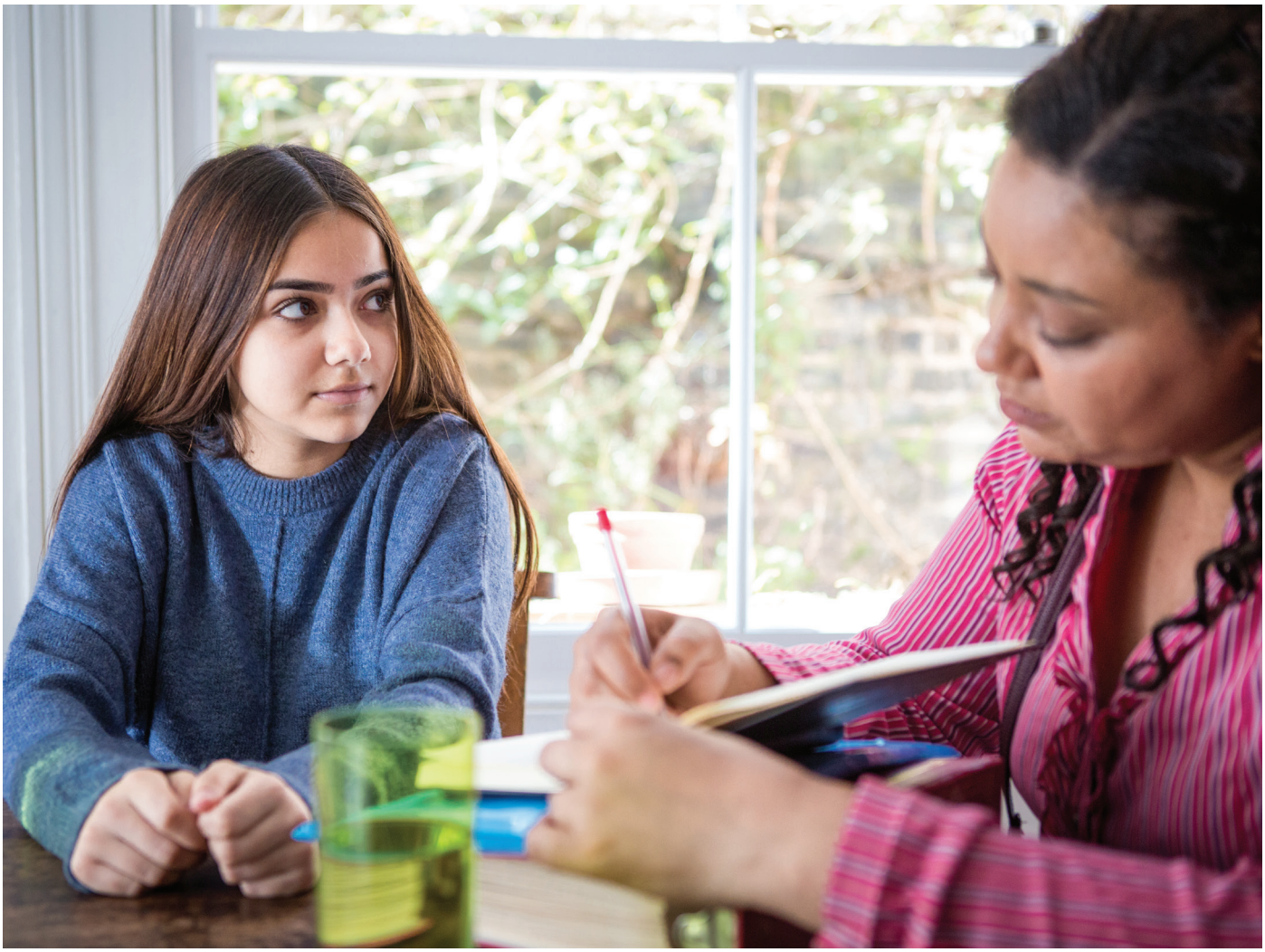
CordisBright

Local commissioning of services addressing child sexual abuse and exploitation in England

A rapid review incorporating findings from five locations

Kam Kaur and Christine Christie, Cordis Bright Consulting

January 2018



Acknowledgements

We would like to thank the professionals in all the five areas studied who agreed to participate in this research. All areas had other competing priorities at the time we undertook this piece of work, and we hugely appreciate the dedicated time they afforded our team with initial enquiries, visits to areas and follow-up work. We also acknowledge the helpful feedback from commissioners in other areas who attended a forum on our draft report in October.

About Cordis Bright Consulting

Cordis Bright provides consultancy, research and evaluation aimed at improving public services. We specialise in children's services, criminal justice, adult social care and the NHS. In children's services, we work with central government, local authorities, the NHS, police and the independent sector, with a particular focus on effectively safeguarding vulnerable children. Recent projects include work on child sexual abuse and exploitation, victims of child trafficking and modern slavery, looked-after children with complex needs, young people with acute mental health needs, and young people with prolific offending histories. Further information is available at **www.cordisbright.co.uk**

About the Centre of expertise on child sexual abuse

The Centre of expertise on child sexual abuse has been established to help bring about significant and system-wide change in how child sexual abuse is responded to locally and nationally.

We do this by identifying, generating and sharing high-quality evidence of what works to prevent and tackle child sexual abuse (including child sexual exploitation), to inform both policy and practice.

The Centre is funded by the Home Office and led by Barnardo's, and works closely with key partners from academic institutions, local authorities, health, education, police and the voluntary sector.

Table of contents

Executive summary

On behalf of the Centre of expertise on child sexual abuse, Cordis Bright undertook an independent review in spring 2017 of how child sexual abuse and exploitation (CSA/CSE) services were commissioned in five local areas in England.

The review sought to clarify local approaches developed through local authorities, health and wellbeing boards, Offices of the Police and Crime Commissioners (OPCCs), NHS England and clinical commissioning groups (CCGs). It aimed to identify challenges, weaknesses and strengths in current local commissioning which might be of broader interest. Commissioners' views were also sought on the support they were looking for, including how the Centre of expertise might help.

Following a review of the literature, Cordis Bright conducted interviews with 30 commissioners, commissioning partners, service providers and local practitioner experts across the five local areas. In view of the link with CSA/CSE, harmful sexual behaviour (HSB) was included in the review as it progressed.

Limitations

The review was a rapid research exercise informed by evidence from five sites. Whilst these sites provide a degree of diversity, the findings will not fully reflect experiences in all locations in England, and do not incorporate experiences in Wales.

The findings reflect a point in time (spring 2017) and should be considered with reference to emerging developments which may influence change, such as the impending release by the NHS of its strategy on sexual abuse.

The review focused on local commissioning and does not provide direct insight into centralised commissioning processes. However, some of its findings may be useful to decision-makers in that context.

Findings

The findings, drawn from the interviews, are summarised thematically here. A key caveat to the findings is the fact that the fieldwork was limited to five local authority areas in England.

A theme underpinning many of the findings, and reported in all five areas, is the impact of the current economic climate on local service provision. Stakeholders reported that local commissioners' budgets are diminishing, as is the independently generated income of voluntary and community sector (VCS) service providers.

Commissioning challenges

Local commissioners were said to face a number of common challenges:

- The high profile accorded to CSE by central government has been beneficial, but has not yet been extended to CSA and HSB.
- Whilst CSE service commissioning practice appear well-developed, CSA and HSB services are not commissioned (or delivered in-house) with the same transparency and robustness.
- The use of short-term contracts (usually lasting three years) limits VCS partnership/investment opportunities.

- Good commissioning partnerships (with other commissioners or the VCS) will require a significant amount of investment to develop and maintain.
- Cuts to commissioning teams limit the scope and quality of commissioning activity.
- There needs to be more detail on CSA/CSE and HSB, including online elements of abuse, in local population needs assessments.
- Health bodies and schools are not always seen by others as engaged as full partners in the commissioning of local CSA/CSE and HSB services.
- There is no quality assurance framework to ensure that schools have appropriate safeguarding care pathways or commissioned CSA/CSE/HSB response services.
- There is no consensus on good outcomes measurement – in particular focusing on 'distance travelled' for an individual (emotional wellbeing, improvement in relationship with family and friends, access to positive alternative activities and engagement in learning) – for CSA/CSE and HSB services.

Stakeholders wanted:

- CSA and HSB to be included in CSE commissioning governance, reported as usually being overseen by the Director of Children's Services and a local safeguarding children board (LSCB) subgroup
- mental health trusts to have in place governance and partnership arrangements focusing on CSA/CSE recovery
- more focus from the OPCCs on children and young people, including funding for the vital role of sexual assault referral centres (SARCs)
- all areas to have an explicit, integrated CSA, CSE and HSB strategy
- national CSA/CSE and HSB commissioning guidance which minimises contract-monitoring activity.

Gaps in commissioned services

Local areas expressed concerns including the following:

- There has been a significant reduction in prevention services for CSE and HSB. More investment is required from schools, public health budgets and CCGs.
- There has not been any CSA prevention work.
- There has been a significant reduction in school nursing services. Nurses have been a key contact for identification/disclosure of CSA/CSE.
- Responding to online abuse needs to be included in local CSA/CSE and HSB services.
- The regionalisation of the SARCs may be supported on medical grounds, but has increased travel time for children and young people. Additionally, more follow-up counselling support sessions funded through SARCs are needed.
- There is a significant shortfall in follow-up or recovery services for children who have experienced CSA/CSE and/or HSB. Where budgets are not protected for existing services, the services risk losing the flexibility needed for victims to disclose and recover.
- Transition from children's to adults' services is difficult for survivors of CSA and CSE.
- The volume of HSB is growing, but services are reducing.

Commissioning practice highlights

Local areas felt that **good governance** includes:

- visible, active senior leadership
- joint children's social care and public health commissioning teams
- mental health trusts focusing on CSA/CSE recovery.

Local areas felt that **innovative needs assessments** include:

- local multi-agency CSA/CSE/HSB reviews and audits
- mapping of local CSA/CSE and HSB services
- integrated or linked CSA/CSE and HSB strategies
- regional commissioning of CSA/CSE and HSB services
- support for the VCS to bid for independent funding.

Local areas felt that **good commissioning processes** include:

- good statutory and VCS partnership
- outcomes measurement focused on the 'distance travelled' for a service user
- contract terms lengthened to a minimum of five years.

Local areas felt that **good services** include:

- renewed focus on CSA/CSE prevention and early intervention
- support for schools to respond to HSB
- joint management by CSA/CSE and HSB services of their overlapping cases
- support for young people aged 18+ who are CSE survivors
- floating support from child and adolescent mental health services (CAMHS)
- provider consortiums
- local CSE initiatives and similar initiatives for CSA and HSB
- skilling-up of generic service staff – including adverse childhood experiences (ACEs) training – so they can respond well to undisclosed CSA/CSE
- a shift in focus, from CSE only to include CSA
- recognition that protective parents are an essential part of children's recovery.

Commissioning support (from the Centre of expertise or elsewhere)

Local areas requested support with the following:

National conversation

- Practical research to build a better picture nationally around CSA, CSE and HSB.
- A recognised model for a counselling, advice, mentoring and advocacy recovery service for CSA/CSE victims.
- Improving the public's understanding about CSA, CSE and HSB.

Scrutiny and policy

- Developing a national 'best practice tool', with training, for all professionals to identify and assess CSA/CSE.
- Securing a mandatory focus on CSA/CSE in the 0–19 years Healthy Child Programme.

Information, advice and guidance

- Promoting a better understanding across the children's and health workforces of the impact of trauma in relation to CSA/CSE and HSB.
- Further promoting best practice and training for the non-specialist workforce on how to talk to, and listen to, children and young people (to establish suspected or disclosed abuse or abusing).

Networking and engagement

- Supporting networking, information-sharing and peer review between local safeguarding CSA/CSE and HSB and single- or multi-agency commissioning teams.

Conclusion

Although the findings from this review are limited by the fact that only five local authority areas were engaged with, many of the findings are likely to resonate with other areas.

From our research with those five local areas, it appears that CSE commissioning practice and initiatives are good. However, prevention services have been significantly reduced, and there is a need to invest in CSA and HSB commissioning practice and service provision. There was a growing concern among stakeholders about increasing demand for CSA, CSE and HSB services, including in particular a service response to the online facilitation of these abuses.

Of real concern to local areas was the feeling that funding for services is inadequate in the light of growing demand and cuts to local non-commissioned VCS provision. A need for greater engagement from health bodies and schools was raised consistently by other commissioning partners: both these partners have a vital role to play.

Whilst the local authority areas would clearly welcome any support that the Centre of expertise on child sexual abuse could provide, there are some key gaps that can be addressed only by central government.

1. Introduction

This independent review was commissioned by the Centre of expertise on child sexual abuse, to increase understanding of how child sexual abuse and exploitation (CSA/CSE) services are commissioned in England, and how commissioners of services can usefully be supported to meet the challenges they face.

The findings will be of broad interest, not only to commissioners but to all those involved in developing good commissioning processes, and those working with commissioners to implement or report on services.

Context for the research was established with a literature review. This was followed by interviews with commissioners, commissioning partners, service providers and local practitioner experts across five local areas of England. Thirty participants were involved, with a minimum of six in each local area.

1.1 Project aim

The project aimed to ask some pertinent questions to inform the Centre of expertise about:

- the 'who, what, why and how' of commissioning practice for CSA/CSE services
- the challenges and the strengths of current CSA/CSE work
- what the future of local commissioning might look like
- the support that local stakeholders might want from the Centre of expertise and others.

It is accepted that the five case studies presented here offer just a snapshot of work being commissioned and delivered.

1.2 Definitions

The Government's definition of CSA in England, as set out in *Working Together to Safeguard Children* (Department for Education, 2015), is as follows:

> '[CSA] involves 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 (including via the internet).'

The definition of CSE, as set out in *Child Sexual Exploitation: Definition and Guide for Practitioners* (Department for Education, 2017), is:

> 'Child sexual exploitation is a form of child sexual abuse. It occurs 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 (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'

There is a different statutory definition of CSE in Wales, set out the *All Wales Protocol: Safeguarding and Promoting the Welfare of Children and Young People who are at Risk of Abuse through Sexual Exploitation* (Welsh Assembly Government, 2009). In January 2017, the Welsh Government commissioned a review of this definition and its statutory guidance on CSE safeguarding; the review has recommended developing an updated definition (Hallett et al, 2017).

In recent years, national attention has been placed on providing services for victims or potential victims of CSE specifically; this has been due in part to large-scale investigations (e.g. in Rotherham and Rochdale) identifying a significant risk of exploitation of vulnerable groups, and the historical failure of services in some geographical areas to protect children and young people effectively. However, a recent rapid evidence assessment of risk indicators for CSA and CSE (Webb and Holmes, 2015) cautioned that conceptualising these as separate forms of abuse risks creating artificial distinctions between forms of abuse that remain similar from a victim's perspective, or creating 'silos' in policy and practice, thus further risking that some forms of abuse are overlooked.

For the purpose of this review, emphasis has been placed on services for CSA more generally, inclusive of those services specifically targeting children at risk of or experiencing sexual exploitation (incorporating online CSE in the form of indecent images of children, live streaming of abuse, and grooming/coercion for the purposes of sexual abuse).

