Hull City Council

Children, Young People and Family Services

Making Improvement Happen Together

# Child Sexual Abuse - Best Practice Guidance

**Contents**

## 1. Introduction

This practice guidance has been produced to help practitioners work effectively with children and young people when there are concerns about child sexual abuse in the family environment. This is an important yet challenging area of work which requires practitioners to feel confident and supported. It is an area of our practice that can raise difficult feelings and we need to feel able to be reflective and share our thoughts and concerns in order to work effectively.

The context of working with sexual abuse can be a difficult and demanding one; there is often a level of denial and secrecy and the family may not want, or be able to acknowledge difficulties. This can result in the practitioner needing to develop effective relationships with the family and the onus is on us to be creative and determined in how we achieve this. We can be a factor in creating resistance but also a tool for minimising resistance.

Practitioners can feel less confident in working with sexual abuse because key information is frequently unknown. There is a need to work with this uncertainty and accept that we may never achieve the clarity that we want.

This work will achieve the best outcomes for children when the practitioner has access to regular, reflective supervision and has developed open and trusting partnership working with other key agencies.

Whilst the number of children that we work with who have experienced sexual abuse is relatively low it can be even less frequent for practitioners from other agencies and we need to be mindful of their need for support and guidance from ourselves and our organisation. There is a useful checklist for self-preparation available in, Intra-familial child sexual abuse: *Risk factors, indicators and protective factors Practice Tool, Research in Practice p27.*

## 2. Definition of child sexual abuse in the family

Working Together to Safeguard Children 2018 defines sexual abuse as follows:

*'Sexual abuse 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).*

*Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.'*

Sexual abuse often occurs in conjunction with other forms of child abuse, such as emotional abuse and physical abuse and this can be related to the adult that is abusing trying to maintain control and secrecy.

Children from the age of birth onwards can be sexually abused. Child sexual abuse is strongly associated with adverse outcomes across the life course including: physical health problems; poor mental health and wellbeing; externalising behaviours such as substance misuse; difficulties in interpersonal relationships; socio-economic impacts including lower levels of education and income; and vulnerability to victimisation both as a child and an adult (Fisher et al, 2017).

*Definition of child sexual abuse in the family environment*
There are a number of definitions of child sexual abuse in the family environment. The first one below has been adopted by Ofsted to inform the Joint Targeted Area Inspection in this area of work.

This definition has been taken from a 2014 report on the inquiry undertaken by the Children's Commissioner into child sexual abuse in the family environment. The report published in November 2015 is called 'Protecting Children from Harm' and defined sexual abuse in the family environment as follows:

*'Sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member, or someone otherwise linked to the family context or environment, whether or not they are a family member. Within this definition, perpetrators may be close to the victim (e.g. father, uncle, and stepfather) or less familiar (e.g. family friend, babysitter).' Perpetrators can also be female, such as mother, aunt and stepmother.*

Some of the findings from the report include that:
The estimated proportion of children that suffer sexual abuse is about 11%;

- Two thirds of child sexual abuse takes place within the family environment or the close circle around it;
- Only one in eight children in England who are sexually abused come to the attention of statutory authorities;
- Children often do not recognise that they have been abused until they are older;
- Practitioners working with children need additional support to help them identify victims of sexual abuse; and
- Child sexual abuse in the family environment often comes to the attention of statutory and non-statutory agencies as a result of a secondary presenting factor, for example self-harm, which becomes the focus of intervention. Child sexual abuse, the underlying issue, may not be identified.

A second definition is made by the Crown Prosecution Service (Guidelines 2013):

*These offences reflect the modern family unit and take account of situations where someone is living within the same household as a child and assuming a position of trust or authority over that child, as well as relationships defined by blood ties, adoption, fostering, marriage or living together as partners.*

## 3. How we might identify child sexual abuse in the family

Sexual abuse which takes place within family environments often remains hidden and can be the most difficult type of abuse for children and young people to speak about or for families to openly acknowledge.

It can be particularly difficult to disclose abuse by a sibling. Sexual abuse by sibling is the most common type of sexual abuse in the family environment; 'Sibling sexual abuse is more common (possibly three to five times more) than sexual abuse perpetrated by other family members (Monahan, 2010). We also know that adolescents who display harmful sexual behaviour usually do so first within their family (Miranda and Corcoran, 2000).

Many children and young people do not initially recognise themselves as victims of sexual abuse - as the child may not understand what is happening and may not even know that it is wrong especially as the perpetrator will seek to reduce the risk of disclosure by normalising the behaviour, threatening them, telling them they will not be believed or blaming them in some way for their own abuse.

Children who are sexually abused may exhibit a range of signs but any one sign doesn't necessarily mean that a child is being sexually abused; however if you identify the presence of number of signs you will need to consider the possibility of sexual abuse and consult with others who know the child to see whether they also have concerns.

*Signs include:*

- Changes in behaviour, including becoming more anxious, aggressive, withdrawn, clingy;
- Problems in school, difficulty concentrating, drop off in academic performance;
- Sleep problems or regressed behaviours i.e. bed wetting;
- Being frightened of or seeking to avoid spending time with a particular person;
- Knowledge of / or interest in sexual behaviour/language that is inappropriate for their age;
- Harmful sexual behaviour;
- Children who behave sexually or play sexual games;
- Physical symptoms including painful urination, pregnancy (particularly where the identity of the father is vague or secret), STIs, discharge or unexplained bleeding;
- Poor hygiene;
- Injuries and bruises on parts of the body where other explanations are not available especially bruises, bite marks or other injuries to breasts, buttocks, lower abdomen or thighs;
- Soreness in genital / anal areas;
- Injuries to the mouth, which may be noted by dental practitioners.

*Other Factors*

- Frequent house moves;

- Isolation of children (and other members) within the family from practitioners, and the wider community;
- Failure to register with a GP;
- Frequent absences from school;
- Failure to cooperate with agencies or to let police, children's social care or other agencies into the home, or not letting children be seen alone by professionals;
- Attempts to disguise injuries or attribute them to other causes;
- A child or young person who self-harms, misuses drugs, alcohol or solvents, and / or develops mental health difficulties;
- Repeated pregnancies with no information on the father;
- Genetic abnormalities in pregnancy or in children who are born.

In the long term people who have been sexually abused are more likely to suffer with depression, anxiety, eating disorders and post-traumatic stress disorder (PTSD). They are also more likely to self-harm, become involved in criminal behaviour, misuse drugs and alcohol, and to commit suicide as young adults.

Often children and young people do not tell anyone when they experience abuse and there are various complex reasons for this. These include that they may not feel unsafe or indeed recognise what has happened as abuse. Other reasons include embarrassment and shame, not knowing it was wrong, fear because they've been threatened by the abuser, not wanting to get into trouble, thinking nobody will believe them, not knowing how to tell or having the words to say, liking or loving the abuser and wanting to protect him/her – especially where it is a close relative or parent, and lastly the child may think that you already know about it.

Children and young people may find it easier to talk to someone first who is not in their family. This might be because they wish to protect someone such as their parent or carer. This will clearly be made easier if the child has a network of supportive adults around them. It is not the most important thing who the child chooses to tell, but that they are able to tell someone.

When people abuse children, they rely on secrecy and try to silence the child and to build trust with adults such as ourselves as practitioners. By doing this they count on us to be silent too if we have a worry about them. We can tackle this secrecy by supporting children to develop trusting and open relationships with the people in their safety network and working with children to help them recognise when their sense of safety has been breached

Adapted from Wrench 2016

## 4. Practice principles when working with child sexual abuse

The principles below are aimed at supporting practitioners in their work in this area.


## 5. The impact of child sexual abuse

The complex relationship between sexual abuse and other aspects of a person's life means it is not usually possible to say that an outcome has been caused by their experience of child sexual abuse (CSA). Factors which may influence the impact of abuse include its severity and duration, the age at which it occurred, the relationship between victim and perpetrator and other difficulties and supports in a child's life (Allnock, 2016). There is currently no research that differentiates impact of intra-familial abuse by gender of abuser or victim.