1.3 Context

This rapid review has been carried out at a time when, research suggests, commissioners face challenges which they may welcome support to address. For example:

- Significant numbers of children and young people experience CSA/CSE, and the police have been receiving increasing numbers of reports of child abuse (affected by the Independent Inquiry into Child Sexual Abuse). At the current rate of increase, it is anticipated that the police will be investigating 200,000 cases by 2020 (Laville, 2016).
- Service provision is needed to support young children, young teens and older adolescents (Pona and Baillie, 2015). Child protection processes and procedures have traditionally worked for young children in a family context, rather than adolescents (Hanson and Holmes, 2013). Improved services in recent years for adolescents experiencing CSA/CSE need consolidation for 16–17-year-olds (Local Government Association, 2014; HM Government, 2015). Service pathways for over-18s also need to be explored.
- Service innovation such as trauma-informed services (and other new approaches, such as to tackle online grooming and abuse) will require multi-agency collaboration and cultural change. There is strong and growing evidence of a link between trauma and mental health and wellbeing (Sweeney et al, 2016). There is also emerging evidence that trauma-informed systems are effective. The Department of Health is promoting a trauma-informed approach for children who have experienced CSA/CSE (Christie, 2018), particularly where the child also has other adverse childhood experiences.
- There is variation in the knowledge and confidence of professionals who work with children and young people experiencing sexual abuse. Research into social workers' knowledge and confidence around CSA found that they had difficulties in identifying sexual abuse, particularly when more evident indicators of neglect or physical abuse were presented (Martin et al, 2014). The research also suggested that social workers were operating too frequently without the support, time, knowledge and training they needed to ensure the identification of sexual abuse and the protection of extremely vulnerable children.
- There has been considerable variation in the level and nature of service provision between local areas. Similarly, joint targeted area inspection (JTAI) 'deep dives' into CSE and missing children in 2016 found variation in practice across areas. Where engagement with young people was

good, professionals were persistent and skilled in engaging and building relationships with young people, and understood their specific needs and strengths as well as the impact of abuse and trauma (Ofsted, 2016). However, in a small number of cases there was evidence of poor-quality assessments and planning and inappropriate language used, such as around giving consent.

1.4 Methodology

Rapid literature review

The research team conducted a rapid literature review in spring 2017 in order to develop a context within which the case study areas were operating. The aim was to create a framework for understanding the challenges and responses that the research team anticipated would be raised by the stakeholders in the case study areas.

The findings from the rapid literature review are set out in Chapter 2, and details of its methodology can be found in Appendix 1.

Case studies

The research team worked with the Centre of expertise on child sexual abuse to secure the agreement of local areas to be case studies. The research team:

- reviewed relevant local documentation provided by commissioners and their partners
- analysed locally available datasets about the commissioning process and outcomes
- scrutinised inspection reports, national commissioning models, national/local key performance indicators and serious case reviews to glean further information about outcomes and/or relative effectiveness
- undertook interviews in March 2017 with at least six individuals (commissioners, partners, service providers and representative groups) in each case study area, who could provide expert information on:
    - local approaches to commissioning
    - issues, challenges, strengths and weaknesses in commissioning approaches
    - the extent to which commissioning met local need
    - how commissioning would and/or should develop in future.

See Appendix 2 for a profile of the respondents across the case study areas.

The fieldwork focused on undertaking interviews, as this would be the best way of collecting information in a way that facilitated exploring the local context in depth and with nuance.

The fieldwork comprised visits to case study areas as well as follow-up desktop research. This approach enabled the research team to meet with individuals face to face (combined with telephone and email contact), whilst also collating relevant data. The information was then used to draft a commissioning case study for each area. The team consulted each area to ensure that the case studies were accurate, before anonymising each case study. The case studies are confidential and will not be published.

The results from the case studies and the literature review were combined in a thematic review, examining the cross-cutting issues, current strengths and areas for improvement in the commissioning of services. Forming Chapter 3 of this report, the thematic review seeks to facilitate the identification of barriers to improvements and any levers that might be employed in addressing these.

Feedback from other commissioners

Another key element of the review was a workshop, held at the Home Office on 5th October 2017, with 15 commissioning experts from outside the five case study areas. Following a presentation on the thematic review's methodology and findings, feedback was gathered from the participants; this feedback is summarised in Appendix 4.

1.5 Limitations

The review was a rapid research exercise informed by evidence from five sites. Whilst these sites provide a degree of diversity, the findings will not fully reflect experiences in all locations in England, and do not incorporate experiences in Wales.

The findings reflect a point in time (spring 2017) and should be considered with reference to emerging developments which may influence change, such as the impending release by the NHS of its strategy on sexual abuse.

The review focused on local commissioning and does not provide direct insight into centralised commissioning processes. However, some of its findings may be useful to decision-makers in that context.

2. Rapid literature review

The purpose of the rapid literature review was to:

- understand local approaches to the commissioning of CSA services
- help identify geographical areas with effective, interesting or innovative commissioning practices which could offer the potential for case studies.

This chapter starts with definitions, raises key issues relating to the 'who, what, why and how' of local commissioning, and finally summarises the key themes as a context for the fieldwork findings in Chapter 3.

In view of the link with CSA/CSE, harmful sexual behaviour (HSB) was included in the review as it progressed.

2.1 Who commissions and provides services, and for whom?

Who are the commissioners?

Local authorities

Local authorities' statutory responsibility to safeguard children has given them a key leadership role around CSA, ranging from understanding the profile and prevalence of sexual abuse in their local area to working with partners to ensure that responses are coordinated (Cameron et al, 2015).

Local authorities have played a central role in commissioning services for children who are vulnerable to or victims of CSA, by providing services through their children's social care departments as well as commissioning through grants or external funding applications (Golding and Duggal, 2011). Evidence from the literature suggests that, as increasing emphasis has been placed on the importance of local strategies to promote understanding and coordinate a response to CSA, responsibility for the commissioning and monitoring of services has fallen primarily to local authorities – with local safeguarding children boards (LSCBs) playing a particularly important role (Solihull LSCB, 2017; Stoke-on-Trent and Staffordshire Safeguarding Children Boards, 2016). A recent NHS England report identified LSCBs as 'key stakeholders' to support and drive change in the development of CSA hubs (Harewood, 2017:22).

Local authority public health

Health and wellbeing boards (HWBs), as leaders in the local health and care system, have played a key role in ensuring that CSA has been part of the local joint strategic needs assessment (JSNA) and joint health and wellbeing strategy (JHWS) – and that the commissioning, planning and delivery of local services has fully met the needs identified in the JSNA and JHWS (Department of Health, 2014).

Clinical commissioning groups and NHS England

The health sector has also played a key role in the commissioning of services for CSA. In a recent survey mapping therapeutic service provision for CSA across the UK (Allnock et al, 2015), the greatest proportion of statutory services within the sample were funded by NHS England, which is perhaps unsurprising given that more than half of these services were child and adolescent mental health services (CAMHS).

NHS England and clinical commissioning groups (CCGs) have also been highlighted repeatedly in the literature as being involved in the commissioning of statutory specialist services, such as sexual assault referral centres (SARCs) and those involving the training of healthcare staff (e.g. hospital doctors, GPs and sexual health nurses) (Harewood, 2017).

Offices of the Police and Crime Commissioners

The Offices of the Police and Crime Commissioners (OPCCs) have provided funding (together with the Secretary of State for Health via NHS England) for regional SARCs, and some OPCCs have also funded Independent Sexual Violence Advisors (ISVAs) for young people aged 13–18 years – known as CHISVAs – as well as adults. OPCCs' contributions in local authority areas outside London have included funding for a CSE Coordinator post; the development of a multi-agency framework; and additional funding to HSB services or for counselling of young male victims of CSE. However, the OPCCs have focused largely on adult victims of violence against women and girls (VAWG).

Who are the services commissioned for?

Services commissioned for CSA have typically aimed to target all children and young people considered vulnerable and at risk, in addition to those who are known victims and survivors. Some gaps in provision were identified in this literature review. Recent reports have highlighted differences in approaches based on characteristics such as age, gender, ethnicity, disability and gang affiliation, and the targeting of frontline professionals, families and specific local communities and populations.

Age

There have been mixed views about gaps in commissioning based on the age of the child or young person. For instance, Allnock et al (2015) pointed out that many services had age eligibility criteria which could restrict access, particularly to younger children: as a result, services for younger children were relatively scarcer. A complication highlighted by this research is that young children are developmentally unable to understand or articulate their experience of abuse. The younger a child is when abuse starts, the longer the delay in their disclosing (Allnock and Miller, 2013). Other research has identified gaps in services for older young people, including child protection processes and procedures (Hanson and Holmes, 2013) and services for those aged 16–17 (Local Government Association, 2014).

Ethnicity and disability

Gaps in service provision for minority ethnic or cultural groups have been readily identified – and particularly in the provision of statutory services, which certain communities may be less likely to engage with (MBARC, 2016; Hackney Council, 2016). Another emerging theme has been the significant lack of services commissioned to target children and young people with disabilities, despite growing consensus that they are highly vulnerable to abuse and exploitation (Horvath et al, 2014; Children's Commissioner for England, 2015).

Gang-affiliated and missing children

In line with best evidence-based practice, many CSA service commissioners have recognised that cases of CSA often exhibit other co-presenting problems such as going missing, criminality, trafficking and/or gang association (Beckett et al, 2014; Berelowitz et al, 2012). Strategic plans for tackling CSA in a number of local areas have been linked to policies and operational responses to associated issues, in order to enable a consistent approach (Local Government Association, 2014). This has often involved the commissioning of co-located, multi-agency services, such as the Engage team in Blackburn or the Joint Action Team in Portsmouth, which have provided assessments/interviews and support for both suspected victims of CSA and CSE and those who have returned from missing episodes (ibid).

Boys and men

Although the majority of CSA services primarily target girls and young women, there has been a growing recognition in some local areas (e.g. Leeds, Bradford) that service provision must be tailored and improved to target men and boys who may be victims and/or perpetrators of sexual abuse

(McNaughton Nicholls et al, 2014; Yorkshire MESMAC, 2016). In developing services for this group, some local areas have allocated a key youth worker specialising in working with men and boys (Christie, 2014). Six local sites across the UK have worked in partnership with the voluntary sector organisation MsUnderstood to identify strengths and areas for development in their work with boys and young men, including identifying mechanisms for ensuring safety in the public environments in which young men spend their time (Firmin et al, 2015).

Targeting the greater network

Emphasis has also been placed on commissioning consultation and training services for frontline professionals – including teachers, school and sexual health nurses and social workers – in order to promote early prevention and identification of risk indicators (Ofsted, 2016).

A number of local areas have recognised the importance of targeting and engaging specific local communities and minority ethnic populations – for example, the Protect and Respect service run by the NSPCC included provision for the local Muslim community through seminars at a mosque (Berelowitz et al, 2013).

Who is being commissioned?

Overall, the literature suggests that the agencies commissioned to provide support for CSA were typically:

- CAMHS
- social services, e.g. social workers and child protection agencies
- the voluntary sector, i.e. national and/or local charities
- schools
- health agencies or workers, e.g. GP practices, paediatricians and sexual health clinics
- police.

Generic versus specialist services

Statutory services across the UK have commissioned a range of specialist interventions, some of which have been used for case consultancy and some as the main source of support for sexually abused children (Beckett et al, 2014).

Whilst specialist services may be thought of as more responsive and tailored to victims of sexual violence, it is clear that, in the current climate of heightened awareness and increasing demand, generic services have been identifying and supporting children and young people who have experienced CSA (Allnock et al, 2015). A review of the 'pathway' for victims of CSA in London found that the majority of children's services were generic, and in only a few London boroughs were services for CSA specifically commissioned from paediatricians and CAMHS. This was highlighted as a noted difference from other regions of the UK, where holistic, multi-agency service provision has been evidenced (Goddard et al, 2015).

CAMHS have been perhaps the most widely commissioned generic service for children and young people, and have often received referrals from other statutory agencies such as social services. However, issues relating to the commissioning and provision of CAMHS, particularly significant issues with accessibility, have frequently been referenced throughout the literature. Strict access criteria and long waiting times, for example, have been common barriers to service provision identified in relation to CAMHS and other statutory health services, with increasing concerns about vulnerable children and young people 'falling through the cracks' (Department of Health, 2015).

Commissioning restrictions have meant that, in some areas, statutory service provision has been unable to target all of those in need. SARC provision in London, for example, was not commissioned to provide medical aftercare or sexual health screening for children under 13 years of age, or counselling or emotional support for children and young people under 18 (Goddard et al, 2015). Reliance on referral to a paediatrician could leave gaps in service provision for a highly vulnerable population.

According to a survey of therapeutic services for CSA in the UK, the voluntary sector has been the single largest source of funding for specialist services (Allnock et al, 2015). The reliance on national and local charities to provide specialist support for victims and/or potential victims of CSA has been a common theme within the literature (Coy et al, 2017). Many local areas have emphasised the importance of third-sector organisations in their ability to reach vulnerable and hard-to-engage groups of young people who may avoid statutory services; their strengths in community outreach; and their ability to provide bespoke, longer-term support to victims (Action for Children, 2009; Camden Safeguarding Children Board, 2017; Allnock et al, 2015).

National and local charities

National voluntary sector agencies such as the NSPCC, Barnardo's and The Children's Society are typically associated with provision of CSA/CSE services across localities in England. Other national charities including Street UK, Imkaan and MsUnderstood have been commissioned by a number of local areas, owing to their focused engagement with specific target groups (e.g. black and minority ethnic groups, girls and Muslim communities) (Beckett et al, 2014)

Within the literature reviewed, there is less evidence about the role of local community charities commissioned to provide CSA services. Safer London Foundation, a pan-London voluntary-sector agency, was identified as a partner agency in a report on London CSA service provision (Beckett et al, 2014). The Oxfordshire CSE subgroup of the Oxfordshire Safeguarding Children Board (OSCB) emphasised the role of the local voluntary organisation Donnington Doorstep in targeting parents whose children were assessed as being at high risk of CSE; its parent worker post was subsequently commissioned by Barnardo's (OSCB, 2015). Other local voluntary sector providers identified by individual city councils and local authorities included VAWG organisations, generic youth work service providers, missing services, creative arts groups, addiction services and victim support groups.

A strategic approach to working with the voluntary sector

The 'Time to Listen' Inspectorate report (Ofsted, 2016) highlighted the London borough of Croydon as evidencing effective practice in the commissioning of services for CSA/CSE:

> 'There is a clear strategic approach in Croydon to commissioning and working with the voluntary sector to build capacity and expertise in working with children at risk of child sexual exploitation and those who are missing. This approach was seen to be making a positive difference in cases reviewed for this inspection. Safer London (a children's charity), for example, provides a range of services to children and their families. This includes direct work with over 300 young people in Croydon in 2015-16, with high rates of engagement (92% of young people remain engaged in direct work at three months after first contact). The feedback from children and young people who access this service is very positive.'

2.2 What services are commissioned?

CSA has become a major policy priority in recent years. Following a number of high-profile cases across the UK and a growing evidence base on both the nature and the scale of the issue, increasing pressure was placed on local areas to identify, prevent and respond to the issue within their communities (Paskell, 2012). Despite a number of independent reviews and evaluations indicating that implementation of CSA strategies by LSCBs was slow (Pearce, 2014), local authorities and their partners have increasingly been addressing this issue through the commissioning of a wide range of services and interventions (Coy et al, 2017). These services typically address one or more of the following key elements of the care pathway:

- Prevention through education and awareness.[1]
- Identification of vulnerability/risk.
- Diversion and short-term intervention.
- Recovery.

Prevention through education and awareness

The role of schools

Many local areas have acknowledged the important role of schools and education in preventing CSA through raising awareness of exploitation and abuse issues amongst children (Office of the Children's Commissioner, 2015). A recent report found that many services already commissioned or in development involved training teachers and school nurses to identify signs of risk of CSA, or identifying a named CSA/CSE lead in every secondary school with direct links to the LSCB (Davies, 2016). In Liverpool, for example, work in schools was a key aspect of prevention work. Training and involving school professionals, particularly head teachers, meant that they were clear about referral pathways and involved in multi-agency CSE meetings, leading to a greater reported confidence in identifying children at risk (Ofsted, 2016).

Other areas have commissioned services aimed at educating students and raising awareness around issues relating to sexual abuse. In Oxfordshire, a pilot programme titled Values versus Violence (VVVuk), which was being promoted for continuation by statutory partners, offered primary schools an education programme which aimed to develop pupils' sense of personal values and understanding of how good values can help them make better choices and lead safer lives (OSCB, 2015). Many local areas, including Buckinghamshire, Portsmouth and Oxfordshire, commissioned an educational theatre based production for young people titled *Chelsea's Choice*; Oxfordshire took this production to all of the county's secondary schools, reaching 12,000 children in years 8 and 9 (Local Government Association, 2014).

Awareness campaigns and training

In addition to awareness campaigns commissioned to target children and young people, such as the 'RU Wise2it?' social media campaign launched by Portsmouth Council, a few local areas have recognised the importance of encouraging community-wide engagement and involvement in preventing and identifying risks associated with CSA, and with CSE in particular (Local Government Association, 2014). Many local areas reviewed had commissioned the provision of training and workshops for frontline and professional staff who directly or indirectly worked with children and young people, in order to help increase professionals' awareness and boost their confidence in identifying risk and making referrals.

1 In general, education and awareness activities aimed at children and young people, communities and those working with them are referred to as prevention activities. There has recently been debate about use of the term 'prevention' in this context, based on two concerns: firstly, there is very limited evidence that education and awareness programmes affect the likelihood of abuse taking place; and secondly, 'prevention' suggests that children and young people themselves are responsible for preventing abuse from happening to them. The term is used in this report as it reflects the terminology used by participants in the study.

‘Licensing splinter group’

Developed in partnership between the Slough LCSB and Thames Valley Police, a CSE awareness-raising campaign was delivered to licensed premises, including taxi firms and private hire taxi drivers. A ‘licensing splinter group’ was established with links to the CSE subgroup and with representation from Slough Borough Council, a CSE specialist team worker, and police. Teams made coordinated premise visits, developed informational brochures and posters, and educated taxi drivers and workers in licensed establishments such as hotels and pubs about the warning signs of CSE. The Local Government Association (2014) said this model of awareness-raising on a community-wide level demonstrated good practice in promoting vigilance across sectors and encouraging referrals from individuals working in environments identified as being at high risk for sexual exploitation.

Awareness campaign for parents

Camden local authority helped local families to commence a ‘Stop Sexual Exploitation’ campaign aimed at other parents and carers in the borough. Posters were put up on local buses and at Underground stations, highlighting the primary warning signs of sexual abuse and exploitation, and giving details of a webpage providing further support and information. In addition, local parents designed and authored leaflets and keyrings with similar warnings, to support parents and families to open up conversations with their children about staying safe (Berelowitz et al, 2013).

Identifying and addressing vulnerability/risk

Local areas identified as evidencing best practice in understanding and tackling CSA/CSE demonstrated:

- a good understanding of local risks, vulnerable children in their areas, and patterns of offending
- collaborative working to engage and work with children and families, and persistence and skill in engaging young people
- a shared understanding between relevant teams that patterns of offending and the profile of those at risk can change over time, as can modes of grooming (Ofsted, 2016).

Project Phoenix

Project Phoenix is Greater Manchester’s single, collaborative effort to improve consistency and cross-border working between local authorities. Under Project Phoenix, as of 2013 there were specialist CSE teams in place in each of the 10 districts of Greater Manchester. One of its primary achievements has been to develop and produce a risk assessment tool used to measure a young person’s risk of CSA/CSE: young people across all areas of Greater Manchester will receive the same assessment, meaning that local authorities and key partners have a shared definition and understanding of risk. This structured professional judgement tool has also allowed for a consistent approach to data collection, enabling a fuller picture of the scale and scope of CSA/CSE issues to be developed (Berelowitz et al, 2013; Webb and Holmes, 2015).

Addressing predatory behaviour

Part of understanding the risk of sexual abuse on a local level is identifying and addressing predatory behaviour. Alongside police and other key partners' efforts to profile and prosecute offenders, many local areas have highlighted the helpfulness of collaboration with youth offending services to address peer-on-peer violence (Firmin and Curtis, 2015; Smith et al, 2013).

Other areas have commissioned services to specifically address sexually harmful behaviours. One example is the Buckinghamshire Child and Adolescent Harmful Behaviour Service (CAHBS), commissioned to offer consultation, assessment and intervention for young people with HSB. The service has used a psychological framework and structured risk assessments, and has provided training to local partner agencies in conjunction with the LSCB to increase awareness and assessments of problematic behaviour (Buckinghamshire CSCLSC, 2015).

Diversion and early service provision

A commonly identified challenge in addressing CSA is that children identified as being at risk may experience different levels of service provision across first response and locality teams (MBARC, 2016; Harewood, 2017). Lack of communication between key agencies involved in service delivery may prevent children and young people from receiving a swift joint approach to address their needs. In response, some local areas have developed co-located, specialist teams and service centres with high levels of information-sharing between key agencies.

CSE specialist services

A number of local areas have commissioned specialist CSE teams incorporating partners from agencies including social care, police, health and the voluntary sector. These services have provided local areas with a first point of contact for all professionals working with children if and when concerns are raised, and have enabled sites to pool information and expertise.

Some specialist teams have also improved accessibility by enabling self-referrals from children, young people, or any individual in their network such as a teacher or carer (Christie, 2014; OSCB, 2015). The Kingfisher Team, for instance, is a joint team set up by social care and police in Oxfordshire with the support of local health services, the city council and recently Barnardo's; it was developed as a centre of knowledge and skill offering a first response to concerns about CSE. Low caseload numbers and strong relationships with other agencies are just some of the ways in which this team has demonstrated good practice (OSCB, 2015).

Similar examples have been seen elsewhere. Blackburn with Darwen LSCB developed a co-located, multi-agency response to CSE with the establishment of the Engage Team. With police, social care and health as its key partners, and the voluntary sector as a key delivery partner (e.g. providing staff members), the team includes young people's workers, social workers, nurses, a parent support worker, a detective sergeant and detective constables. Many external partners have also been also involved in the work of the team, with virtual support from the wider group of partners (e.g. youth offending, schools, the women's centre, the drug and alcohol service and licensing services) who have weekly team meetings. In 2014 the team was also given responsibility for conducting initial interviews with children and young people returning from a missing episode. In line with good practice, which emphasises the need for CSA services to be child-centred and non-stigmatising, the Engage Team has used young people's workers as its preferred main point of contact (Local Government Association, 2014).

Calderdale Council has commissioned the co-location of police officers and social workers in a specialist CSE team at the police station, with key agencies such as The Children's Society's 'Safe Hands', the youth offending team and health and youth services forming parts of the virtual team. Daily briefings have allowed for any intelligence to be shared immediately, ensuring that children

identified as being at risk have been safeguarded immediately, with weekly meetings attended by the wider operational group of partner agencies to improve consistency and timely communication (Local Government Association, 2014).

Sexual assault referral centres

Another partnership model of service provision is the SARC: a specialist statutory service, often commissioned by the Secretary of State for Health via NHS England, which aims to coordinate medical, legal and advocacy arrangements for victims under one roof (Robinson and Hudson, 2011). A number of SARCS, such as those in Nottinghamshire and the Harbour Centre in Norfolk, have been commissioned to deliver specialist services for children and young people (Adams, 2014; Musgrave et al, 2014). These 24/7 support centres have either employed or provided access to Independent Sexual Violence Advisors and Child Advocates, whose role is to provide emotional and practical support through the criminal justice system, including attending court and advising on post-trial matters such as compensation claims (Robinson and Hudson, 2011). Whilst this 'one stop shop' model of service provision has elements of good practice (i.e. multi-agency working, child-friendly environments and specialist staff), some reviews have highlighted concerns about whether users of SARCs will access connected care and receive adequate emotional support (Allnock et al, 2015; Goddard et al, 2015).

Community-led, voluntary sector support centres such as Rape Crisis Centres have also been commissioned to provide specialist, early intervention support to child victims of sexual abuse, and their perceived independence from statutory agencies has been highlighted as their key strength in gaining access to and maintaining relationships with victims (Robinson and Hudson, 2011). An evaluation of the Triangle Project in Brighton, which undertakes specialist interviews for very young and disabled children on behalf of the police, identified a number of good practice elements including the use of intermediaries throughout the investigative process and extending to the court; a child-friendly environment adapted to appeal to different age groups; the active consultation of young people in decision-making, and centralisation of the process in one place (Davidson et al, 2012; Horvath et al, 2014).

Recovery – therapeutic interventions

Growing evidence indicates that children and young people who are victims of sexual abuse will often require short- and long-term interventions involving emotional support, counselling and/or intensive clinical therapy. Local areas have begun to identify a significant need for more integrated responses to trauma recovery, and treatment for the mental health problems typically associated with sexual abuse, in addition to services aimed at early prevention and identification (Wallace, 2016; Christie, 2014). An independent evaluation report from Oxfordshire highlighted that current therapeutic support for children was 'sparse' and 'often not adequate' (Humphreys, 2015).

Therapeutic work for children and young people has primarily operated via the statutory sector, with CAMHS providing the large majority of this work (Allnock et al, 2012). However, significant barriers to effective emotional support – relating to accessibility, resources and the secondary prioritisation of sexual abuse compared to other mental health issues – have been identified (Department of Health, 2015; Goddard et al, 2015). As a result, the VCS or multi-agency specialist teams have increasingly been commissioned to provide counselling and emotional support.

Some local areas have made arrangements to try to increase the accessibility of CAMHS. In Stoke-on-Trent, a CAMHS worker liaised with one of the safeguarding teams so that, when concerns were raised about a child, they could be assessed and a service identified more quickly; feedback from social care staff indicated that this link enabled young people to access CAMHS more efficiently (Christie, 2014).

Amongst voluntary-sector services, therapeutic interventions involving creative play have consistently been used, whilst cognitive behavioural therapy (CBT) has been more common among statutory

sector services (Allnock et al, 2012; Allnock et al, 2015). Some differences in therapeutic service provision for CSE compared to other forms of CSA have been identified: specialist CSE therapeutic services have typically supported older children, and have been more likely to provide family therapy, compared to services for other forms of CSA (Allnock et al, 2015; Children's Commissioner for England, 2015).

A research study, commissioned by the NSPCC, surveyed 195 therapeutic services for children and found that only 20% were specifically dedicated to work with children who had experienced sexual abuse; the majority were embedded within generic services providing therapeutic support for a range of mental health or behavioural problems (Allnock et al, 2012).

Overall, this review identified few rigorous evaluations of therapeutic interventions for children and young people who are victims of sexual abuse, despite the central theme that demand for such services greatly outweighs the current provision.

'Letting the Future In'

'Letting the Future In' is a structured therapeutic intervention developed by the NSPCC, and implemented by 20 NSPCC service centres across England, Wales and Northern Ireland since 2011 (Carpenter et al, 2016). It is available to children aged 4–17 who have made a disclosure and experienced sexual abuse, and involves individual sessions for the child as well as additional support sessions for the child's primary carer. An impact evaluation examining the outcomes of this therapy found that older children and young people receiving treatment had a statistically significant decrease in clinical symptoms (i.e. distress, trauma-related symptoms) at six-month follow-up. Elements of good practice highlighted by children and carers were the positive therapeutic relationship and the supportive atmosphere fostered by practitioners (Carpenter et al, 2016). Whilst further development of this and other therapeutic interventions is needed, particularly amongst younger children, this independent evaluation provided promising evidence of the effectiveness of therapeutic support in decreasing mental health problems associated with experiences of sexual abuse.

2.3 Why are services commissioned?

Commissioning services for CSA can be seen as largely outcome-focused, with the needs of children, young people and their families at its core. Effective commissioning of CSA services should therefore involve a framework determining the specific needs of a local area, and how best to deploy resources strategically so that outcomes and objectives can be achieved (Women's Aid, 2014).

Are robust needs assessments being performed?

This review produced some promising evidence to suggest that local areas have been conducting needs assessments – in many cases, JSNAs – to better understand the needs of victims and perpetrators of CSA/CSE and inform the commissioning of services to meet these needs. Many services have carried out reviews of current activity relating to CSA/CSE or sexual violence more generally, utilising data from the police, the VCS and health and social care agencies to inform new commissioning arrangements or review local service provision already in place (Winters, 2011; Devon County Council, 2013; Musgrave et al, 2014).

Continuously assessing the profile of CSA within a local area, and amending intervention approaches accordingly, is a part of assessing local need effectively. In Croydon, for example, the CSE subgroup was able to evidence how its continuous analysis of local risks resulted in the development of services to target identified risk, such as in the recognition of the prevalence of peer-on-peer sexual

abuse; as a result, work was being developed to identify and address sexually harmful behaviour at a much earlier stage through joint working between children's social care and local youth offending services (Ofsted, 2016). Gaps in local CSA service provision, particularly in the areas of prevention (i.e. staff awareness training, work in schools) and the therapeutic and emotional support offered to victims, have frequently been highlighted within needs assessments, leading to evidence-based recommendations for service delivery based on need (Adams, 2014).

Are clear outcomes for services being articulated?

Whilst it appears that the majority of local authorities have been involved in the comprehensive development of services commissioned to meet the needs of children and young people at risk of CSA, a need has consistently been highlighted for further information – in particular on outcomes – to assess the clinical effectiveness and cost-effectiveness of discrete services (Stoke-on-Trent and Staffordshire Safeguarding Children Boards, 2016; Goddard et al, 2015; Shuker, 2016). Assessing outcomes of services has been felt to be hardest in areas where services are not co-located or multi-agency, owing to challenges and barriers in information-sharing and data collection. Evaluating existing initiatives has frequently been acknowledged to be challenging, particularly for CSA services where a number of external factors – such as the length of intervention or other variables having an impact on a child's development or wellbeing – may affect the 'success' of a particular approach (Berelowitz et al, 2013). However, without a clear outcome-monitoring structure, strategic commissioners and service providers have remained unclear about the extent to which their approaches are being implemented or whether they are having the desired impact. In a review of service provision for CSA in London boroughs, 10 out of 30 reported having an outcomes framework for monitoring progress against their CSE strategies and action plans (Beckett et al, 2014).

Outcomes articulated by LCSBs or other local CSA strategic frameworks have often included increased rates of prosecutions of perpetrators, improved information-sharing between partner agencies, and increased rates of referrals of vulnerable children to services (West Midlands Metropolitan Authorities, 2014; Davies, 2016). Positive outcomes for children and young people in local areas have included the building of trusting relationships with professional staff; reductions in missing episodes; increased self-esteem or feelings of safety; living in stable and secure accommodation; and reduced contact with coercive/abuse individuals or peers (Ofsted, 2016; West Midlands Metropolitan Authorities, 2014).

Within local needs assessments and evaluations reviewed for this report, individual, child-centred outcomes have sometimes been less explicit or obviously identified. Audits and independent reviews of local approaches to CSA/CSE have made similar recommendations that local authorities and LCSBs should create definitions of what a 'good' outcome might look like for a child who has experienced sexual abuse or exploitation, and how these outcomes can be measured and recorded (Christie, 2014; Children's Commissioner for England, 2015).