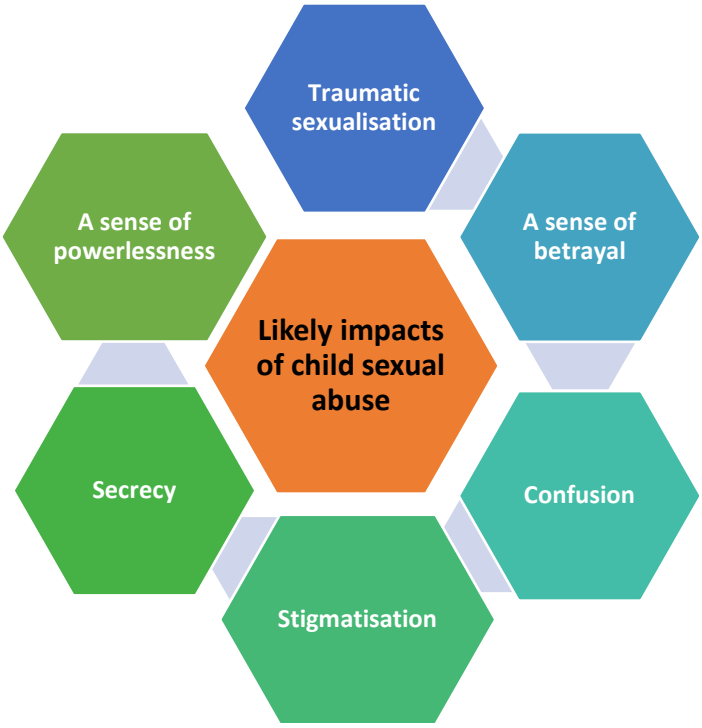
An influential model (Finkelhor and Browne, 1986) proposed four likely impacts of CSA:

- *traumatic sexualisation* – where sexuality, sexual feelings and attitudes develop inappropriately:
- *a sense of betrayal* - because of harm caused by someone the child vitally depended upon
- *a sense of powerlessness* - because the child's will is constantly contravened; and
- *stigmatisation* - where shame or guilt are reinforced and become part of the child's self-image

To these can be added two addition impacts from Glaser 1991:

- *secrecy* - including the fear and isolation this creates; and
- *confusion* - because the child is involved in behaviour that feels wrong but has been instigated by trusted adults)

While these impacts are not unique to intra-familial CSA, their combination and intensity in this context makes the experience particularly damaging.




CSA is strongly associated with the following adverse outcomes across the life course (Fisher et al, 2017):

- Physical health problems, including immediate impacts and long-term illness and disability (Heger et al, 2002; Allnock et al, 2015)
- Poor mental health and wellbeing (One in Four, 2015; Chen et al, 2010; Maniglio, 2009)
- Externalising behaviours such as substance misuse, 'risky' sexual behaviours, and offending (One in Four, 2015; Maniglio, 2009; Ogloff et al, 2012)
- Difficulties in interpersonal relationships (Kia-Keating et al, 2010; Kristensen and Lau, 2011; Liang et al, 2006; Seltmann and Wright, 2013; One in Four, 2015; Allbaugh et al, 2014; Sneddon et al, 2016)
- Socio-economic impacts, including lower levels of education and income (Boden et al, 2007; Fergusson et al, 2013; Pereira et al, 2017; Nelson, 2009; Barrett et al, 2014; Lee and Tolman, 2006)
- Vulnerability to revictimisation, both as a child and as an adult (Filipas and Ullman, 2006; Barnes et al, 2009; Sneddon et al, 2016; Finkelhor et al, 2007).

However, not every child who experiences sexual abuse suffers serious consequences (Sneddon et al, 2016). The poorest outcomes tend to be for children whose sexual abuse is combined with other adversities (such as bereavement and loss) and/or other forms of

maltreatment (Finkelhor et al, 2007), and recent research suggests that it is the accumulation of victimisation across the life course that has the most negative effects (Scott et al, 2015).

A number of factors may contribute to an individual's resilience to the impacts of CSA, both at the time of the abuse and later in life (Kogan, 2005; Ullman and Brecklin, 2002; Salter et al, 2003). These factors include high self-esteem or self-reliance, the development of positive coping strategies and the informal support a child receives from adults in their life, or through school, religious groups or social clubs (Allnock and Hynes, 2009).

Adapted from 'Key messages from research on intra-familial child sexual abuse' McNeish and Scott, Centre of expertise on child sexual abuse, 2018 p5.

**6. Responding when a child speaks out about being abused**

In addition to the information in this section, there is a useful chapter in the Intra-familial child sexual abuse: Risk factors, indicators and protective factors toolkit, Research in Practice, 2018 pp24-25. This includes information about Achieving Best Evidence (ABE) Interviews.

When a child or young person has been sexually abused, it is possible that they will not verbally disclosure to you what has happened and seeking a disclosure from the child should not be your goal. However, if a child or young person does speak out, the following points adapted from the chapter on managing disclosures, Wrench 2016, pp.15-17 will support you.

*Your initial response is highly important* – so try your best to stay calm, or at least control your expressions when you may feel panic and shock. Think about how the child might be feeling and be ready to help them manage any distress or anxiety. Even if it is distressing to talk about, sometimes children and young people experience relief when abuse is spoken about openly for the first time. Don't forget to tell the child you are pleased s/he was able to tell you;

*Let the child know s/he is believed.* When a child or young person speaks out about being sexually abused, your default position should always to believe the child. Children very rarely lie about sexual abuse and many will have been discouraged from disclosing by being told no one will believe them by their abusers;

*Record well what you are told* - Be clear about what the child or young person has told you to be sure you have understood properly and then record it in written form with information about the date, time and context;

*Reassure the child the abuse was not their fault* – to do this, you could say things like, 'You are so brave and so right to tell me about this.' 'I'm sorry this happened to you and it isn't your fault.' 'How clever of you to remember to tell someone in your network.' This is a message that will need repeating many times before the child will begin to be able to integrate it, but is a starting point for removing any sense of blame or shame from the child;

*Don't 'interview' the child* - Don't pressure the child for more detail or information – if a police investigation ensues for example, s/he will have to re-tell this story many times and you need

to remember, unless you are a police officer, you are not investigating the allegation. It is not uncommon for children to drip feed you parts of their story, this can often be about testing out your response before sharing the full story. Be prepared and consider if are you able to tolerate it, think about if you still like the child even though you know this new information about them; and prepare our thoughts about whether you will believe them. You should also be mindful that not all the information will necessarily be shared by the child or young person in one conversation and that's okay. It's really important not to put pressure on children to say more. Use their language and go at their pace.

*Listen attentively and only ask open ended questions* - There are many examples of open questions – the following might be helpful: 'Can you tell me a bit more about that?' 'Where did this happen?' 'What did the person say/do?' 'Has this happened more than once?' 'How do you feel when this happens?'

*Don't promise confidentiality* – You can't promise to keep the disclosure secret. Be open with the child and talk to the child about who needs to know and how they will be told;

*Look after yourself* – It is important to recognise that such conversations have an impact on you as a worker/parent/carer and if possible de-brief with a colleague, friend or partner after the session. Liaise with the appropriate professionals later on depending on your organisational context and in line with safeguarding procedures.

## 7. Building a trusting relationship with the child

When building relationships with children and young people, we need to carefully consider what they have experienced, what they are feeling and how they are behaving, as fear can dramatically affect this. It is equally important to be aware of what their possible arousal states might look like.

Individuals experiencing the traumatic event (e.g. siblings) can develop different adaptive styles to cope with stressors and the following are suggestions of common fight, flight freeze responses. This is by no means an exhaustive list but it will support you to recognise possible signs that a child or young person is not feeling safe (and adults too).

Trauma responses in children - adapted from:
http://trauma-recovery.ca/impact-effects-of-trauma/fight-flight-freeze-responses/

| Fight | Flight | Freeze |
|---|---|---|
| Oppositional behaviour | Withdrawal | Stilling |
| Verbal/physical aggression | Escaping | Watchfulness |
| Hyperactivity / bouncing off walls / silliness | Running away | Daydreaming or looking dazed |
| Testing boundaries | Avoidance – sit alone in class | Over-compliance or denial of needs |
| Trouble concentrating | Self-isolation – stay in bedroom, not doing activities | Shutting down emotionally / constricted emotional expression |

Blaustein and Kinneburgh, 2010

A further trauma response is 'Flop' (Lodrick, 2007, Ogden & Minton 2000, Porges 1995, 2004). It is the mostly likely response if all other strategies have failed and usually follows Freeze. The body shifts from a state of muscular tension to a floppy state. Lodrick (2007, p.6) describes how the 'survival purpose of flop s evident: if 'impact' is going to occur the likelihood of surviving it will be increased if the body yields, and psychologically in the short term at least, the situation will be more bearable if the higher brain functions are 'offline''. Flop is commonly utilised in incidents of sexual abuse or physical abuse. Adapted from Wrench, 2018 pp32-33.