2.4 How are services being commissioned?

Commissioning models

Joint working, multi-agency commissioning

The role of joint working, often through local strategic partnerships whereby services are commissioned from multiple agencies including CCGs, the city council/local authority, the LSCB and other partners (e.g. the police, the public health service and the VCS) is evident within the literature (Women's Aid, 2014; Local Government Association, 2014; Sharp-Jeffs et al, 2017).

Many local areas such as Buckinghamshire and Oxfordshire have indicated the use of joint commissioning strategies in commissioning services for CSA/CSE (Buckinghamshire CSCLSC, 2015; OSCB, 2015). The process of producing joint commissioning strategies is a key platform for exploring sexual abuse and exploitation issues locally, and has been emphasised as an effective way for commissioners to help consolidate joint working between health, local authority and wider partners (e.g. housing, police, education and the VCS).

However, joint strategies such as these are not without challenges to effective service commissioning: in recent independent reviews, interviewed practitioners have emphasised the increasing complexity and competitiveness of the commissioning process (Allnock et al, 2015; Beckett et al, 2014). Similarly, as referenced in an evaluation of the London CSA pathway (Goddard et al, 2015), CCGs and local authorities had generally moved to joint children's commissioning roles as of 2014; this reorganisation had led to a period of change, financial constraints, and a certain degree of confusion about health partner engagement in commissioning.

Incorporating the voices of children, young people and their carers

Amongst commissioners, local authorities and their partners, there has been a growing awareness of the importance of seeking out and translating the views of children and young people into positive action around service planning and delivery (Adams, 2014; Camden Safeguarding Children Board, 2017). In line with models of good practice which emphasise that children and young people should be at the heart of any strategy or approach, some commissioning bodies have consulted children and families to assess need and consult on which services should be developed or recommissioned (Adams, 2014).

Consultation with service users has been incorporated into service design and provision in many places (Buckinghamshire CSCLSC, 2015; Otway, 2015). Ofsted (2013) highlighted the work of Street Safe Lancashire as a good-practice example of involving children and young people in the design and development of CSE services: the Lancashire LSCB consulted young people who had accessed local CSE services to provide a guide titled 'Standing Tall After Feeling Small' which presented their needs, concerns and experiences in their own words (Webb and Holmes, 2015).

Who are the main partners?

A recurrent issue throughout the literature examined for this review is that no local approach to address CSA can be the responsibility of a single agency; instead, addressing CSA must be a holistic effort which employs effectively the strengths of all key statutory, voluntary and private sector partners.

Health and social care

With a statutory obligation to support and protect children and adolescents from harm, social care services – and particularly social workers – have consistently been identified as central to multi-agency partnerships and commissioning strategies. Health agencies have an equally vital role to play, whether through frontline medical staff such as A&E doctors and sexual health nurses identifying at-risk young people, or through mental health practitioners supporting recovery at any stage of the pathway.

Police

A significant role exists for the police in the development of multi-agency partnerships to tackle CSA, particularly in the successful identification and prosecution of perpetrators of sexual violence.

Voluntary sector

Voluntary sector partnerships have been recognised as fundamental to an effective local response to CSE (Jago et al, 2011; Berelowitz et al, 2013), primarily because of their ability to employ creative methods and target specific groups.

In a review of service provision across London boroughs, 70% of the boroughs that responded to a survey said they had a formal partnership with the voluntary sector, and in most cases this partnership was for service delivery (Allnock et al, 2015). However, the same study indicated some concerns by voluntary sector providers about the degree to which voluntary sector contributions were embedded in systemic responses to the problem; this may be suggestive of a larger issue around how commissioning arrangements employ and enable voluntary partners, specifically around information-sharing and the planning/delivery of local responses (Allnock et al, 2015; Women's Aid, 2014).

How are services commissioned geographically?

Whilst the commissioning of services for CSA appears to have occurred primarily via local authorities, with LSCBs playing a central role, there has been some evidence of local councils forming joint strategies to address CSA/CSE on a regional level. One example was a region which established a CSE strategic group on a metropolitan area regional level, involving seven local councils and the police force in the region in addition to the voluntary sector and health representatives (West Midlands Metropolitan Authorities, 2014; Local Government Association, 2014). Together, these councils and their partners developed 15 regional standards and pathways for tackling CSE, together with guidance for frontline practitioners and managers to support implementation. The work was based on the 'See Me Hear Me' framework developed by the Office of the Children's Commissioner. The strategy allowed for a unified regional approach to be put in place to complement locally tailored pathways in each council area.

How long are services being commissioned for?

This review has highlighted the impact of financial insecurities around funding as a common challenge faced by local commissioners and providers of CSA services. Commissioning bodies have been reluctant or unable to commit to contracts of longer than one year; meanwhile, providers of services may have struggled to provide effective, evidence-based services in such a short timeframe (Christie, 2014).

This sentiment was echoed in a review of therapeutic services in the UK, where commissioners and service providers highlighted their concern that contracts for specialist provision were too short; and that insecurities around funding streams, and the persistent need for services to make funding applications, could have a negative impact on the children and young people needing services (Allnock et al, 2015).

2.5 Summary of key themes

Local areas highlighted in the literature as exemplifying effective practice techniques have had a detailed understanding of the local risk and needs relating to CSA, and have continuously updated this profile based on regular assessments. Multi-agency working amongst key partner agencies (particularly social care, the health sector, the police and the VCS) has been central to effective and innovative commissioning frameworks, allowing local areas to provide a more consistent and reliable approach with improved levels of communication and information-sharing. Schools have been identified by a number of local areas as a crucial arena for awareness-raising and the early identification of risk. The literature suggests that the most effective local approaches have addressed abusive and harmful behaviour in addition to vulnerability within a population – for instance, by commissioning services for young people with HSB or by facilitating and supporting victims through the court process.

The literature highlights that a majority of services commissioned to address CSA/CSE on a local level have remained over-reliant on verbal disclosure of incidences by victims. Particularly in cases of intra-familial sexual abuse (estimated by the Children's Commissioner for England (2015) to account

for up to two-thirds of all CSA cases), where the majority of victims are unlikely to come forward on their own, the need has been identified to continue and further develop assertive efforts that raise awareness and train professionals to identify risk (Horvath et al, 2014). Issues relating to accessibility, particularly of statutory services such as CAMHS, have been highlighted throughout the literature (Allnock et al, 2012). Particularly vulnerable target groups, such as children and young people from black and minority ethnic groups and those with disabilities, have been even less likely to access statutory services, making the role of community-based, specialist, independent agencies all the more imperative to local commissioning strategies. There have been gaps in the provision of aftercare for victims and survivors of CSA, particularly emotional and therapeutic support.

3. Thematic review

This thematic review outlines the key issues emerging from the five case studies of local authority areas that participated in the rapid review. The case studies reflect evidence from interviews conducted with key stakeholders who had responsibility for commissioning and providing services for CSA, CSE and HSB, and a selection of documentary evidence provided by the local authority in each case.

The interviews sought to establish:

- what CSA and CSE services are being commissioned
- how CSA and CSE services are being commissioned
- who is involved in commissioning and running CSA and CSE services
- what relative strengths and areas for development exist in the commissioning of CSA and CSE services.

Each of the sections in this chapter relates to one of the specific questions asked in the interviews with stakeholders; these questions are listed in full in Appendix 3.

The commissioning landscape for CSA/CSE and HSB services in local authority areas is so complex that it would be unrealistic for a rapid review to propose a definitive list of challenges and promising initiatives for commissioners across all local authorities in England. Nevertheless, the inclusion of a range of sites across England makes it possible to offer a snapshot of the state of CSA/CSE and HSB commissioning and service delivery which is applicable to England more broadly. A presentation on the review's findings was given to commissioners from a further 16 areas in October 2017, and feedback from this presentation (reported in Appendix 4) supports the transferability of the findings.

In summary, the challenges for commissioning identified by stakeholders, and promising commissioning activity in local authority areas, include the following:

- There are robust governance, strategies and partnerships for CSE but not for CSA and HSB, both of which are largely subsumed within children's social care. Stakeholders were particularly concerned to promote a focus on preventing, identifying and responding well to CSA.
- In terms of operational commissioning issues:
    - Local needs assessments for CSA/CSE and HSB are needed, including for online abuse.
    - Longer contract periods are desirable to promote co-production and VCS investment in local service delivery for CSA/CSE and HSB.
    - Funding for services for CSA/CSE and HSB is inadequate in the light of growing demand and cuts to local non-commissioned VCS provision. Contributions from health and schools are needed.
    - Most local authorities now have joint children's social care and public health commissioning teams; in some cases these teams also have the CAMHS Tier 1 and 2 budget/commissioning responsibility.
- It would be helpful to have health governance for CSA/CSE recovery services. Some areas are beginning to plan for skilling-up generic service staff so they can respond well to undisclosed CSA/CSE. Health bodies have a role in ensuring that the multi-agency partnership focus is primarily on helping the child recover (rather than prosecuting the perpetrator).
- Concern was expressed, by multiple participants from more than one location, about the need for schools and academies to responsibility for putting in place good-quality responses to safeguarding in general, and to CSA/CSE and HSB in particular – especially as school nursing services have been cut back.

- Local authority partnerships are running well-developed CSE initiatives, although prevention services have been significantly reduced and need to target CSA and sexualised behaviour/HSB.
- Local partnerships would like, with support from central government, to tackle CSA/CSE and HSB as a single issue which is recognised by staff and the public as 'mainstream' rather than exceptional. Support should be provided for parents and families, and for adult survivors.
- There is a significant shortfall in medium- to long-term support and counselling for children who experience CSA, CSE and HSB. (This is support for trauma, not mental health problems.) There is also a big shortfall in CAMHS provision.
- There needs to be more understanding of 'what works' in recovery from CSA/CSE and HSB, e.g. large scale evidence-gathering on service offer and impact from recovery services.
- The regionalisation of SARCs has created problems in terms of increasing travel times.
- VCS services provide independence and expertise, which are highly valued by both the statutory services and service users.
- There remain challenges to effective outcomes measurement, including:
    - the need for consensus 'about what good looks like'
    - the need to measure 'distance travelled' for an individual (emotional wellbeing, improvement in relationship with family and friends, access to positive alternative activities and engagement in learning)
    - the need for case lengths (and therefore service throughput) to vary with the service user's needs
    - acceptance that service user outcomes vary too much to be used to monitor organisational performance
    - the need to include outcomes measurement for (currently non-commissioned) CSA and HSB services.

3.1 Commissioning structure

'What local approaches are in place for commissioning CSA/CSE services?'

Governance and partnerships

Across the five case study areas, stakeholders reported robust high-level governance and scrutiny of the local multi-agency response to CSE. There is no scrutiny specifically focused on CSA or HSB: these areas are subsumed, respectively, within the governance and scrutiny arrangements for generic children's social care and youth offending responses.

Accountability for CSE service commissioning sits within the CSE governance arrangements, including the elements of CSA and HSB service that are externally commissioned. At a minimum, the commissioning team reports directly into both the Director of Children's Services and to an LSCB subgroup. In some of the local areas, the commissioning team also reports to a multi-agency commissioning steering group.

At an operational level, all the local authorities have a multi-agency CSE panel which monitors all local CSE cases. This panel sometimes covers HSB as well; otherwise, HSB cases are monitored in generic forums for youth offender management and persons of concern (for non-criminal justice cases).

There was a view amongst mental health trusts that, whilst the child protection pathway for CSA addresses assessment and early intervention, it would be beneficial to have in place governance and partnership arrangements focused explicitly on the local recovery response to CSA.

There are separate governance arrangements for each regional SARC. The OPCCs, together with NHS England, provide funding for regional SARCs; some OPCCs fund ISVAs for young people aged 13–18 as well as adults, but the OPCCs are largely focused on adult victims of VAWG.

There was a consensus that 'multi-agency partnership working' is good. This is largely for CSE, however, because not many services are commissioned for CSA and almost none for HSB. Within this positive view of CSE partnership working, exception was made for the ongoing difficulty and delays in accessing CAMHS and receiving a sustained service.

There was also a consensus that statutory and commissioned VCS services have engaged well in partnership. The local multi-agency experience was that, in order to achieve and then maintain good partnership, all partners need to:

- define 'good' partnership working
- require their workforce (including senior management) to demonstrate an attitude of collaboration through, for example, synchronising multi-agency agendas, focusing on multi-agency outcomes and extending their daily activity beyond narrowly defined agency remits
- require their workforce to share information proactively
- appoint staff who demonstrate commitment to, and skill in, developing good joint-working (for example, by being confident and skilled networkers)
- invest in systems to facilitate cooperation between agencies and services.

Local CSE strategic and operational forums are described as including CSA, but activity to date has been limited to CSE. HSB is not mentioned in this context; it is managed largely within local youth offending forums.

Needs assessment

There was a consensus about the need to know the scale of CSA, CSE and HSB locally – not just numbers but an understanding of how vulnerabilities are being created, how they manifest, how they are sustained and the processes that translate vulnerability into becoming a victim of CSA or CSE.

There is no robust population CSA/CSE needs assessment across the five local areas. Most areas cited cost as the reason for this gap. One commissioner said that there was no point if the needs could in any case not be met. Another commissioner's view was that, in the current economic climate, such an assessment is even more important as it would enable the local partnership to prioritise the most vulnerable.

CSA/CSE conducted online has not been assessed in any way across the five areas; the main reason given was that local safeguarding partnerships have yet to prioritise online elements of CSA/CSE/HSB as an issue in need of population assessment, partly because of the perceived challenges of carrying out such an assessment. Tackling new challenges like this is important, however, because the profile of CSA, CSE and HSB is changing rapidly and a whole new service response is needed for online abuse.

That said, some local areas are undertaking some forms of profiling or consultation around need, e.g. police problem-profiling, service mapping, and service-user consultation:

- Police problem-profiling has been used for CSE, and some areas have Home Office-funded analysts to assist with this. An issue is how to gather and use data in a tactical way as well as for service planning. The problem-profiling has not become multi-agency as originally envisaged, and is now being scaled back owing to reductions in police budgets.

- For one local authority, a useful exercise has been the joint commissioning team's mapping of all the CSE/VAWG services in each geographical area/region. By identifying gaps in prevention work and in recovery services for children who have been abused, and highlighting access issues in terms of service location and hours of opening, this has informed the new CSE service specification.
- Where there is consultation to assess need, it is focused on service users' views and needs, and is driven by commissioning or recommissioning agendas. This means that two key groups are rarely consulted:
    - service users of internally provided services (such as CSA provided by children's social care and HSB provided largely by youth offending services)
    - non-users of services (i.e. those who may have been abused or have abused but have not come to notice, or have tried and failed to access a service).

Stakeholders also reported that day-to-day analysis of CSA, CSE and HSB data is not possible across organisations and services, because the definitions of each and the flagging of cases are so variable that reports cannot be drawn from IT databases.

It was reported (by all five areas) that the VCS is not involved in developing the JSNA, which stakeholders agreed is in any case not detailed enough to be useful for CSA, CSE or HSB commissioning. The VCS aims to 'fill gaps' in service and can only do this well if it knows the local need and existing response.

CSA/CSE strategy

All areas have specific CSE strategies; however, only one has a CSA strategy, and there are no areas with specific HSB strategies. This is because – as with governance arrangements above – CSA and HSB are encompassed by children's social care and youth offending plans or strategies. This appeared to some interviewees to be a false distinction because, they argued, all three need to follow the child protection care pathway. The experience of VCS service providers, across all areas, inclined them to view CSA, CSE and HSB as sufficiently similar to make an overarching sexual abuse strategy desirable.

Stakeholders reported that the quality of commissioning strategies is mixed. They highlighted a lack of comprehensive information on local need; reactive rather than proactive approaches; insufficient lead-times before recommissioning needs to take place; lack of integration with other strategies; and service-focused rather than outcomes-focused strategies. One local authority is planning to integrate the CAMHS Delivery Plan or 'Mental and Emotional Wellbeing Delivery Plan' into the CSA and CSE strategies, to ensure that CAMHS Tier 1 and Tier 2 (non-clinical) support is highlighted and receives commissioning and performance monitoring attention.

It was reported that local authorities would welcome greater join-up between local authority/LSCB plans and strategies for CSA, CSE and HSB in two further areas:

- OPCCs' VAWG strategies
- NHS plans, e.g. Sustainability and Transformation Plans.

Several mental health trusts are developing CSA/CSE strategies which recognise that children and adults need a generic, trauma-informed mental health service, because many individuals present with or seek help for symptoms which may be related to undisclosed CSA/CSE. The service needs to be sufficiently skilled to support the child or adult who has been abused, regardless of whether there is a verbal disclosure.

Funding

Across the five areas, there are no pooled budgets in operation for CSE, CSA or HSB. Having different funding streams was felt to be particularly time-consuming for VCS providers, which have to bid to different local commissioners for contracts, manage different funding periods and report on different performance measures.

Funding for CSA and HSB is largely used for services that are provided directly by the local authority. Funding for commissioned CSE services, and a small amount of CSA counselling provided by the VCS, is from the children's social care budget. Where there is a commissioned HSB service, it is funded by children's social care. In one area, the OPCC provides some additional funding (via the area's community safety partnership); in another, external support for individual HSB cases is paid for by youth offending services.

There was a consensus that local authority budgets for CSA, CSE and HSB service commissioning are inadequate in relation to the size of the problem. Local authorities have tried to protect the CSA/CSE budgets; however, keeping a budget unchanged for five to six years means that it has been reducing in real terms at a time when referrals are increasing as a result of work undertaken to increase identification. Stakeholders agreed that the gap could be partly addressed through contributions from local CCGs and much larger contributions from schools, some of which are already funding generic pastoral and counselling services.

In several local authority areas, commissioners reported, large VCS organisations are giving notice that they can no longer continue to deliver CSE services without funding from the local authority, as they have had reductions in their funding. In two local authority areas' recent recommissioning exercises for the core CSE and missing children service, the incumbent provider declined the invitation to bid, on the basis that there was not enough money in the contract to meet the specified demand safely.

Pressure on local VCS organisations

The experience of one (counselling) service illustrates the pressure faced by small, local VCS organisations.

The service's funding reduces by £15,000 per year whilst the demand is at 430% of the level five years ago.

The service supports individuals aged 13 years and over who have experienced sexual assault and/or intimate partner violence (domestic abuse). Half of the service users have experienced CSE, and half of those are under 18.

However, as local authority funding for the service comes from children's social care, only 25% of the service (the part that supports under-18s who have experienced CSE) receives ongoing statutory funding. The remaining funding comes from elsewhere.

Adult services do not provide any funding for individuals rendered vulnerable as a result of having survived CSE.

Both commissioners and providers felt that funding (or contract) time periods are too short. In some cases the contract period is 12 months, or the contract is 'rolled over' for 12 months at a time. If a stable staff team is important for good support for children who have experienced sexual abuse and exploitation, this type of commissioning practice is counter-productive. Large contracts are usually let for three years with a potential two-year extension. However, some commissioners recognised that contracts are likely to be most effective if they are 5–10 years long. In the view of stakeholders, this:

- creates a 'value-adding' partnership, not a commissioner-provider 'transactional' relationship
- stimulates provider investment and innovation
- improves staff stability and hence quality of service delivery
- improves multi-agency relationships/joint working
- offers stability and security for service users.

Stakeholders reported that short-term funding particularly affects proactive/preventative work. Reactive services meet immediate acute need, and the impact can be easily measured. Preventative work requires more preparation on the ground, and the outcomes are much more difficult to measure.

The foremost reason why contract periods are not longer is that commissioners do not know how much money they will have in the future. They are also influenced to some extent by an inherited commissioning culture of short contract periods to allow for changing service user needs. Some stakeholders noted that flexible specifications could address the latter issue by allowing for variation in the intensity, volume or type of service during the contract period.

There has been money from the Department of Health Better Care Fund – formerly the Integration Transformation Fund – for improving CSE (but not CSA or HSB) responses, e.g. the development of a CSE pathway within a mental health trust; support for victims through the court process; and the appointment of a part-time family therapist as a 'floating' support for children who have experienced CSE, and for their parents.

OPCC contributions in local authority areas outside London have included funding for a CSE Coordinator's post; the development of a multi-agency CSE outcomes framework; and additional funding to HSB services or for counselling for young male victims of CSE.

In London:

- Funding has been available through the Mayor's Office for local authorities to bid for posts – for example, under the London Gang Exit programme. However, this is relatively short-term funding, i.e. for two- to three-year periods.
- There is encouragement from the Mayor's Office for Policing and Crime (MOPAC) and the Metropolitan Police Service for sub-regional services in London, and some local authorities are bidding with their neighbouring local authorities. Many services are already being shared by the boroughs, e.g. trading standards, licensing, and noise nuisance.
- An example of a good pan-London service contract, supported by MOPAC, is a CSE keyworker/advocate service which can be 'bought into' by boroughs. The model is that a single local authority or several neighbouring local authorities together, can purchase support for 7–10 CSE-affected children. This number of children makes up a caseload for one practitioner, whom the service will employ, train and provide management and clinical supervision for.

3.2 Commissioning partners

'Who is involved in commissioning? What are the relative strengths and areas for development locally?'

Statutory partners

Many local authorities have developed a single children's social care and public health commissioning team, which 'co-commissions' with the practice or clinical experts. A commissioning framework may, for example, involve a quarterly checklist which assesses whether each contract is:

- offering added value (although this is increasingly challenging as VCS budgets, as well as commissioning budgets, are reduced)
- undertaking safeguarding audits
- facilitating young people's participation
- providing monitoring data
- receiving referrals from the right range of local sources.

Stakeholders reported that the public health system is still 'skilling-up' to cope with the difference between prescribed NHS commissioning processes and the much more flexible local authority approach. Public health contracts relevant to CSA, CSE and HSB include the 0–19 years Healthy Child Programme, the sexual health service, school nursing, health visiting and substance misuse services.

In most areas, CCGs are not involved in CSA, CSE or HSB commissioning. Other agency commissioners felt that children and young people would get better access to counselling/advocacy services below the CAMHS threshold if the CCGs would take on the health service responsibility for helping children to recover (CAMHS Tiers 1 and 2). It appears that, where they do commission services, these are generic (e.g. counselling). In one area, the CCGs have transferred the CAMHS Tier 1 and 2 budgets to the local authority's joint commissioning team. The team has commissioned the mental health charity MIND and worked with the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme, and also emotional wellbeing support services from VCS agencies; we found this to be interesting, innovative practice.

OPCCs engage and consult with the VCS and service users (e.g. through focus groups) when commissioning services such as SARCs or restorative justice services.

Partnership between statutory and VCS commissioned services was described as good by the commissioners. However, the VCS view was that service users would benefit from better services if the relationship between the commissioners and the providers could be more equal: the providers are not in a strong enough position to address service delivery issues proactively. The inequality stems from a power imbalance fuelled by short, three- to five-year contracts, which keeps the 'bidding and contract award' relationship to the fore at the expense of a true 'partnership' relationship involving more sharing of concerns and data, challenge, shared innovation and investment.

Budget reductions have had an impact on local authority commissioning teams. For example, a part-time commissioning manager is now responsible for substance misuse, teen pregnancy, CSE, young carers, healthy schools and children with disabilities. Commissioning teams reported that there is not enough time to absorb new information/evidence-based research, consult, plan and commission, monitor and nurture, and trouble-shoot the commissioner/provider relationship.

In so far as the improvement of service quality for service users depends on support and challenge between partners, this appears to work best where the VCS brings its own or other external funding. The provider is then not subject to the pressures that the commissioners are facing, although the VCS is, of course, subject to parallel pressures such as reducing budgets.

Involvement of the voluntary sector

Commissioners reported that the pressure to get providers to provide more for less creates stress. There is a tension between developing and maintaining a good partnership relationship and the relentless drive to extract more from the 'partner' agency.

In most areas, VCS organisations supporting victims of CSE are consulted on:

- children's needs
- gaps in service
- service successes (e.g. case lengths and outcomes)
- challenges (e.g. difficulties in engaging some children).

However, the VCS is excluded in most areas from 'influencing commissioning', e.g. design and development of the service specifications. They felt that this is because commissioners are concerned about conflict of interest. The VCS would like, at a minimum, to be involved in the medium- to long-term shaping of local CSA, CSE and HSB services.

The VCS is consulted in sexual health service commissioning and recommissioning – but, as above, not in terms of the design and development of the service specifications.

There is so little VCS provision for CSA and HSB that there is no commissioning-driven assessment and consultation, nor VCS involvement in service planning and review.

Involvement of service users and/or victims

In all local areas, the views of children and young people who are affected by or involved in CSE are gathered to inform the commissioning of CSE services. For example, after parents/carers in one area said that there was no support for them, a parent/carers support worker was introduced into the multi-agency specialist CSE team.

It appears also that local authority commissioners now consult children and young people at all points in service design and provision. For example, in one CSE service tendering process, service users designed three of the new commissioned service tender evaluation questions and were part of the evaluation process, including being on the commissioning panel.

Promoting CSE service users' voices

In one local authority area, the VCS has funded an initiative to promote CSE service users' voices: a coordinator has convened and supports a board comprising participation officers from local VCS providers of CSE services.

When statutory or VCS services are seeking input from service users, they put in a request to the board, which identifies the most appropriate service users from within the organisations on the board and supports them to participate.

Young people are trained to participate in roles such as recruitment, service design and service satisfaction/outcomes feedback. 'Post-abuse' services have been developed in this way. The initiative has greatly enriched the range and quality of service-user contribution to CSE at all points of service commissioning: commissioners can be confident that feedback is from a broader and more representative group of children, young people and parents than has been the case in the past.

Owing to the in-house nature of CSA and HSB services, pre-commissioning consultation does not happen. There is likely to be some information available from children and young people's input on their individual cases, but this does not appear to be collated; together with the CSE-related service user data, it can at most provide information about ***satisfaction*** with services rather than the ***effectiveness*** of services (see section 3.6).

Other than for sexual health commissioning, there appears to be no consultation with non-users of services to determine the extent of and reasons for services not being taken up.

Our research identified no examples of health commissioners consulting service users to inform commissioning strategies.

3.3 Local priorities

'What local priorities are there in relation to CSA and CSE?'

Stakeholders highlighted that there has been politically driven pressure to focus on CSE as the priority issue. Within this there are tensions, e.g. between focusing on 'street' or online grooming, generic or minority populations, and current victims or adult survivors. Despite budget reductions, work is still being done to increase identification, including with parents.

A majority of stakeholders expressed the view that CSA should be prioritised over CSE because it is seen as potentially a bigger, though less visible, problem. Other than some counselling or the option to refer for CAMHS support, there are no services to support the recovery of children who have experienced CSA. This includes suspected CSA, where many children are not in a position to disclose or receive counselling directly about the abuse; instead, they need a more generic approach which builds their resilience, increases their chance of avoiding re-victimisation and creates the possibility of a disclosure.

The health view was that caution is needed in allowing the CSA/CSE agenda to be dominated by the criminal justice system, as the child's wellbeing should come before the prosecution of the offender. There was a consensus that children who have experienced CSA need the same sort of befriending/trusting relationship that is offered to children who have experienced CSE.

Stakeholders were aware of the need for CSA and HSB services. Some stakeholders felt that CSA, CSE and HSB should be grouped together and addressed equally, in recognition of the fact that the vulnerabilities and types of trauma associated with all three are the same.

Amongst both commissioners and the VCS, there was anxiety that budget reductions will lead to a retreat from specialist services to generic services, with timeframes and assessment processes that will be unable to accommodate the long time period needed for CSA and CSE to be identified, disclosed or recognised by the victim, and then treated (with expert understanding needed to support recovery from complex trauma). Sexual health services are focused on CSE and not CSA or HSB.

3.4 Commissioned services

'What CSA and CSE services are commissioned locally? What are the relative strengths and areas for development locally? In particular, to what extent is local need being met?'

Local service aims

Stakeholders expressed the view that government departments (through policy, regulation and funding) and the law have compartmentalised CSA, CSE and HSB, which in fact are much more similar than different – and, even more importantly, have shaped the view of them as 'exceptional' when in fact they are very prevalent.

As noted above, commissioned services are largely for CSE and missing children. There is almost no commissioned support for CSA, and very little for HSB.

Prevention services

As noted in section 2,2, local areas describe education and awareness activities about consent, CSA and CSE as 'prevention' services. The bulk of prevention activity has tended to be directed at CSE. In one local authority area, for instance, the Home Office Police Innovation Fund has funded CSE prevention in the form of education and training in schools, amongst professionals and in the community (the night-time economy, shopping centres, pharmacists etc). Most local authorities have rolled out CSE dramas to primary and secondary schools, and awareness-raising/education for businesses and communities. More recently, however, these prevention activities have been reduced in response to budget cuts.

Some local authority areas noted the challenges in addressing CSE within particular black and minority ethnic communities and with refugees and asylum seekers, and in tackling the issue of consent in relation to children with learning disabilities. These issues and others are likely to apply also to online CSE (particularly for children with learning disabilities), CSA and HSB, although stakeholders did not refer to them in those contexts.

Stakeholders highlighted the challenge of getting the right balance between a focus on assessment and recovery and the anticipated rise in demand if there is no prevention work. Local authorities are exploring how to fund more preventative services again. There was agreement that schools, public health and the CCGs should take more responsibility for commissioning prevention activity: the view was expressed that schools, for example, have focused until now on improving identification and referral of CSE, and now need to shift the focus to prevention. However, whereas CSE input into training for teachers around personal, social, health and economic (PHSE) education used to be free, schools now have to purchase it – and there is evidence that there has been a reduction in the number of schools doing so.

Our research suggests that none of the local partnerships undertakes CSA prevention activity. Stakeholders agreed that prevention needs to include CSA, CSE and HSB. One local authority children's social care department has recently sought advice from the NSPCC about a CSA prevention strategy for 5–10-year-olds in schools: 'what does intra-familial CSA look like'.

CCGs and NHS trusts have funded CSE awareness raising/education for health staff.

Raising awareness of CSA/CSE amongst professionals

In one local area, CCG commissioners are currently reviewing how well providers share information with the CCG about CSA/CSE in their caseloads. There has been a lot of awareness-raising and training for primary care teams and GPs; this is done by the Named Doctor, who has specialised in safeguarding children. The message is that professionals should know what 'normal' presentation/behaviour is and be curious about why a child might be displaying anything that is not 'normal' – urging staff to 'think the unthinkable', rather than thinking 'that's young people for you nowadays'.

In another local area, CAMHS and the charity YoungMinds are piloting Routine Enquiry about Childhood Adversity (REACh) in mental health services, and CAMHS is piloting an adverse childhood experiences study.