It is not unusual for individuals' belief systems to become very rigid when they have experienced repeated stressors, complex relational trauma or have lived in environments characterised by danger, chaos and unpredictability. This is important to remember when carrying out assessments where vulnerable children and their families might have a set of assumptions relating to relationships that could include the following: 'I cannot trust anyone, especially adults or people in authority', 'I am not safe', 'No one can help me', 'I am powerless', 'the world is a dangerous place', 'I am not a good person' and 'I don't deserve care'.
Adapted from Wrench 2018, p29

## 8. Building safety into our assessments

To begin to create a sense of safety for the child and family in your assessment work, your priority must be to convey that you can be trusted and are safe; this can be achieved by being consistent, emotionally available and dependable.

As practitioners we need to consider how we help the child to regulate during the assessment:

- what will help you to feel safe during this conversation;
- how will you let me know when you have had enough; and
- where should we do this; anything else that will help.

If you believe or become aware that a child is in a trauma state (hyper or hypo aroused), it will be important for you to offer some modulation activity to sooth the child's sensory system. This can be useful at the start and end of any session with the child.

You will need a different approach and different options for a child with high energy compared to a child who is withdrawn.

It may be necessary for the 'high energy' child to expend energy, and in this case, introducing some kind of movement can be helpful. This might include a bounce on the trampoline outside in the garden or doing star jumps, going for a fast, marching walk outdoors, or if they are a young child playing a game of push me over, pull me up.

Activities that connect people are better suited to a more withdrawn child such as throwing a ball to each other or blowing a feather across a cushion and back.

All these types of activities activate the brain stem and can support improved regulation for the child or young person but you will need to base the activity where the child's energy level is at.

When children begin to dysregulate or you see some evidence of high arousal, it is helpful to have some options ready for sensory soothing. This includes something for the child to suck like a lolly or a chew like a toffee or a sensory toy like a tangle or fidget cube to occupy little hands and ease anxiety. Other options include gently blowing bubbles or simple, child friendly breathing exercises are also soothing activities to do together.
Adapted from Wrench 2018, p34

**9. Whole family focused interventions**

Interventions that focus on the whole family as well as the individual child are important (Carpenter et al, 2016; Horvath et al, 2014). Children and young people often feel responsible for the distress of their family in the aftermath of sexual abuse, and this can be reduced through providing support to non-abusing family members (Warrington et al, 2017).

The disclosure of CSA is a major life crisis for a non- abusing parent, often with long-term effects on their mental health (Humphreys, 1995; Lipton, 1997; Elliott and Carnes, 2001; Hill, 2001). This can be particularly so if they experienced abuse in childhood themselves. Children are more likely to disclose to their non-abusing parent than to anyone else (Warrington et al, 2017),and the way a non-offending parent responds to the disclosure of their child's abuse is crucial, with good support from parents linked to better adjustment in children (Elliott and Carnes, 2001; Kendall-Tackett et al, 1993). Some researchers conclude that the support needs of non-abusing carers are therefore inseparable from those of their child, and their distress should not be overlooked by professionals (van Toledo and Seymour, 2013).

Findings from trials of trauma-focused CBT point to the importance of carer involvement and education in achieving positive outcomes for children and in reducing carers' stress (Macdonald et al, 2012). A review of 56 systematic reviews identified strong evidence that CBT for non-abusing parents and school-age children is effective in preventing deterioration of child mental health and/or recurrence of abuse (Stewart-Brown and Schrader-McMillan, 2011; Corcoran and Pillai, 2008). However, even more modest parent-focused interventions (including instructional videotapes based on social learning theory) provided to a parent at the time of a sexual abuse disclosure appeared to have benefits for parents and children (Stewart-Brown and Schrader-McMillan, 2011).

Some parents value parent support groups, particularly those combining support with information about the dynamics and impacts of abuse and practical advice on how to deal with children's feelings and behaviours. Parents who have participated in such groups report increased wellbeing and confidence, reduced stress, and greater ability to care for their child and deal with professionals. Groups help participants build vital social networks with others who share similar experiences, help to normalise children's behaviour, and may reduce depression (van Toledo and Seymour, 2013; Hernandez et al, 2009).

*Key messages from research – Family focused interventions p7*

*Family meetings*

Hull Children and Young People and Family Services promotes the use of family meetings to address difficulties within the family and build on strengths and safety. When there is evidence of intergenerational sexual abuse, careful consideration should be given to the use of a family meeting.

The family meeting process empowers a family and their network to draw on their strengths and resources to make a safe plan for their children. These meetings ensure the family network have a chance to hear and discuss the concerns. They also give an opportunity for everyone to be listened to including the child and young person(s). It can be an opportunity to be informed of any resources that could help them improve family life. When there are concerns that a child may be being sexually abused it is important that the situation and the risks are well understood and a clear 'bottom line' statement is prepared by the social worker. This statement will help the family to fully understand what risks they are helping to manage and ensure that the child is safe.

Lastly, in your assessments, be mindful of considering intergeneration cycles of abuse. Don't just focus on the individual child. Ask the right questions to understand the experience of others in the family. Consider intergenerational cycles of abuse – think about this and the impact on parenting. You are advised to read this guidance in conjunction with Hull's CYPFS **Assessment – Best Practice Guidance.**

**10. Approach to siblings – responding to the different needs of children in the family**

As with any form of abuse the impact on all siblings and children in the household should be considered carefully and individually. The following are some of the key themes:

- All children are affected both directly / indirectly by abuse that happens within a family. The feelings that arise from concerns about sexual abuse or a sibling disclosing are complex and need to be carefully understood for each individual child;

- It is important that assumptions are not made regarding who is at risk (i.e. gender / age range) within a family grouping. These judgments should only be made after a robust assessment;

- Children and young people respond and react to sexual abuse is a range of ways and just because a sibling is not externalising their feelings does not necessarily mean that they are not at risk or are not experiencing abuse;

- Children take time to process and understand what has happened to them within their families and may, for example, find it very difficult to come to terms with the behaviour of a previously trusted adult. Children need time and support to explore these feelings;

- Siblings can be an important source of help and support but when sexual abuse is an issue these relationships and their roles within the family need to be carefully considered;

- Siblings can be the perpetrators of harmful sexual behaviour and this may be happening as a result of their own abuse experiences and may overlap with ongoing abuse from a known adult or adults;

- Sibling sexual abuse is more common (possibly three to five times more) than perpetrated by other members of the family;

- Consideration needs to be given to who will help other children in the family understand any decision making processes;

- There may only be one child that has been sexually abused in the family. This may (but not always) lead to an element of victim blaming; the non-abused children may want the abuser to still live in the family home. The child who makes the allegation may be ostracised by their siblings or other family members.

## 11. Effective working with disabled children – understanding the research

*Increased risk and vulnerability*
Research indicates an increased prevalence for disabled children compared to non-disabled children to being victims of child sexual abuse. This is related to being usually more dependent on caregivers, having increased limitations on communication and less likely to be seen as potential victims (Sullivan and Knutson, 2000).

To help understand this increased risk and vulnerability to experiencing abuse, it is helpful to be aware of the following factors (Murray & Osborne 2009): disabled children generally have fewer contacts outside the home, and this increased social isolation means they may struggle to find opportunities to tell others about abuse; there is often dependency on parents / caregivers or paid carers for personal care and assistance in daily life; the ability to actively resist or avoid abuse may be impaired (e.g. limited mobility or speech and language difficulties); communication needs may make it harder to tell someone about the abuse so it may endure for longer; access to trusted adults may be limited; they are vulnerable to bullying and harassment which can be so severe as to constitute assault or abuse; and there may be limited access to personal safety programmes and personal, sex, health and relationship education, resulting in a lack of awareness of what constitutes abusive treatment or consent issues.

*Communication style*
Disabled children have the same rights and needs as all non-disabled children. For all children good assessment is critical in identifying and meeting the children's needs; key to this is being able communicate directly with them. Effective communication relies on respecting and working with the child's individual communication needs. The following pointers will help you (adapted from Koprowska 2008): get to know what suits the child and adjust our pace and

communication style accordingly; avoid complex grammar, ambiguous terminology or idiom; check out their understanding and ensure you don't reach a decision without their full involvement; respect their chosen form of communication (e.g. British Sign Language as a full and complex language); all more time for meetings; be patient; use interpreters, especially for critical assessment sessions and meetings; offer creative means of communication: pen and paper; gesture, drawing; form words clearly and don't cover your mouth when speaking; and where possible learn skills in pictorial or non-verbal communication in advance (e.g. Makaton or PECS)

Adapted from Wrench, 2018, pp.58-59)

**12. Working with parents with learning disabilities**

The Department of Health / Department for Education's good practice guidance on working with parents with a learning disability (2007) sets out five principles in any situation:

- Provision of accessible information and communication;
- Clear and coordinated referral, assessment and eligibility criteria;
- Support designed to meet assessed need of parents and children;
- Long term support if this is needed; and
- Access to an independent advocacy service.