In another local area, the 'Signs of Safety' approach is being introduced in two local authorities. It is designed to identify and articulate the key risks, and to tackle them in a very simple and collaborative way with the full involvement of the family and relevant professionals.

There was a consensus that staff in schools, and elsewhere, are ill-equipped to tackle HSB. Stakeholders reported that they do not tend to see it as a safeguarding issue and are not supported to address or make referrals concerning sexualised behaviour. Some areas used to have services for sexualised behaviour, but these were lost as part of budget reductions.

Services that identify and respond to risk

There was a consensus that non-specialist staff are still not confident to tackle CSA, are confused about the difference between CSA and CSE, and do not know how to access the appropriate service. In consequence, the responsibility remains with the child to understand that they are being abused and to disclose. Some local areas are addressing this by:

- identifying those universal service staff with whom children are most likely to come into contact, and delivering training to them
- introducing training on adverse childhood experiences (ACEs) to increase understanding and recognition of the impact of trauma
- promoting easy 'step-up' for cases from early help services via the multi-agency safeguarding hub (MASH), in recognition of the fact that suspected or disclosed CSA often emerges as cases progress.

All local authorities have multi-agency specialist CSE teams or 'hubs'; most include CSE nurses. Some areas have separate multi-agency teams responding to historical CSA/CSE.

Stakeholders agreed that parents are not currently included as partners in identifying and responding to CSA, CSE or HSB. There was a consensus that all three have a growing online element, which urgently needs a service response.

All areas have a CSE panel which oversees all CSE cases; in some areas, members of the CSE panel also attend panels which monitor 'persons of concern' (which would include HSB).

There are some promising local initiatives – all relating to CSE – such as CSE Champions and CSE Super Heroes, and one of the areas has a VCS service which has developed online resources. A local mental health NHS trust has introduced a 'floating CAMHS response' for CSE children and families, which has flexibility to intervene at a preventative or early intervention stage. Two local authorities have CSE and missing children services which provide very early support/detached youth work so that children not supported by children's social care are not lost to the system: the services offer support in relation to substance misuse, any need for counselling, CSE and going missing.

With regard to prevention and identification in schools, sexual health team services have been reduced as a result of funding cuts. Stakeholders were concerned that the school nursing service has been depleted: school nurses were identified by the children in the high-profile CSE cases as the one professional they felt they could turn to for help. The anticipation was that identification of CSE is going to drop.

A number of stakeholders were concerned about the regionalisation of the SARCs, because of the increase in travelling time for local children, e.g. a 1½-hour journey each way in addition to the time spent at the SARC itself. The number of counselling support sessions funded through SARCs is considered too low to be effective.

Services that respond, support and treat

All the commissioners, and health staff in particular, expressed frustration at the lack of funding to provide the support needed by children who have suffered CSE and CSA.

Stakeholders agreed that good commissioned provision usually depends on the VCS provider being well-established and having an excellent reputation locally.

A number of areas for improvement were identified, including the following:

- There is a significant shortfall in medium- to long-term support and counselling (more than 10 sessions) for children who have experienced CSA, CSE and/or HSB. Counselling offered without advocacy has been found to be relatively ineffectual, because the 'whole life' issues affecting the child are not resolvable in a weekly counselling session. There is a promising recognition across all the local authority areas that this type of support needs to be delivered within a trusting relationship. For this, the social worker or keyworker needs to have a low caseload and easy access to expert trauma-informed support (e.g. CAMHS).
- There is no support for parents and families. Stakeholders reported that offering short-term interventions without access to longer-term support does not work and is more expensive in the long run as problems re-emerge. Children (and their families) need different lengths of time and intensity of intervention in order to recover.
- SARCs – or, in some areas, paediatric sexual assault services (PSAS) – are the care pathway for all children under 18 years in need of a CSA forensic medical examination. However, stakeholders reported that the number of follow-up support sessions through the SARC funding needs to be significantly increased if they are to be effective.

Supplementing the SARC/PSAS offer

SARC/PSAS services include, for example, nine crisis counselling sessions. Now that the SARCs are regional, these sessions are subcontracted for each individual child to a local provider in the child's region.

The process is that the SARC/PSAS staff undertake the forensic medical examination and assess the child's need for trauma support. If support is felt to be needed, the child is then referred by the SARC/PSAS to their local VCS provider.

Local providers reported that it takes on average seven sessions for the child to develop sufficient trust to begin to benefit from the sessions. Local providers are therefore supplementing the SARC/PSAS offer with, for example, an additional 24 sessions to the initial nine. The sessions take a CBT-trauma approach.

Where it is available, stakeholders said they valued access to CAMHS expertise in the form of consultation to the MASH teams or hubs. As part of the commissioned main CSE service in some local authority areas, keywork support is provided for children and young people whose cases go through the court process. This includes support for children who have had to be moved out of the local area.

There was a consensus that transition from children's to adults' services is difficult for survivors of CSA and CSE. In some local authority areas, support services have been extended so that, in addition to offering support for care leavers and young people/adults with disabilities, support is also available for former service users and young mothers up to the age of 24 years.

Services for perpetrators and those with harmful sexual behaviour

Stakeholders agreed that there are not enough perpetrator programmes for young people or adults. In some areas, youth offending staff have been 'Assessment Intervention Moving on' (AIM) trained and they use the 'Good Lives' model. For under-11s, this work is undertaken by specialist social workers.

However, under-resourcing across all areas means that, rather than there being a commissioned local VCS service, one-off care packages are purchased for children considered to be 'high risk'.

Commissioners noted that these packages are difficult to benchmark and monitor for service quality, and that local knowledge and expertise is not being developed and retained.

Stakeholders were concerned because the volume of HSB is growing, fuelled by the internet. There is very little dedicated support for the families of young people who have sexually harmed others; these families can feel ostracised and victimised in their local communities.

HSB referrals on the rise

Commissioners reported increasing demand for services for sexualised behaviour and HSB. This information is coming from local sources such as:

- recent CSE police operations
- information coming into multi-agency operational CSE panels
- partner agencies reporting that their staff are identifying sexualised behaviour and HSB more
- information from youth offender services and the currently commissioned HSB services.

In one area, the number of referrals into their HSB service has risen by 168% in the past six years. The commissioner said:

> "The HSB service currently has a three-month waiting list. This is the highest waiting list they have ever had and there was no waiting list three years ago. They are increasingly signposting young people at lower risk levels, or just giving advice, where previously they would have worked directly with them. ACEs are exceptionally relevant, supporting the need for a 'whole' child."

A national VCS children and families service provider reported that it has developed a framework that will support professionals in all agencies to work with HSB and "demystify it". It is doing this in a local authority, and is well supported by the statutory education partners in 40 primary schools. The programme helps staff to identify and manage early sexualised behaviour including sexting, peer-on-peer and CSE. Accompanied by an e-learning pack, it has been very well-received; including by faith and special schools; the next step is to roll it out in secondary schools.

3.5 Organisations

'What types of organisations are being commissioned to run CSA and CSE services? What are their relative strengths and areas for development?'

Statutory, voluntary sector and private organisations

CSA and HSB are addressed by statutory services, in-house.

For CSE there are statutory, in-house-led multi-agency teams for assessment and short-term intervention, with the VCS for recovery intervention and support through court.

There was a consensus that the VCS is valued by service users for its independence, and by statutory services for its expertise around CSA and HSB in addition to CSE. A number of stakeholders noted that there are probably many individuals who seek support from VCS-provided services such as the local sexual assault and domestic abuse service (13+ years), either because they did not disclose CSA (or were not believed at the time) and are seeking help retrospectively, or because they have more recently experienced re-victimisation through CSE or domestic abuse/sexual assault as adults.

There are challenges in current relations between commissioners and VCS provider relations:

- The statutory and commissioned services largely do not allow each other access to their databases to share information quickly and easily (although there are exceptions).
- Co-location would improve information-sharing, because of the informal conversations that develop between formal meetings.
- The rapidly changing nature of CSA, CSE and HSB (in terms of age range, online elements, locations and related harms) means that flexibility in response is key. However, the commissioner-provider relationship is set by inflexible contract specifications/budgets (although, again, there are exceptions).
- Short-term contracts diminish the providers' ability to contribute as true partners (see section 3.2).

In some areas, the VCS has responded to the need for better information-sharing, seamless case management and flexible responses by setting up provider consortiums. They have needed support from the statutory sector to do this.

A concern was expressed that the flexibilities accorded to schools enable them to employ agencies or individuals who are not registered with a standard-setting national body such as the Charity Commission or the British Association for Counselling and Psychotherapy (BACP). In one area, a participant in the case study raised this issue with Health Education England.

Additionally, there is no quality assurance check on the process/care pathway that schools put in place for children seeking medical or safeguarding assistance. An example was provided of a local academy which requires children to approach their teacher to request an appointment with the school nurse. In light of the fact that school nursing is now purchased, this has the appearance of a gatekeeping measure.

3.6 Outcomes measurement

'How effectively are outcomes being measured in relation to commissioning of CSA/CSE services?'

There was a consensus that outcomes are not being measured effectively. This was generally felt to be because the information is about numbers, process, inputs and timescales, rather than 'distance travelled' for the service user.

At the same time, commissioners and providers were keen to minimise the diversion of resources into data collection and analysis.

In terms of the practicalities of current contract monitoring, both commissioners and providers were concerned about the service user experience in situations where a set number of sessions are offered. Providers feel pressure to close cases, and commissioners want feedback that the service user feels sufficiently recovered at the point that the sessions are completed.

However, there was acknowledgement that, in the words of one stakeholder:

> "The variation in individuals' circumstances, experiences and characteristics means that it is unrealistic to use outcomes for individuals to make fine judgements about service delivery."

According to another stakeholder, the difficulty with outcomes measurement for CSA/CSE is that, even if it were undertaken systematically across all services, it would still address only (a) those children who are known to have been abused, and (b) the short-term outcomes from receiving a service. A longitudinal study is needed to establish what works three, five and 10 years after case closure. This may shine a light on the likelihood of re-victimisation and how it happens; and provide information about the intergenerational impact of the abuse and the recovery service.

There are initiatives to agree outcomes across the local multi-agency partnerships, some for CSE (such as the outcomes framework currently being implemented over two local authority areas) and others for all types of child abuse. These address the fact that commissioners from different organisations focus on different performance measures. There was a consensus that a matrix of measures is needed, from individual to population: over time, for example, commissioners should be able to gauge 'success' by measuring reduction in prevalence levels. This ability is needed to cope with the degree of variability between cases and the challenges in measuring short- and long-term outcomes for individuals.

The lack of focus on CSA is reflected in the fact that, now that child protection plans record only one category, neglect rather than CSA tends to be chosen. Some stakeholders noted that the lack of focus on CSA means that cases tend to be either closed or taken forward under 'neglect' when (as is usual) joint investigative activity by children's social care and the police produces forensic evidence in relation to CSA. The stakeholders' concern was that, although it is easier to work with a family under the category of neglect, there is the potential that sexually abused children are not receiving the services they need to recover.

Some local authorities have been very successful in measuring outcomes by undertaking internal reviews of multi-agency practice. This has brought out into the open partnership working issues, the resolution of which has improved the overall response to CSE.

3.7 Future development of commissioning practices

'How will and/or should local commissioning approaches for CSA and CSE services develop into the future?'

All five case study areas had common views with regard to how commissioning of CSA/CSE should look like in the future. For instance, there was a consensus that a pooling of resources and expertise is needed – and particularly a strong tie-up of health and local authority services, as it was felt to be evident that CSE cannot be tackled by a single agency and that CSA and HSB need a greater focus and resource.

There was also a view that true collaboration with regard to commissioning should include statutory services supporting the VCS to bid for national or regional grant funding. There was a broad understanding across the case study areas of the need for better joint commissioning, and acknowledgement that this will take a huge amount of investment by all stakeholders in order to be successful. There needs to be a move to a 'partnership model' within joined-up approaches, not just a commissioner-subcontractor model.

Related to this, stakeholders were keen for there to be an increase in public health engagement in tackling CSA/CSE, prioritising the topic similarly to, for instance, obesity.

All areas are collating some information on local need, but there was consensus that this could be better – and that the information gathered needs to directly inform all future service specification and delivery.

A preventative response to CSA/CSE is an issue that areas wanted to be able to commission and focus on; however, funding cuts are making this a real challenge. All areas considered that investment in the future needs to refocus on prevention, with flexibility to tailor services for individual needs, more recovery service capacity and a commitment to intervening earlier.

The desire was expressed for future commissioning to create co-located, multi-disciplinary teams; this is already well progressed in one of the case study areas. Stakeholders view it as a clear advantage, in that the issues that children are facing are addressed holistically, rather than being discussed at continuous short meetings which can be less effective in providing the best intervention and achieving the best outcomes.

There is currently little opportunity for VCS organisations to influence the service design; stakeholders said this needs to be addressed, and raised concerns that commissioners may choose less skilled providers because of funding cuts. The issue of short-term funding also affects service delivery and in particular frontline staff; many stakeholders recommended longer funding periods such as 5–10 years.

Planning for services in the future also needs to take a more inclusive approach to adverse childhood experiences and recognise poly-victimisation. It is not just the experience of CSA/CSE that needs addressing: all other aspects of the child's life need to be fully considered, and their needs addressed. In addition, it needs to be understood that children are not currently being supported for long enough: recovery can take a long time, and children need time to build up trusted relationships, often with one key individual.

Stakeholders commented on the need for a more concerted effort to speed up the prosecution process: delays are having a detrimental impact on victims' education, in particular at critical periods of sitting GCSEs and A-Levels. Furthermore, commissioning needs to take responsibility for the current gap in services for young people from their 18th birthday until adult services get involved with them in their early 20s.

The need to address peer-on-peer abuse was also expressed, as there is currently no overarching multi-agency strategy for this.

All stakeholders believed there is a need for an outcomes framework, which should be developed to provide an accurate picture of the local CSA/CSE and HSB service offer's effectiveness. The incentive to work as a consortium is underpinned by ongoing funding reductions and the need to streamline managements and back office costs, but in this environment the need and desire to deliver an integrated case holder model can be lost. The danger is that this results in a cost-cutting drive towards the commissioning of generic support services, thus losing the specialism needed to promote the recovery of victims of sexual abuse.

Ultimately, commissioning should acknowledge that CSA can be an invasive, destructive and life-altering traumatic event which may happen in childhood, adolescence or even adulthood. The right intervention at the right time is best determined through a joined-up, collaborative approach.

3.8 Support from the Centre of expertise and/or its partners

'What support would you find helpful from the Centre of expertise on child sexual abuse and/or other partners?'

All stakeholders agreed that there is a lack of information about what works, what does not and what should be focused on. A key theme to emerge is ensuring that areas have a standardised approach to measuring risks and outcomes. Other responses focused mainly on four key areas:

- National conversation.
- Scrutiny and policy.
- Information, advice and guidance (IAG).
- Networking and engagement.

This is not an exhaustive list, as all areas reported a wide-ranging list of gaps and concerns that need to be developed, and help they would like.