Information should be made available to them in Easy Read formats.

The Working Together Parents Network updated these principles and the following key messages for practitioners are adapted from their update in 2016:

- Be respectful;
- Be on time;
- Speak directly to parents;
- Don't use jargon – speak in Plain English;
- Think before you talk;
- Listen and really 'hear' what is being said;
- Explain clearly what is happening;
- Be honest if you can't help ;
- Be patient; and
- Make enough time to communicate effectively.

Adapted from the Working Together Parents Network, 2016 p7

**13. Considering the impact of gender**

Gender is a characteristic which may mitigate against certain adverse consequences for some children and increase difficulties for others. Girls and boys express their distress in different ways and may therefore have different therapeutic needs.

Until the last decade, research (and practice) has tended to focus on sexual abuse of females, supported by the popular, but inaccurate, view that males are the perpetrators of child sexual abuse, not victims. An extensive literature review observed that child sexual abuse can have similar psychological impacts on males as on females, males are less likely to disclose that they have

been abused, and clinicians are less likely to explore this. There is an urgent need for services to better identify and address the needs of male survivors.

Research has found that girls are more likely to internalise their distress through, for example, anxiety, depression and self-harm, whereas boys are more likely to externalise and display 'hyper-masculine compensation' such as aggression, anti-social behaviour, violence to others and homophobic behaviour.

Females have also been found to display higher levels of eating disorders, suicidal behaviour and alcohol consumption, and males more difficulties at school, substance misuse, delinquency and reckless sexual behaviour. They also face additional impacts in pregnancy and childbirth: increased risk (over non-abused girls) of adolescent pregnancy, stress, depression and negative life events during pregnancy, childbirth complications, post-natal depression, abortions and STD.

Females CSA survivors are more likely to come from families demonstrating greater conflict and less cohesion. Women may find it more difficult to separate from abusive parents, because they feel a duty to care for them in old age or to maintain a kin network. Family dysfunction is not common for males, but issues around socioeconomic status can be.

For males, constructions around masculinity and male sexuality may make coming to terms with the experience of abuse difficult in a particular way. For many men abused in boyhood by other males, seeking help is inconceivable, inhibited as they can be by feelings of shame or confusion of sexuality and identity. However, boys abused by women are even less likely to report their abuse, and this is an area that needs further research.

Reproduced from*:* Therapeutic Services for Sexually abused Children and Young People Scoping the Evidence Base - Prepared by Debra Allnock and Patricia Hynes, (NSPCC 2012).

**14. Confident working with culture and ethnicity**

Family culture and ethnicity should be considered from the child's perspective and what you know of them:

- The child's view of you and what you represent;
- The belief systems and values of the child's culture, and how these conflict or agree with your own values, status and belief system;
- The structures and decision making in the child's close and extended family and the child's place within this;
- The importance or otherwise of the family network;
- The traditional solutions to problems;
- Sex roles;
- If this family are first or second-generation immigrants, the likely losses experienced in moving to / living in Britain; and
- The racial / cultural pressures and the impact on the child of talking with you

Adapted from Howes, pp 128-129 in Horwarth (2010), citing Harris 2006.

**15. The role of Strategy Discussions and meetings**

It is crucial to have a clear multi-agency approach to managing sexual abuse. Whilst it is still important that situations are dealt with in a timely manner, planning and preparation are vital.

Sexual abuse most often happens in secret and efforts are made by perpetrators to ensure that children do not disclose to trusted adults. Therefore, without the effective sharing, gathering and analysis of all information, it is not possible to put effective plans in place to make children safer.

An effective strategy meeting should include social care, police and health and the agency which made the referral. In this context, Legal services should also be involved. The strategy meeting should:

- Share available information;
- Agree when / who will see the child alone – consider race / ethnicity / language / disability;
- Decide whether a S47 enquiry is appropriate;
- Include timescales of actions/when/for what purpose/by whom;
- Decide on a single agency or joint enquiry/investigation;
- Agree immediate action/interim support services/care arrangements for children;
- Consider if the risk is too great for children to remain / is there a need for the alleged perpetrator to be removed;
- If the child is in hospital, consider arrangements for contact;
- Consider the timing of any criminal investigation – Achieving Best Evidence;
- Agree who/how information will be shared with;
- Agree feedback on any outcomes.

**16. Effective uses of child protection and statutory processes**

It is important that child protection conferences are well planned and as much information is gathered prior to the day of the meeting. Specific consideration should be given to who should be invited and the likely impact on the other members of the family that may also attend. Children and young people should be referred to the advocacy service to ensure that their views are heard.

Whilst children and young people should be given the space and the time to give their views they should not be placed under any pressure to disclose. Children need to feel safe and have developed a trusting relationship before they will consider the benefits of talking about their experiences.

At the time of the Initial Child Protection Conference the perpetrator of the abuse may not have been identified and the concerns may need to be considered without this information. At this stage it is important that specific assumptions are not made about who the likely perpetrator of the abuse is, as this may place the children at additional and unintended risk.

Social workers and the conference chair will need to work together to ensure that the meeting is effective and safe for the child.

**17. Child protection medicals**

The child protection medical is an important aspect of section 47 enquiries and can enable us to better understand what might be happening for a child or young person. It is however also important that children and young people do not undergo unnecessary medical examinations; is it therefore important for us to be clear how this part of the process can support professionals to achieve the best outcomes for children and young people.

If a child or young person makes a disclosure or is showing signs that indicate that they may have been or are continuing to be sexually abused, the child protection medical may provide an important part of this emerging picture. This can be particularly important given the level of secrecy and lack of openness that characterises sexual abuse concerns.

For some children and young people a medical examination may be helpful; it may help them to more clearly feel that they have been heard and believed and can also be reassured that there is no long term physical impact from the abuse. Going forward this may assist in helping children and young people to better come to terms with what has happened and help them to start re-building their lives.

The scope of the medical will always be proportionate to the presenting concerns and an examination of the child's genitalia will not be undertaken unless this is appropriate. It is not a routine part of the child protection medical.

It is important that the paediatrician is involved in strategy discussions and this responsibility is particularly highlighted in Working Together 2018.

*The medical examination*

The examination will be conducted by an expert paediatrician, many of whom will have specific forensic training. The paediatrician will meet with the family, the child or young person together at the start of the process. However, if known, the alleged perpetrator should not be present at the meeting. This joint meeting ensures that everyone has heard the same information and this helps to build trust and confidence.

The paediatrician will need the young person to be with a parent or carer with parental responsibility. If the child or young person is on a Full Care Order, permission by the responsible social work Service Delivery Manager from the local authority will be needed. If the child or young person is subject to an interim order the permission of the court will be required. If the young person is over 16 it will be assumed that they are competent to give consent. If they are 13 + then the paediatrician, in conjunction with the social work will make an assessment of competency at the time of the medical. Particular attention should be given to young people with learning disabilities and their ability to consent. A capacity assessment may be required.

The paediatrician will seek consent for the examination and for any photographs or video recording that is taken for diagnostic or evidential purposes, for the writing of the report (for social care, police and the court) and for any swabs or additional evidence.

The paediatrician will take a full history and this will generally include a genogram. The medical is evidence based and the paediatrician will use the Royal College of Paediatrics and Child Health (the physical Signs of Sexual Abuse 2015) guidance. They will, where appropriate quote from these evidenced based guidelines and will use the terminology used in this publication in their reports.

The report and opinion of the paediatrician is subject to routine peer review. The paediatrician may also seek advice and support from a colleague at the time of the medical. The paediatrician will write a report and will try and ensure that this reflects, as closely as possible what has been verbally reported at the time of the examination. Whilst the paediatrician is wanting to be clear about their findings they are also endeavouring to be balanced in the wording of their conclusions.