National conversation

a) Increase the research and available information around CSA, which needs to match that around CSE.

b) Give statutory services easier access to external funding. Currently it is difficult even to partner with a VCS agency in supporting its bidding, as funding from grant-making trusts has to go through a tendering process which commissioners can find overcomplicated.

c) Offer a service specifically for children who have been traumatised but who do not have a mental health disorder. This should offer a mix of counselling, advice, mentoring and advocacy over a flexible time period, tailored to the service user's recovery needs.

d) Formally acknowledge that effective CSA/CSE recovery requires a level of funding that ensures the support is intensive and, where needed, can be in place for longer. Additionally, provide guidance on how commissioned services should take a whole-life approach, so that children who have completed immediate recovery work can subsequently access help at times that may trigger trauma (such as transition to secondary school, puberty, transition to adulthood and becoming a parent).

e) Recovery services are essential, but so is prevention. Create greater national focus and resourcing so that services can intervene early to make a difference in children's lives.

f) Recognise how government and Ofsted priorities influence local responses, and the potential for higher-level priorities to have unintended consequences at a local level.

g) Promote debate on key issues such as the costs and benefits of child houses and the usefulness of child abuse categories.

h) Support local commissioners to help improve knowledge and understanding of CSA/CSE/HSB and ensure that commissioning approaches and specifications are outcomes-focused and align with effective practice.

i) Commission practical research to build a much better picture nationally around CSA, CSE and HSB.

j) Help to improve the public's understanding of CSA, CSE and HSB. The public will be better able to prevent, identify and respond well to harm if they are alert to potential perpetrators (not just media stereotypes), the dynamics of grooming, online dangers, and behaviour and symptoms indicating that a child may be traumatised.

Scrutiny and policy

k) Bring a focus on CSA which complements good work around CSE. This should be supported by both basic and advanced training to improve confidence and competence at all points on the care pathway.

l) Areas are grappling with best practice 'tools' for assessing the risk of CSA/CSE. Develop better understanding of how tools are used and experienced in practice.

m) Support local areas to understand risk factors that are specific to CSA/CSE, and help commissioners understand the multiple disadvantages that families face, which may require specific and flexible service provision.

n) Consider offering a CSA/CSE evaluation service for local authorities. Stakeholders in the case studies were aware that the Centre of expertise has recently offered funding for evaluation of services, and were interested in pursuing this opportunity.

o) Prioritise children's health and wellbeing/recovery beyond the reduction of risk.

p) Support a mandatory focus on CSA/CSE in the 0–19 years Healthy Child Programme (e.g. alongside obesity).

q) Prioritise early intervention, with quicker access to counselling in a choice of settings such as schools and GP surgeries. This may prove challenging in times of austerity, but it is critical.

Information, advice and guidance (IAG)

r) Provide information and intelligence about all aspects of CSA/CSE and HSB. Commissioners and providers said they would welcome a system of sharing good practice across the country, in a format that is easily accessed. Within this, more research is needed, including on:

- understanding 'what works' in recovery from CSA/CSE and HSB
- supporting children and young people with undisclosed CSA/CSE
- knowledge of the county lines,[2] organised crime networks and trafficking.

s) Ensure everyone recognises that missing and trafficked children are part of this cohort, and information and practice is shared.

t) Address the under-development/scarcity of sexualised behaviour and HSB prevention and recovery services, and professional lack of confidence – for example, through guidance on what a good local response might look like.

u) Be available for professional consultation, advice and visits; feedback from the Centre would be useful in order to help local safeguarding partnerships improve their CSA/CSE and HSB service structure, systems and practice.

v) Promote a better understanding across the whole children's workforce of the dynamics and impact of trauma, and coercion and control. Additionally, it would be helpful to carry out a longitudinal study over a 10-year period, with sourced funding, into how individuals process trauma from CSA/CSE.

w) Help the non-CSA/CSE/HSB workforce to be skilled-up to engage directly with children and young people, so that children not fall through the net. This could be achieved with a national practice-based training package and resource pack.

Networking and engagement

x) Support networking between local safeguarding children commissioning teams, with particular emphasis on including health commissioners. This could be through networks, virtual conferences and a commissioning newsletter about good commissioning practice, e.g. outcomes measurement, service specifications, flexible contracting and models for consortium working.

y) Encourage the OPCCs to raise the profile of CSA/CSE in their Victims' Strategies, and better support local commissioners and local communities in embedding sexual abuse services.

z) Develop and maintain a web-based directory of campaigns, drama groups and community initiatives – e.g. those set up by parents whose children have been harmed, or by statutory or voluntary sector professionals.

aa) Support the development of ways in which services or commissioners in local areas and regions can better benchmark against each other (peer review).

2 County lines, or 'going country', means groups or gangs using young people or vulnerable adults to carry and sell drugs from borough to borough, and across county boundaries.

4. Conclusion

This rapid review has highlighted many of the current challenges for local safeguarding partnerships in commissioning CSE, CSA and HSB services. It has also identified promising commissioning activity across local authorities.

During the fieldwork for the review, the research team became aware of the amount of dedicated time and effort required by commissioners and providers to successfully negotiate the different (and changing) agendas and timelines, competing pressures, performance targets and needs of the various local safeguarding partners – and the needs of service users.

Two examples are from local authority commissioning teams looking to recommission their core CSE and missing service. In one case, it took two years for joint commissioning arrangements to be agreed before recommissioning of the CSE and missing service could begin; in the second case, the commissioning team spent 18 months skilling-up the local VCS provider network to be 'commissioning-ready' before it commenced the recommissioning. The promising commissioning activity highlighted in this report reflects this and other types of investment by the commissioners and the provider agencies.

Local authority areas have been fostering good practice and promoting new initiatives in commissioning and service delivery in the face of a shrinking financial envelope. As one case study participant said:

> "The local authority budget for [CSA/CSE] commissioning was always inadequate in relation to the size and demographics of the area; and it has remained unchanged for five to six years, which means that it has been reducing in real terms at a time when referrals are increasing as a result of work undertaken to improve identification."

There is a growing concern about increasing demand for CSA, CSE and HSB services, including in particular a service response to the online facilitation of these abuses.

We have found that local authority partnerships are running well-developed CSE initiatives, although prevention services have been significantly reduced. There is an ongoing need for CAMHS Tier 1 and 2 recovery services, and a similar need for more CAMHS provision at higher tiers. CSA and HSB should be targeted with the same rigour as CSE; contributions for addressing all three abuses are beginning to be looked for from health bodies and schools.

The local authority areas participating in this review welcomed the role that the Centre of expertise on child sexual abuse could play in assisting them to improve local commissioning, particularly by further developing national and cross-locality conversations and evidence-sharing. The research team note, however, that only central government can address some of the key challenges in delivering effective CSA/CSE and HSB services to meet need.

References

Action for Children (2009) *Preparing for the Future: Supporting Children and Young People Who Have Been Sexually Abused.* London: Action for Children.

Adams, R. (2014) *Nottinghamshire Joint Strategic Needs Assessment: Sexual Abuse*. Nottingham: Nottinghamshire County Council Domestic and Sexual Abuse Executive.

Allnock, D. and Miller, P. (2013) *No One Noticed, No One Heard: A Study of Disclosures of Childhood Abuse.* London: NSPCC.

Allnock, D., Radford, L., Bunting, L., Price, A., Morgan-Klein, N., Ellis, J. and Stafford, A. (2012) In demand: Therapeutic services for children and young people who have experienced sexual abuse. *Child Abuse Review*, 21(5): 318–334.

Allnock, D., Sneddon, H. and Ackerley, E. (2015) *Mapping Therapeutic Services for Sexual Abuse in the UK in 2015.* Luton: University of Bedfordshire International Centre.

Beckett, H., Firmin, C., Hynes, P. and Pearce, J. (2014) *Tackling Child Sexual Exploitation: A Study of Current Practice in London*. Luton: University of Bedfordshire.

Berelowitz, S., Clinton, J., Firmin, C., Gulyurtlu, S. and Edwards, G. (2013) *'If Only Someone Had Listened': Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups. Final report.* London: Office of the Children's Commissioner.

Berelowitz, S., Firmin, C., Edwards, G. and Gulyurtlu, S. (2012) *'I Thought I Was the Only One. The Only One in the World': The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups. Interim Report.* London: Office of the Children's Commissioner.

Buckinghamshire Children's Social Care and Learning Select Committee (2015) *How Are We Preventing Child Sexual Exploitation and Supporting Young People in Buckinghamshire?* Aylesbury: Buckinghamshire County Council.

Camden Safeguarding Children Board (2017) *Annual Report 2016/17*. London: CSCB.

Cameron, G., Mendez Sayer, E., Thomson, L. and Wilson, S. (2015) *Child Sexual Exploitation: A Study of International Comparisons*. London: Office for Public Management.

Carpenter, J., Jessiman, T., Patsios, D., Hackett, S. and Phillips, J. (2016) *Letting the Future In: A Therapeutic Intervention for Children Affected by Sexual Abuse and their Carers.* London: NSPCC.

Christie, E.C. (2018) *A Trauma-informed Health and Care Approach for Responding to Child Sexual Abuse and Exploitation: Current Knowledge Report.* London: Department of Health, forthcoming.

Christie, C. (2014) *The Child Sexual Exploitation Service and Missing Children Service for Young People in Stoke-on-Trent: A Review*. Epsom: Chanon Consulting.

Children's Commissioner for England (2015) *Protecting Children from Harm: A Critical Assessment of Child Sexual Abuse in the Family Network in England and Priorities for Action*. London: Office of the Children's Commissioner.

Coy, M., Sharp-Jeffs, N. and Kelly, L. (2017) *Key Messages from Research on Child Sexual Exploitation: Strategic Commissioning of Children's Services.* Barkingside: Centre of expertise on child sexual abuse.

Davidson, J., Bifulco, A., Grove-Hills, J. and Chan, J. (2012) *An Exploration of Metropolitan Police Investigative Practices with Child Victims of Sexual Abuse*. London: Centre for Abuse and Trauma Studies, Kingston University.

Davies, C.T. (2016) *An Overview of the Multi-Agency Response to Child Sexual Exploitation in Peterborough*. Peterborough: Peterborough Safeguarding Children Board.

Department for Education (2015) *Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children*. London: DfE.

Department for Education (2017) *Child Sexual Exploitation. Definition and a Guide for Practitioners, Local Leaders and Decision Makers Working to Protect Children from Child Sexual Exploitation.* London: DfE.

Department of Health (2014) *Health Working Group Report on Child Sexual Exploitation: Response to the Recommendations*. London: DH.

Department of Health (2015) *Future in Mind: Promoting, Protecting and Improving Our Children and Young People's Mental Health and Wellbeing*. London: DH.

Devon County Council (2013) *Domestic and Sexual Violence and Abuse Joint Strategic Health Needs Assessment (2nd edition)*. Exeter: Devon Safeguarding Children Board.

Firmin, C., Curtis, G. and Tat, J.K. (2015) *Thematic Briefing #1: Responses to Boys and Young Men Affected by Peer-on-Peer Abuse – Work across MsUnderstood Local Sites*. London: MsUnderstood Partnership.

Firmin, C. and Curtis, G. (2015) *Practitioner Briefing #3: Peer-on-Peer Abuse and Exploitation – The Role of Youth Offending Services in Building a Local Response*. London: MsUnderstood Partnership.

Golding, N. and Duggal, A. (2011) *Commissioning Services for Women and Children Who Experience Violence or Abuse – A Guide for Health Commissioners*. London: Department of Health.

Goddard, A., Harewood, E. and Brennan, L. (2015) *Review of Pathway Following Sexual Assault for Children and Young People in London*. London: NHS England/King's College Hospital NHS Foundation Trust.

Hackney Council (2016) *London Borough of Hackney Violence against Women and Girls Strategy 2016–2019*. London: Hackney Council.

Hallett, S., Crowley, A., Deerfield, K., Staples, E. and Rees, A. (2017) *Review of the Wales Safeguarding Children and Young People from Sexual Exploitation (CSE) Statutory Guidance*. Cardiff: Welsh Government.

Hanson, E. and Holmes, D. (2013) *That Difficult Age: Developing a More Effective Response to Risks in Adolescence.* Dartington: Research in Practice.

Harewood, E. (2017). *Child Sexual Abuse Hub Toolkit: A Practical Guide for Commissioners and Practitioners to Establish a CSA Hub*. London: NHS England.

HM Government (2015) *Tackling Child Sexual Exploitation*. London: Cabinet Office.

Horvath, M., Davidson, J.C., Grove-Hills, J., Gekoski, A. and Choak, C. (2014). *'It's a Lonely Journey': A Rapid Evidence Assessment on Intrafamilial Child Sexual Abuse.* London: Office of the Children's Commissioner.

Humphreys, S. (2015) *Independent Commentary: Oxfordshire Stock-Take*. Oxford: Oxfordshire Safeguarding Children Board.

Jago, S., Arocha, L., Brodie, I., Melrose, M., Pearce, J. and Warrington, C. (2011) ***What's Going on to Safeguard Children and Young People from Sexual Exploitation? How Local Partnerships Respond to Child Sexual Exploitation***. Luton: University of Bedfordshire.

Laville, S. (2016). Police expect 30,000 new child abuse reports from Goddard inquiry. ***The Guardian***, 19th May.

Local Government Association (2014) ***Tackling Child Sexual Exploitation: A Resource Pack for Councils***. London: LGA.

Martin, L., Brady, G., Kwhali, J., Brown, S.J., Crowe, S. and Matouskova, G. (2014) ***Social Workers' Knowledge and Confidence When Working with Cases of Child Sexual Abuse: What Are the Issues and Challenges?*** London: NSPCC

MBARC (2016) ***Sexual Violence against Children and Young People: The London Sexual Violence Needs Assessment 2016 for MOPAC and NHS England.*** London: Mayor's Office for Policing and Crime.

Musgrave, S., Pickup, L., Maskrey, V., Blyth, A., Notley, C. and Holland, R. (2014) ***A Health Needs Assessment for Complainants of Sexual Assault in Norfolk and Suffolk***. Norwich: University of East Anglia.

McNaughton Nicholls, C., Harvey, S. and Paskell, C. (2014) ***Gendered Perceptions: What Professionals Say about the Sexual Exploitation of Boys and Young Men in the UK***. Barkingside: Barnardo's.

Ofsted (2016) ***'Time to Listen' – A Joined Up Response to Child Sexual Exploitation and Missing Children.*** Manchester: Ofsted Inspectorate.

Oxfordshire Safeguarding Children Board (2015) ***Position Statement in Regards to Child Sexual Exploitation within Oxfordshire.*** Oxford: OSCB.

Office of the Children's Commissioner (2015) ***Protecting Children from Harm: A Critical Assessment of Child Sexual Abuse in the Family Network in England and Priorities for Action.*** London: Office of the Children's Commissioner.

Otway, P. (2015) ***Barnsley All-Age Mental Health and Wellbeing Commissioning Strategy 2015–2020***. Barnsley: NHS Barnsley Clinical Commissioning Group.

Paskell, C. (2012) ***Tackling Child Sexual Exploitation: Helping Local Authorities to Develop Effective Responses.*** Barkingside: Barnardo's.

Pearce, J. (2014) 'What's going on' to safeguard children and young people from child sexual exploitation: A review of local safeguarding children boards' work to protect children from sexual exploitation. ***Child Abuse Review***, 23(3): 159–170.

Pona, I. and Baillie, D. (2015) ***Old Enough to Know Better? Why Sexually Exploited Older Teenagers Are Being Overlooked.*** London: The Children's Society.

Robinson, A. and Hudson, K. (2011) Different yet complementary: Two approaches to supporting victims of sexual violence in the UK. ***Criminology and Criminal Justice***, 11(5): 515–533.

Sharp-Jeffs, N., Coy, M. and Kelly, L. (2017). ***Key Messages from Research on Child Sexual Exploitation: Multi-agency Working.*** Barkingside: Centre of expertise on child sexual abuse.