*Key principles for the social worker:*

- It is important that the child or young person is prepared for the child protection medical and any anxiety that the social worker has about the process is not communicated;

- The paediatrician should be involved in the strategy discussion and subsequent meetings;

- If a social worker is unsure if a medical would be appropriate they may want to consult with one of the safeguarding nurses, or a paediatrician as well as with someone from within their own line management;

- The medical can be an important part of the information gathering process which may enable the child or young person to be better protected from harm.

**18. Assessment, plans and reviews**

When planning for assessment with cases involving sexual abuse, think about how to gather information using different methods. It is important to not just look to the non-abusive parent to solve everything and it must also be acknowledged that it's not just the child who has been abused and traumatised.

Assessing a non-abusing parent's capacity to protect is a priority; we are looking to draw on and help develop the strengths of the significant adults in the child's life. The non-abusing parent's ability to participate openly in the assessment is likely to be improved if the assessment takes place with the alleged offender out of the family home. If this is not possible, the assessment work needs to be done with the non-abusing parent on their own, separate from the alleged offender.

Someone who is suspected as an alleged offender cannot also be assessed as a potential protector. This can happen when both parents have been involved in sexually abusing their

children. Workers sometimes feel that a parent (often the mother) once separated from the abuser (often the father), poses no risk. This would need to be specifically assessed.

**For more information – The Intra-familial child sexual abuse vulnerability template on p28 of the Intra-familial child sexual abuse: Risk factors, indicators and protective factors Practice Tool, Research in Practice, may be helpful**

Most current advice regarding the assessment of sexual abuse is based on the assumption that we have a disclosure – but the following assessment advice can be used as the basis of an assessment whether there has been a disclosure or not.

The following is taken from practice guidance document - Durham, A (2013), Sexual abuse: assessment and support of non-abusing carers.Durham (2013) highlights some useful areas to cover when completing an assessment involving child sexual abuse:

*Family social history*

- Exploration of family relationships, identifying key attachments and any history of loss or bereavement.
- Details of the relationship between the alleged abuser and children in the family.
- Details of parenting relationships; sibling relationships and family dynamics.
- Identification of any key extended family relationships or key extra-familial friendships.
- Known details of the children's peer relationships.
- The children's education history and current school progress.
- Brief history of the children's general health and development.

*Level of knowledge and acceptance of the reported sexual abuse*

- The extent of the non-abusing carer's understanding and knowledge of the reported sexual abuse, how they found out and who else knows and how.
- The extent to which the non-abusing carer has discussed the reported sexual abuse with the alleged perpetrator. Also whether or not the abuse was reported or discussed with anyone else.
- The extent to which it is accepted and believed that the sexual abuse has happened, and who the non-abusing carer feels is responsible – the extent to which it is believed that what was reported amounts to sexual abuse.
- The non-abusing carer's attitude and beliefs about the reported sexual abuse – any evidence of minimising, re-framing or disbelieving the reported sexual abuse.
- The extent to which non-abusing carer have discussed the reported sexual abuse with their children, and with any other family members.

*General understanding of sexual abuse*

- Exploration of what the non-abusing carer understands about what sexual abuse is, and his or her ability to distinguish between appropriate, and inappropriate or harmful, sexual behaviour.
- Non-abusing carer's understanding of the widespread nature of sexual abuse – how and why sexual abuse takes place – including an understanding of the "thinking errors" and the planning, targeting and grooming process that abusers use to gain access to children.

- Exploration of the extent to which the non-abusing carer understands the impact of child sexual abuse and why children and young people often find it difficult to tell.

*History of abuse in the family*

- Known details of physical or sexual abuse experienced by any members of the family, whether or not it was reported, and what the consequences were.
- How the parents or carers perceive the impact of any abuse their children have experienced.
- Other significant life experiences the children or family have experienced, and whether or not there is any perceived connection with the current reported sexual abuse.
- Non-abusing carer's knowledge and understanding of the sexual behaviours of the (alleged) perpetrator of the reported sexual abuse.
- Non-abusing carer's experience of physical or sexual abuse, or aggressive sexual behaviour committed by the (alleged) perpetrator.

*Capacity to parent the abused child (and siblings)*

- Ability of the non-abusing carer to adapt to and manage the additional needs of a child who has been sexually abused, applying knowledge (new or old) about how to respond to trauma-related behaviours, including flashbacks, intrusive abuse memories, mood swings, anxiety attacks, self-doubt and so on.
- Understanding the importance of continually and consistently reassuring the child that they were not to blame for the abuse and are not responsible for the immediate and wider consequences of reporting the abuse. Being very clear about supporting the child's decision to report the abuse. Assessing the extent to which the non-abusing carer has the sensitivity to carry this out.
- The extent to which the non-abusing carer can be available to support, listen and talk to the child about the abuse and related matters.
- The extent to which the non-abusing carer is prepared or able to recognise the possible need for their child to receive additional support in coping with the impact of the sexual abuse.
- The extent to which the non-abusing carer is prepared or able to recognise the need for additional support.

*Knowledge of children's sexual behaviour and development*

- Non-abusing carer's knowledge of the level of their children's sexual development, activities and understanding.
- Non-abusing carer's understanding of the extent of sex education their children have received, and where from.
- Non-abusing carer's knowledge of any other sexual behaviour their children may have been involved with, and whether they are considered appropriate or inappropriate.
- Non-abusing carer's general ability to distinguish between appropriate and inappropriate sexual behaviour.
- Details of sexual behaviours considered acceptable for children or young people to engage in, and whether this is allowed to vary according to age or development and gender.

- Attitudes and beliefs about gay and lesbian sexuality, again in relation to age and development.
- Family attitudes towards nudity and privacy.

*Other concerning behaviours or difficulties*

- Any other difficulties or problems the children have experienced – health, mental health; social skills; peer group or friendship problems; problems with intimate or sexual relationships; education; experiences of oppression such as racism or name-calling.
- The extent to which the non-abusing carer perceives the child or young person's difficulties as being related to the reported sexual abuse.

*The daily life of the family*

- Non-abusing carer's knowledge of their children's friendships and social networks.
- Whether or not the non-abusing carer considers these friendships to be age appropriate.
- How and where their children's time is spent with friends, and how much time is spent alone.
- The extent to which the non-abusing carer is aware generally of their children's whereabouts.

*Protection of children*

- Details of action taken by the non-abusing carer to protect their own and other children from the person reported to have committed sexual abuse – both inside and outside the home.
- The extent to which the non-abusing carer feels that this protection is necessary.

*Family discipline and control*

- Details of house rules, privacy and family discipline, punishments, sanctions and rewards – does the family use physical punishment.
- How problems are approached and dealt with, and how conflict is resolved.
- Details of who now exercises the most authority in the family and how it is articulated.
- Details of family relationships, whether or not there are any significant divisions or alliances.
- The extent to which difficulty is experienced in exercising discipline and control, boundary setting and so on.

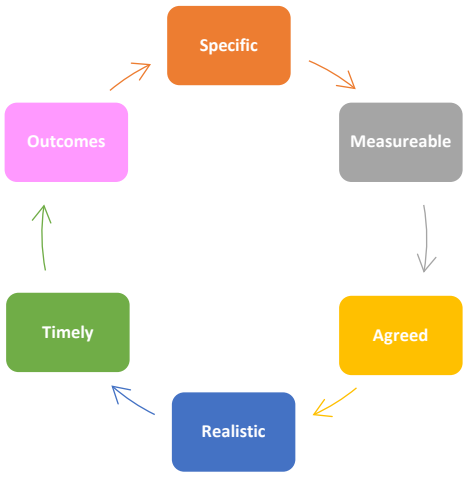
*Household circumstances*

- Details of the physical layout of the house.
- Where parents or carers and children spend their time, who sleeps in which bedroom, and where the bedrooms are located in the house.
- The use of locks and bolts, bathroom rules – whether bathroom and bedroom doors are knocked before rooms are entered.

*Sexually explicit information*

- Details of any use of sexually explicit materials at home, books, pornographic pictures, videos and internet etc.

- The extent to which adult sexual intimacy, behaviour or conversation takes place in the presence or within earshot or sight of children or young people.
- The extent to which children or young people are allowed access to sexually-explicit information, including unsupervised use of the internet.




*Analysis of information and planning*

Once all the information is gathered, it could helpfully be analysed using the Rethink formulation model (6Ps).


This helps us to see what presenting issues we can evidence and what factors are keeping these concerns going so that we ensure our planning is focused on the right areas. Also by ensuring our plans are SMART and outcome focused, we will be able to evidence change and review how plans are keeping children safe.

**19. Family safety planning**

It may sometimes be necessary, as part of the assessment, for a safety plan to be developed with families. Practitioners should ensure that every family member has access to a safe opportunities to reporting anything they feel uncomfortable about.

It is important for families to have clearly stated boundaries about family relationships and sexual behaviour and for parents to be able maintain an authority that ensures that these boundaries are respected. When sexual abuse has occurred within a family, these boundaries may have broken down as part of the grooming process. If this has happened, these boundaries will need to be re-established as a matter of urgency. In many circumstances a

family safety plan, or aspects of it, will need to be set up immediately and before the assessment is completed.

This initial family safety plan can subsequently be modified as necessary, in accordance with information provided by the full assessment. It is best that these arrangements are stated in writing, and signed by all parties involved – a typical plan would include:

- The minimum requirements for risk management, in terms of house rules and supervision;
- A clear identification of actions that are 'risky' i.e. those behaviours or interests that could lead to sexual abuse;
- Details of house rules – bedroom use; bathroom use etc.
- Agreements about supervision;
- Agreements about meeting as a family to discuss the working of the plan;
- Consideration of where an alleged perpetrator in the family would live and ongoing contact arrangements;
- Details about each child or young person's opportunities to speak about the plan in private; and
- Details of professional support to be provided to the family in managing the plan.

By involving, where possible, all children in the household, the plan conveys to all children the message that their future safety is being fully considered and taken seriously. In most circumstances it will be helpful to undertake additional 'keeping safe' work with all children in the family. Lucy Faithfull Foundation provided a simple example of a safety plan agreed with a family and it has been adapted as follows:

**Family Safety Plan**

| **Goal** | **Agreed appropriate boundaries** | **Agreed responses to breach of boundaries** |
|---|---|---|
| *Goal 1*<br>For there to be safe boundaries in the family home e.g. personal space, dress codes at different times of the day | a) No-one to walk around unsuitably dressed e.g. in their underwear, and everyone to have suitable dress for bed e.g. PJ's<br>b) Teach 'knock and wait' before entering bedrooms<br>c) Child to be taught about body parts / ok and not ok touches, privacy – using the books provided – before she is four years old<br>d) Lock to be fitted to bathroom door by the time Child is ten years old<br>e) When using toilet / shower door to be closed | a) Adults to challenge each other if boundaries not kept<br>b) All agree that it is ok for Grandparent to check if boundaries being kept and it is NOT interfering, it is helping with the plan<br>c) Any of the adults to inform social worker if there are serious |

| | | |
|---|---|---|
| | f) Child to get dressed in her bedroom or bathroom<br>g) Get to know people well before introducing them to Child, especially babysitters – no teenagers | concerns about boundaries not being kept |
| *Goal 2*<br>Parent 1 not to put himself in unsafe situations | a) Parent 1 not to add girls under 16 to his contacts / social media, unless his own children<br>b) Parent 1 not to be alone with child's friends in the home<br>c) Parent 1 not to offer to mind other people's children on his own | a) Mum to challenge Dad and inform Nan if she thinks he is breaching agreement<br>d) Parent 1 / Grandparent to remind Parent 2 of vulnerability/ potential false allegations<br>c) Inform social worker if concerned |
| *Goal 3*<br>All family to be safe using technology (Plan to be reviewed to stay up to date with technology) | a) No unsupervised IT use in child's bedroom until she is 13, after talks about safety<br>b) Parents to pin-code and password protect devices with Internet capability, and televisions, to prevent child accessing adult material.<br>c) Child not allowed Facebook until she is 13 after safety talks | a) Parents to consider sanctions if child is not co-operating e.g. confiscating devices<br>b) Grandparent to remind and challenge parents if plan not kept to |

**20. Recognising what can influence our assessments**

Each practitioner brings their own personal and professional beliefs, feelings, values and life experiences to the work place. They may or may not be aware of the influence of these factors on how they work with families. As practitioners we need to take responsibility for ourselves and keep an open mind throughout the assessment. We need to think about our feelings and experiences and how these can distort assessments.

The following is informed by Horwath, Child's World 2010 p121

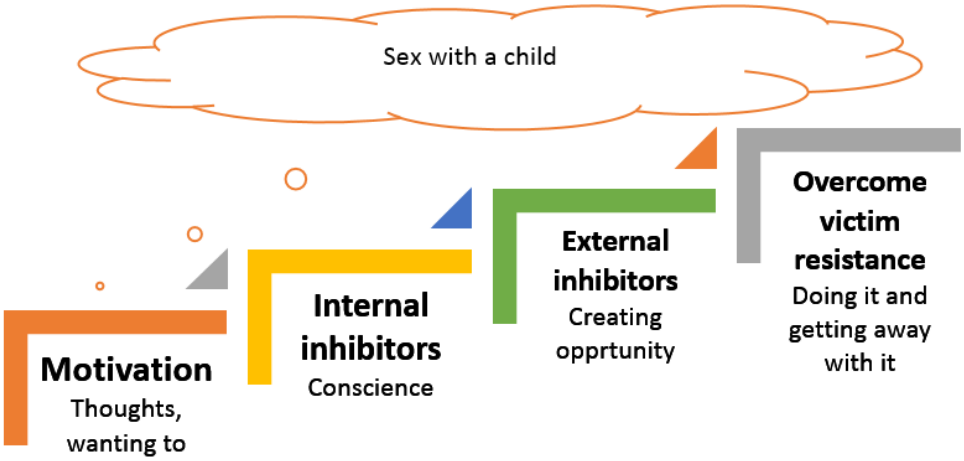
**Ways in which feelings and experiences can distort assessments**

| Subjective response | Impact on assessment |
|---|---|
| ***Over-optimism:***<br>A misguided positive belief in the carer's ability to prevent any further abuse e.g. 'Now that mum knows what he did there's no way she'd let it happen again. You know she's a really nice person'. | This results in overemphasis on assessing strengths and minimising concerns. The practitioner may accept the carer's perception that all is well without an evidence base |
| ***Over-pessimism:***<br>A belief that the carer's initial disbelief that abuse can have taken place will remain and cannot be worked with e.g. | This can lead to an assessment that focuses on concerns and parenting deficits, ignoring or minimising any strengths. It may result in professionals missing that a parent's initial |

| | |
|---|---|
| 'She is a hopeless case, she'll never believe the child, the child is best out of there' | response to finding out about abuse could change and their early responses may have been quite normal. |
| ***Collusion:*** Not keeping an open mind and challenging the carer's views of what causes a child's behaviour, when that behaviour could be a sign of sexual abuse. | In these situations workers focus on the carer's perspective and do not seek evidence or alternative hypothesis to challenge fully explore these beliefs, either though the current assessment or by identifying past patterns of behaviour. |
| ***Fixed idea:*** Holding a specific idea about who the possible abuser might be which will limit our evaluation of other people who are having contact with the child. | The fixed idea is often informed by our pre-existing views of sexual abuse and who is most likely to be a perpetrator. In these situations practitioners tend to gather information that confirms their ideas or simply don't look at the broader picture. |
| ***Overriding beliefs:*** Having a fixed idea about the needs of the family and ways in which they can be met, e.g. 'if we can just ensure the abuser is out of the house for good then everything will be ok' | In these situations practitioners make an early decision about quick simple interventions such as removing a perpetrator from the child's life rather than fully understanding the skills of the family and potential work that could make the network safer. |
| ***Ignoring difference:*** Assessing all families where sexual abuse has happened as the same and therefore ignoring different levels of risk and different potentials for change. | The practitioner tends to categorise families and make judgements about them without considering differences. This can happen when a practitioners unpleasant feelings about sexual abuse prevents them from, making relationships and seeing key differences in individual families. |
| ***Avoidance:*** Failing to ask difficult questions or challenging what the carer says because the language needed to explore things further might be uncomfortable and unfamiliar to practitioners. | This response is most likely to occur if the practitioner is appalled by the subject matter and the possible behaviour and therefore find key areas difficult to explore in-depth within the assessment. |

### 21. Four pre-conditions to child sexual abuse - a model to understand why/how someone may sexually abuse

Finkelhor (1984) proposed a step model to explain four preconditions that are met before sexual abuse occurs and responsibility is clearly placed with the abuser. Finkelhor's model includes individual factors related to the victim, abuser and the family as well as social and cultural factors. It may enhance our understanding of why sexual abuse occurs. The model accounts for both intra and extra familial sexual abuse.