Shuker, L. and Harris, J. (2016) *Overcoming the Challenges of Evaluating Services That Support Young People Affected by Sexual Exploitation: A Realist Approach.* Presentation at the Children and Young People Now conference 'Achieving Outcomes'. **www.alexiproject.org.uk/assets/documents/Presentation-for-Children-and-Young-People-Now-conference.pdf**

Smith, C., Bradbury-Jones, C., Lazenbatt, A. and Taylor, J. (2013). *Provision for Young People Who Have Displayed Harmful Sexual Behaviour: Final Project Report.* Edinburgh: University of Edinburgh/ NSPCC Child Protection Research Centre.

Solihull Local Safeguarding Children Board (2017) *Solihull LSCB Strategy to Tackle Sexual Exploitation 2017–2019.* Solihull: Solihull LSCB.

Stoke-on-Trent and Staffordshire Safeguarding Children Boards (2016) *Child Sexual Abuse Multi-Agency Strategy.* Stafford: Staffordshire Safeguarding Children Board.

Sweeney, A., Clement, S., Filson, B. and Kennedy, A. (2016) Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*, 21(3): 174–192.

Wallace, S. (2016) *Response to Child Sexual Exploitation Scrutiny Report Recommendations.* Plymouth: Plymouth City Council.

Webb, J. and Holmes, D. (2015) *Working Effectively to Address Child Sexual Exploitation: An Evidence Scope*. Dartington: Research in Practice.

Welsh Assembly Government (2009) *All Wales Protocol: Safeguarding and Promoting the Welfare of Children and Young People Who Are at Risk of Abuse through Sexual Exploitation.* Cardiff: WAG.

West Midlands Metropolitan Authorities (2014) *West Midlands Metropolitan Area Child Sexual Exploitation Framework, Incorporating the See Me, Hear Me Framework*. Birmingham: WMMA.

Winters, L. (2011) *Sexual Violence Needs Assessment for Merseyside: Final Report*. Liverpool: Liverpool Public Health Observatory.

Women's Aid (2014) *Successful Commissioning: A Guide for Commissioning Services That Support Women and Children Survivors of Violence*. Bristol: Women's Aid Federation of England.

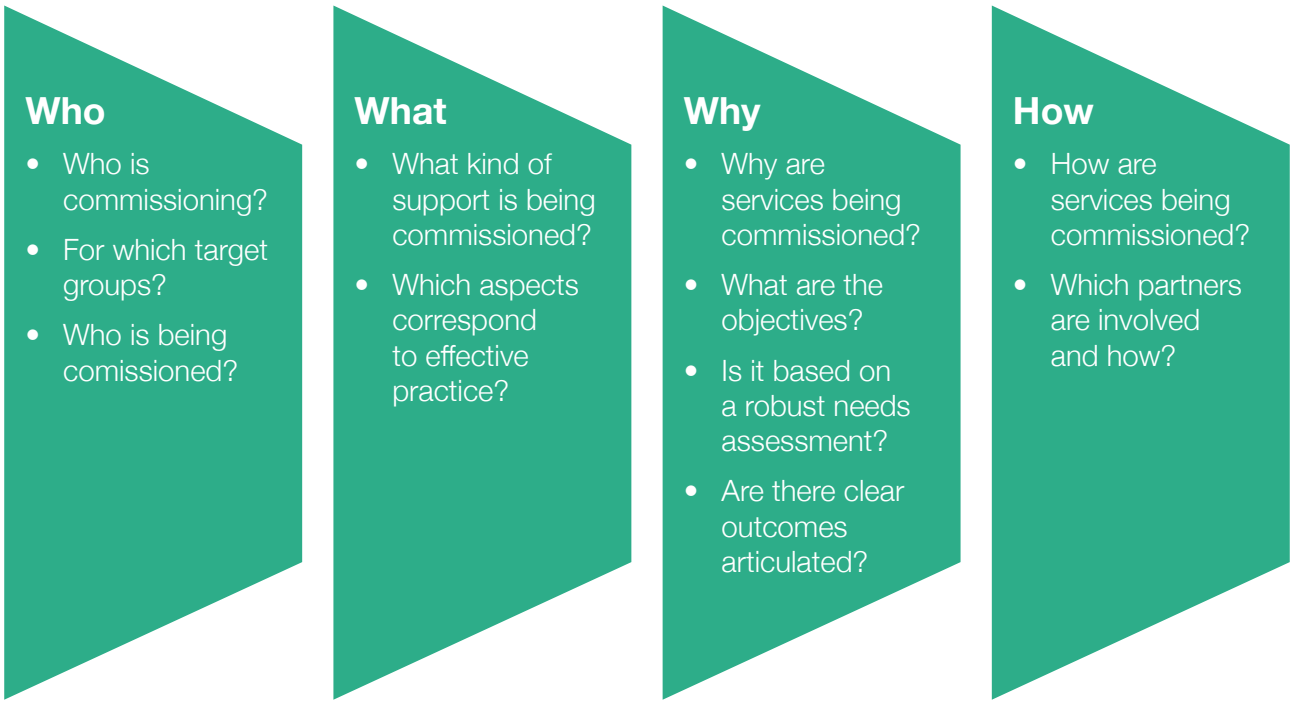
Yorkshire MESMAC (2016). *The BLAST! Project: Impact Document – 2016*. York: Yorkshire MESMAC.

Appendix 1: Literature review methodology

This rapid literature review:

- focused on local approaches from 2010 onwards
- encompassed all relevant partners, i.e. local authorities, police, health and the voluntary and community sector
- included prevention and early intervention as well as therapeutic services and interventions
- considered commissioning for young people beyond 18 years
- focused on England, but considered other areas of the UK if particularly pertinent.

The review sought to address the 'who, what, why and how' of local commissioning:



A bibliography of resources was compiled using the following search terms, which were searched for using Google, Google Scholar and Embase.

Core terms	
"commissioning" +	"child sexual abuse"
"procurement" +	"child sexual exploitation"
"contract" +	
"grant" +	
"framework" +	
"specification" +	
"strategy" +	
"business plan" +	
"action plan" +	
"governance" +	
"performance monitoring" +	
"needs assessment" +	

Secondary terms	
"effective practice" +	"child molestation"
"good practice" +	"grooming"
"services" +	"sexual violence" + "children"
"support" +	"paedophilia"
"prevention" +	"FGM"
"early intervention" +	"child sexual assault"
"therapeutic" +	"child pornography"
"interventions" +	

Each search term or phrase was entered, and abstracts/summaries of reports were scanned for all potentially relevant and publicly accessible articles. The most appropriate and relevant reports were subsequently selected for the bibliography.

The reference lists of comprehensive and relevant reports were also examined and manually searched.

The inclusion criteria of the literature review were as follows:

- Reports/documents published after January 2010.
- Reports/documents from the UK only, with a priority on England, then Wales.
- Priority given to local rather than national approaches.
- Priority given to documents available in PDF or .doc form.

Appendix 2: Profile of interview respondents

	Interviewee	Area A	Area B	Area C	Area D	Area E
1	Local authority – person responsible for commissioning CSA and CSE services	✓	✓	✓	✓	✓
2	Local authority – person responsible for commissioning CSE services	✓	✓	✓	✓	✓
3	CCG – person responsible for commissioning CSA services				✓	✓
4	Director of Public Health – person responsible for commissioning 0–19 years Healthy Child Programme, school health services, sexual health services and ISVA services	✓			✓	✓
5	Public health – person responsible for commissioning sexual health services and ISVA services		✓		✓	✓
6	CAMHS (NHS Trust) provider of CSA/CSE support services – person responsible for service development and delivery	✓	✓		✓	✓
7	OPCC commissioner of victims' services – person responsible for commissioning services for 0–25-year-old victims of intimate personal violence and sexual exploitation		✓	✓ ✓		
8	VCS provider of CSA support services – person responsible for delivering commissioned services for children who have experienced sexual abuse	✓	✓		✓	✓
9	VCS provider of CSE-related services – person responsible for delivering commissioned services for children who have experienced CSE	✓	✓	✓	✓	✓

Appendix 3: Fieldwork materials

Project information

Cordis Bright has been commissioned by the Centre of expertise on child sexual abuse to undertake this rapid research project.

Rapid literature review

We have completed a rapid review of the literature in relation to commissioning approaches for child sexual abuse services and support exploring:

- **Who** – is commissioning, for which target groups, and who is being commissioned?
- **What** – kind of support is being commissioned and which aspects correspond with effective practice?
- **Why** – what are the objectives of commissioning? Is it based on robust needs assessments and are clear outcomes articulated?
- **How** – what commissioning approaches are used and which partners are involved?

Case studies

We have been asked to:

- review relevant local documentation that is provided by commissioners and their partners
- analyse locally available datasets about the commissioning process
- scrutinise inspection reports, national commissioning models, national/local key performance indicators and serious case reviews to glean further information about outcomes and/or relative effectiveness
- arrange to conduct interviews with at least six individuals to explore the local context in-depth and with nuance.

We propose to complete this through a combination of a half-day site visit to case study areas followed by telephone interviews.

Thematic review

The results from the literature review and the case studies will be combined to form a thematic review. This will examine any cross-cutting issues, strengths and weaknesses of commissioning of child sexual abuse services/support, and levers and barriers to improvements. We will then finalise the case studies and thematic review, and draft a Project Report.

Interview questions

1. What local approaches are in place for commissioning child sexual abuse and child sexual exploitation services?

    a. Governance and partnerships
    b. Profiling/assessment of need
    c. Strategy
    d. Funding

    - What are the relative strengths and areas for development of these local approaches?

2. Who is involved in commissioning?
    a. Statutory partners
    b. Voluntary sector
    c. Service users and/or victims
    - What are the relative strengths and areas for development locally?
3. What local priorities are there in relation to child sexual abuse and child sexual exploitation?
4. What child sexual abuse and child sexual exploitation services are commissioned locally?
    a. Prevention
    b. Identifying and responding to risk
    c. Responding, supporting and treating
    d. Perpetrators and those with harmful sexual behaviour
    - What are the relative strengths and areas for development locally? In particular, to what extent is local need being met?
5. What types of organisations are being commissioned to run child sexual abuse and child sexual exploitation services? What are relative strengths and areas for development?
6. How effectively are outcomes being measured in relation to commissioning of child sexual abuse and child sexual exploitation?
7. How will and/or should local commissioning approaches for child sexual abuse and child sexual exploitation services develop into the future?
8. What support would you find helpful from the Centre of expertise on child sexual abuse and/or other partners?

Documentation and data

To help us develop a robust case study, we would like to have access to local documentation and data. This includes information about:

- governance arrangements
- local commissioning strategy and action plan
- needs assessments
- service level agreements and/or funding agreements
- operational care pathways, practice guidance and materials (incl. problem profiles)
- performance monitoring reports and evaluations
- any evaluations/reviews of services
- serious case reviews/other learning reviews involving child sexual abuse or child sexual exploitation
- care pathway and map of local CSA/CSE service provision if available.

Appendix 4: Feedback from other commissioners

This appendix summarises the main areas of discussion at a workshop with local commissioners and national policy-makers in October 2017, where the report's draft findings were explored and possible next steps in response to them were discussed.

The participants were asked to consider:

- the extent to which, and the ways in which, the findings reflect their own experiences locally
- the barriers to implementing improvements and how these should be addressed.

There was a high degree of agreement across all participants that the findings reflect their own experiences locally, regionally and nationally. Their observations included the following:

- Local authorities (and other public services) are experiencing substantial budget restraints. The requirement to spend budgets in full each year is an additional constraint, creating barriers that affect the volume or quality of services for children experiencing sexual harm. These barriers include:
    - increasing social work and other statutory and VCS agency caseloads
    - rising thresholds
    - lack of investment in prevention and early intervention
    - lack of capacity to invest or pump-prime
    - difficulties in responding to peaks and troughs in demand.
- Challenges in achieving the right response to sexual harm have both structural and cultural elements – for example, there are still widespread examples of professionals not recognising when sexual harm has been perpetrated, not seeing sexual harm as their responsibility, feeling that they don't have permission to respond to concerns, and/or blaming the victim for instances of sexual harm.
- There remains a high degree of variation in the extent to which local areas are considering and responding to all aspects of sexual harm – CSA, CSE and HSB.
- A particular challenge is addressing HSB, especially if it is seen as principally a responsibility of youth offending teams. This inhibits the amount of prevention work (either group or individual) that is undertaken, and the timeliness of support when a child or young person is under criminal investigation or prosecution.
- There is a lack of confidence across all professionals working with children and young people in relation to sexual harm. It was felt that this could be addressed nationally for NHS professionals via Health Education England. There was less discussion about the main mechanisms for other professionals. Addressing teaching professionals' confidence may be more difficult, owing to the decentralisation of schools and colleges.
- The lack of confidence and capacity extends to local communities, which can also contribute to preventing and responding to sexual harm – particularly by building children's resilience. There was a view that Public Health Directors could be engaged to develop a framework for responding to the impacts of sexual harm, and might support initiatives such as a widespread public health message about sexual harm that mirrors the 'five-a-day' healthy eating campaign. There is a high degree of variability in the extent to which local areas have a clear sexual harm care pathway for children and young people, which highlights the full range of responses from a low-level concern through to complex harm.

- Many commissioners lack access to data and analytical capabilities which could help them understand the level and extent of local need and how effectively services are addressing these (in terms of reach, quality of service and impact).
- Schools are a key gap in addressing sexual harm effectively. It is rare for a school to have a culture where preventing, identifying and responding to sexual harm is seen as a core and underlying role for the school and its staff: instead, this is often seen as being 'in addition' and/or a burden. Furthermore, school responses to early manifestations of HSB tend to be punitive and lack follow-up support or therapeutic intervention: this can lead to escalation. It was also noted that there is a lack of:
    - knowledge of indicators of sexual harm and appropriate response to support a child victim
    - knowledge of early indicators of HSB
    - group work to explore sexual harm with children and young people.
- Attached to this, proposals to change the Relationships and Sex Education guidance for schools could be tapped into, to ensure that this aspect of the school curriculum is leveraged.
- Collaborative commissioning (between commissioners and statutory and VCS partners), with pooled budgets and joint on-the-ground decision-making and shared risk, is essential to high-quality, responsive and effective services.
- There is a need at a local level for designated and explicit leadership which acts as a champion for effective responses to sexual harm. There was general agreement that each local area should decide which role this should be.
- There is risk, borne of experience, that regular restructuring of services and teams is inhibiting ongoing prioritisation, the development of working relationships, and ability to embed and develop effective practice.
- Involvement of the VCS is a key area for development, as:
    - relatively short contracts are affecting the VCS's ability to invest and innovate
    - there are potential issues with terms and conditions within VCS organisations
    - a different, more collaborative relationship between commissioners and service providers is needed
    - existing commissioning approaches may not be sufficiently sophisticated to cater for delivery over the longer term, when actual services delivered and relative demands may change over time.
- There are examples of VCS organisations working with each other locally to create a consistent 'umbrella' response to sexual harm. This can involve sharing the same approaches to measuring performance and impact, and sharing information on need.
- It is important to involve adult services, especially given the length of time that it can take for an individual to disclose experiences of sexual harm. In Newcastle, for example, all sexual harm services sit under adult services.
- Stakeholders wondered whether there was learning that could be usefully applied from the national strategy to reduce teenage pregnancy rates.
- One stakeholder proposed that further research be undertaken to examine what services are commissioned for victims/survivors of childhood sexual harm who are seeking support as adults.

www.csacentre.org.uk

©January 2018