**Four pre-conditions to child sexual abuse**
Adapted from: David Finkelhor, Child Sexual Abuse: New Theory and Research 1986

The four pre-conditions in more detail are:

*1: Motivation*
The potential abuser needs to have some motivation to sexually abuse. Finkelhor argues that there are three fundamental components subsumed under the motivation to sexually abuse children:

- *Emotional Congruence* in which sexual contact with a child satisfies profound emotional needs;
- *Sexual Arousal* in which the child represents the source of sexual gratification for the abuser; and
- *Blockage* when alternative sources of sexual gratification are either not available or are less satisfactory.

These components are not actual pre-conditions and not all three need to be present for sexual abuse to occur. The three components do explain not only the instances of abusers who are not sexually motivated but enjoy degrading victims and welding power but also the paedophile and the sexually motivated abuser.

*2: Internal inhibitions*
The potential abuser must overcome internal inhibitions that may act against his/her motivation to sexually abuse. No matter how strong the sexual interest in children might be, if the abuser is inhibited by taboos then s/he will not abuse. Arguably, most people have some inhibitions against the sexual abuse of children. Disinhibition is not a source of motivation, it merely releases motivation.

While preconditions 1 & 2 account for the abusers behaviour, preconditions 3 & 4 consider the environment outside the abuser and child which controls whether and whom he abusers.

*3: External inhibitors*

The potential abuser must overcome external obstacles and inhibitions prior to sexual abuse. External inhibitors that may restrain the abuser's action include family constellation, neighbours, peers and societal sanctions as well as the level of supervision a child receives. Although a child cannot be supervised 24 hours per day, lack of supervision has been found to be a contributing factor to sexual abuse as has physical proximity and opportunity. External inhibitors are easily overcome if the potential abuser is left alone with an unsupervised child.

*4: Resistance*

Finally, the potential abuser has to overcome the child's possible resistance to being sexually abused. This capacity to resist may operate in a very subtle covert way and does not necessarily involve overt protestations. Abusers may sense which children are good potential targets, who can be intimidated or co-coerced to keep a secret or otherwise manipulated. Abusers report that they can almost instinctively pick out a vulnerable child on whom to focus their sexual attentions while ignoring those who might resist. Frequently, these children may even be unaware that they are being sexually approached and have little or no capacity to resist. Some of the risk factor that inhibit the capacity to resist include emotional insecurity and deprivation etc.

Knowing which factors make children vulnerable to abuse is essential in formulating prevention programmes. Isolating behaviours that constitute a risk, while emphasising those that enhance resistance or avoidance can empower children to protect themselves. This is not to say that children who are not vulnerable are not abused. Many children may be forced or co-coerced despite displaying resistance and avoidance behaviours. Some instances of abuse are the result of force, threat or violence and no matter how much resistance the child displays it will not prevent the abuse.

The four pre-conditions for sexual abuse come into play in a logical sequence. The abuser must firstly have the motivation and be able to overcome any internal inhibitions. When these have been overcome the potential abuser will need to overcome external inhibitors and finally the resistance of the child.

**22. Possible signs and indicators of abusive behaviour by an adult**

Lucy Faithfull Foundation suggests:

Offending behaviour varies but there may be cause for concern if:

- Insists on physical affection with a child – kissing, hugging, wrestling;
- Gives gifts to child excessively;
- Takes photographs or keeps mementos of children who are not their own;
- Talks about sex frequently, tells sexual jokes / discusses sex with children, inappropriate conversations in presence of children;
- Singles out and gives special attention to one child;
- Seeks to be, or is often, alone with a child in a house, car or room;

- Displays child orientated behaviours or engages in childlike behaviour;
- Overly interested in a child's personal development; and
- Refuses to allow a child privacy or to make their own decisions on personal matters.

**23. Effective working with adults who sexually abuse**

The term used here will be Person Posing a Risk (PPR) to children. An assessment must be carried out on any PPR who may or may not be convicted of an offence relating to the area of risk when a decision needs to be made about whether it is safe for them to have contact with or to live in a household with children.

A PPR to children assessment should be carried out whenever a social work practitioner becomes aware of such an individual who is:

- Living in a household with children;
- Having contact with a household with children; or
- Where the individual is seeking contact or residence (or for another relevant reason).

The framework for the assessment is set out in the online procedures - Person Posing a Risk to Children summarised in the Assessment Framework Workflow and the Person Posing a Risk to Children Assessment.

The social worker should use the assessment as a framework for discussion with the PPR and other members of the household (it is not just as a form to be completed).The information to inform the assessment is obtained by a series of planned interviews, by associated observation of the household interaction, and by information from other agencies.

The task is to assess the degree of risk and consider whether it is acceptable / manageable in the light of other factors. However, Social Workers and Team Managers must bear in mind the PPRTC assessment can take several weeks. Team Managers are responsible for deciding whether there is an evident high risk requiring immediate action to safeguard children, in addition to, or instead of, the commissioning of the PPRtC assessment.

When planning the PPRtC assessment, the Team Manager should consider whether the worker conducting the assessment should be independent, i.e. not already directly involved in working with the family in question.

The PPRtC assessment should be conducted openly with the individual concerned, the main care giver, the children, and all the other members of the household. As the risk assessment will normally require a series of discussions over a period of weeks, an assessment plan should be drawn up and shared with the PPR.

It is important for those undertaking PPRtC assessments to bear in mind the importance of the following factors:

- Consulting other professionals and practitioners who know the family;

- Obtaining clear information about offences, cautions, allegations, and findings of fact;
- Awareness of the process of the assessment – the development of relationships with the interviewer, attitude to authority;
- Observations of family interactions;
- Any changes in attitude/response depending on who is present at interviews; and
- Cultural factors
- Carrying out a thorough check of any programme work that the PPRtC has undertaken or is in the process of being engaged with. This should include talking to programme tutors or reading end of intervention reports – whether treatment was in prison or out.

An alert flag should be added to the Personal Details screen of the Liquidlogic record to advise that a PPRtC assessment has been carried out. Equally, if it has been established that an individual should not have contact or live in the same household with the children, this should also be stated. If the person is known to Multi Agency Public Protection Arrangements (MAPPA), the alert flag could also advise contacting the MAPPA coordinator for confidential information about the person.

**24. Harmful Sexual Behaviour**

For the purposes of this guidance we have identified young people who display harmful sexual behaviour in the following way:

'*Young people who engage in any form of sexual activity with another individual, that they have powers over by virtue of age, emotional maturity, gender, physical strength, intellect and where the victim in this relationship has suffered a sexual exploitation'* (Calder 1999).

Harmful sexual behaviour does not describe a single form of offending behaviour, but rather a variety of different behaviours exhibited by different kinds of children in many varied context. This is one of the reasons why a range of terms are used; 'sexually problematic behaviour', 'harmful sexual behaviour', 'sexual offending behaviour'.

Another difficulty in defining and understanding harmful sexual behaviour is that sexual exploration and experimentation are normal parts of child and adolescent development. There are many sexual behaviours that are to be expected from children as they move from infancy through to adulthood as their understanding of their own sexual sense of self, as well as a mature conception of relationships with others develops. Sometimes, children and young people will stretch the boundaries of developmentally expected behaviour in ways that are non-abusive. Drawing lines that divide average childhood behaviour or adolescent experimentation from what is deemed inappropriate and what is deemed abusive is a complex task.

Practitioner's abilities to determine if a child's sexual behaviour is developmentally expected, inappropriate or abusive will be based on an understanding of healthy normative behaviour and issues of informed consent, power imbalance and exploitation.

Further guidance on this subject can be found in the Scottish *National Guidance on Under Age Sexual Activity: Meeting the Needs of Children and Young People and Identifying Child Protection Concerns*. Indicators of Potential Risk are covered in this.

Around ¼ of sexual abuse is perpetrated by children or young people under the age of 18 (Hackett 2004). The only published Scottish research in this area looked at a sample of 189 cases open to services in Scotland where a young person or child had acted in a sexually abusive way (Hutton and Whyte 2006). This study found that:

- 94% were male, 6% female
- 25% were under 12
- 36% were aged 13-15
- 24% were aged 16-17
- 9% were aged over 18

The histories of abuse experienced by many children and young people who display harmful sexual behaviours reinforces the need for us to retain a child protection perspective in working with this client group. Immediate consideration should be given to whether action requires to be taken under child protection procedures, either to protect the victim or because there is concern about what has caused the child or young person to behave in this way.

When the abuse of a child is alleged to have been carried out by another child or young person, such behaviour should always be treated seriously and be subject to a referral to relevant agencies, both in respect of the victim and the perpetrator.

In the past, it has been assumed that children and young people who present with harmful sexual behaviours were at high risk of sexual reoffending. This is not the case for the majority of young people although there will be a small sub group who are likely to continue such behaviours into adulthood.

Research shows that targeted interventions can be highly effective in reducing risk, even for those children and young people who are at higher risk of continuing harmful behaviours (Worling and Langstrom 2003).

Comprehensive assessment is necessary to identify individuals who are at higher risk of continuing these behaviours into adulthood.

Sexual abuse normally takes place in a secretive context, often involving grooming, coercion or bribery. The offender will often be known to the victim, and will sometimes be related. The victim is likely to be young and vulnerable, and may be deemed not to be a 'credible witness'.

In undertaking this work we need to be conscious of the risks associated with labelling individuals inappropriately and the implications this may have throughout their lives.

Risk management arrangements should be implemented as soon as possible once concerns have been raised: practitioners should not wait until the completion of comprehensive assessments or the resolution of legal issues, as public safety is paramount. Formally, the type of risk management arrangement that will be put in place will depend on whether a child/young person is managed under child care of criminal justice legislation.

**Further information**
The NSPCC website has webpages on Harmful Sexual Behaviour and you can also read the NICE guidelines.

**Young people and new technologies**
Young people now have almost unlimited access to the internet via personal computers and mobile phones. Children do a range of diverse and potentially beneficial things online. Use is now thoroughly embedded in children's daily lives: 93% of 9-16 year old users go online at least weekly (60% go online every day or almost every day.

Unless one makes the strong case that any exposure to sexual images is inevitably harmful in some degree, it must be recognised that some children, may, for example, be exposed to pornographic content with no adverse effects. Others, however, may be harmed – whether upset at the time of the exposure or worried later, or even influenced in their attitudes or behaviour years subsequently (Livingstone and Haddon 2009).

Whether or not there is a casual link between inappropriate use of the interactive technologies and harmful sexual behaviour, three broad areas of concern emerge from the literature in relation to adolescent internet use:

- Sexual bullying or harassment of others online: Children or young people who may experience unwanted/aggressive sexual solicitous material whilst online. One study of online sexual solicitations experienced by young people concluded that 'not all of the sexual solicitors on the internet fit the media stereotype of an older, male predator. Many are young and some are women' (Finkelhor 2000);

- Downloading, trading and production of child abuse images: Children and young people are also known to have downloaded child abuse images (Moultrie 2006);

- Self-victimising behaviour: This involves activities that places the in a vulnerable situation. This can involve posting sexually explicit picture of friends or others online.

Other problematic behaviours online an involved accessing sexual images that are legal but age inappropriate; use of pornography that is obsessive/repetitive or continues after appropriate sanctions; pornography that lacks social boundaries or has a specific and narrow focus; downloading materials that link sex and violence together.

In undertaking this work we need to be conscious of the risks associated with labelling individuals inappropriately and the implications this may have throughout their lives.

Risk management arrangements should be implemented as soon as possible once concerns have been raised: practitioners should not wait until the completion of comprehensive assessments or the resolution of legal issues, as public safety is paramount. Formally, the type of risk management arrangement that will be put in place will depend on whether a child/young person is managed under child care or criminal justice legislation.

**25. Abusive Images of children**

Language is important. We use the term 'abusive images of children' over 'child pornography' because these images *are* abusive of children.

The children are victims and will continue to be victims as the images are viewed over and over. The term pornography has also been used by offenders to minimise their offences.

Offenders can view adult pornography as being victimless or consensual. They may seek to equate child and adult pornography or imply that abusive images of children are not harmful. They may suggest that accessing child pornography was simply part of an *accidental* continuum of exploration on their computer.

The literature and studies to date tell us that the abusive images of children are 'pictures with a purpose' of sexual gratification for the viewer e.g. masturbation. It is not 'just looking'. It is also about the development and maintenance of sexual fantasy.

**26. Good practice when considering contact / family time**

There may be additional considerations when thinking about family time where there has been a disclosure of sexual abuse or there is concern or suspicion:

- Is there an on-going police investigation where there has been a disclosure of sexual abuse? This investigation may have implications on what contact if any can be arranged with the alleged perpetrator but also other non-abusing adults who may also be part of that investigation;

- It is worth thinking about whether a non-abusing carer or family member has played a part in the abuse process, even if this has been unwittingly. Have they been groomed by a perpetrator also and therefore their views and opinions may be difficult or harmful if conveyed to the child – this may need a higher level of supervision;

- The level of supervision required may be higher in cases where abuse has happened or is suspected so consideration may need to be given to things such as children going to the toilet, photos being taken and nappy changes. Does this contact require two supervisors or a backup supervisor to support in toilet trips etc.?

- If a child has suffered sexual abuse, the location of the contact may be significant to them and trigger traumatic memories and thoughts, this should be given careful consideration;

- If contact cannot take place as it is felt unsafe or an on-going police investigation prevents it, this may be upsetting to a child even when they have suffered abuse. They may have complex feelings towards that person and their level of understanding of this abuse being wrong may lead them to actively seek contact with the perpetrator. This needs consideration and spending time with the child to support them to understand why this contact can't happy may be beneficial for that's child's emotional well-being – these conversations may come as part of on-going work with the child; and

- Contact can be a really useful part of any assessment, as it can support practitioners to observe a relationship and how the child's behaviour may change or any areas of concern that are clear during contact.

## 27. Resources for practitioners

There are a number of toolkits, other resources and research papers to support practitioners in working with children, young people and families. Some can be used for any work and some are specific to working with children and young people who have been sexually abused .

### i. General available research resources

Protecting children from Harm – A critical assessment of child sexual abuse in the family network in England and the priorities for action

https://www.csacentre.org.uk/knowledge-in-practice/practice-improvement/supporting-parents-and-carers-guide/

https://www.csacentre.org.uk/knowledge-in-practice/practice-improvement/signs-indicators-template/

https://www.csacentre.org.uk/knowledge-in-practice/practice-improvement/communicating-with-children-guide/

Child Neglect and its Relationship to Sexual harm and Abuse: Responding Effectively to Children's Needs – open access resource considering the potential relationship between neglect and forms of sexual harm an abuse

'Making Noise: Children's Voices for Positive Change after Sexual Abuse' - Children's experiences of help-seeking and support after sexual abuse in the family environment. Camille Warrington with Helen Beckett, Elizabeth Ackerley, Megan Walker and Debbie Allnock

Preventing Child Sexual Abuse: The Role of Schools - examines the important role schools can play in enabling children to recognise abuse.

Measuring the Scale and Changing Nature of Child Sexual Abuse and Child Sexual Exploitation - Scoping Report July 2017, Professor Liz Kelly and Kairika Karsna (Centre of Expertise on Child Sexual Abuse)

Investigating Child Sexual Abuse - examines timescales for sexual abuse prosecutions and makes recommendations.

Therapeutic Services for Sexually Abused Children and Young People Scoping the Evidence Base, Prepared by Debra Allnock and Patricia Hynes Summary Report December 2011

**ii. Resources available from Research in Practice via a log in (partner's free download):**

Intra-familial child sexual abuse: risk factors, indicators and protective factors – Research in Practice April 2018

Online abuse – recognition and response – tips and links: Frontline Tool – Research in Practice 2017

Workers perspectives on harmful sexual behaviour: Research Report (open access)

**iii. Resources available – list from Community Care Inform via an account log in**

*Policy and guidance*

Working together to safeguard children
Source: Department for Education - Published: 2018
This statutory guidance to the Children Act 1989 sets out the responsibilities of local authorities to safeguard children and promote their welfare. It describes the duties of local authorities to children in need and those suffering or likely to suffer significant harm under the Children Act 1989 and 2004. It also defines sexual abuse. It also covers the responsibilities of other organisations, such as the police and health and how they should work together as safeguarding partners. It includes the statutory definition of sexual abuse (p. 104).

What to do if you're worried a child is being abused
Source: Department for Education - Published: 2015
Departmental advice to help practitioners identify the signs of child abuse and neglect and understand what action to take.

Independent Inquiry into Child Sexual Abuse
Source: Independent Inquiry into Child Sexual Abuse
The statutory Independent Inquiry into Child Sexual Abuse has been set up to consider whether, and the extent to which, public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse in England and Wales.

Giving victims a voice: a joint Metropolitan Police and NSPCC report into allegations of sexual abuse made against Jimmy Savile under Operation Yewtree
Source: NSPCC and Metropolitan Police - Published: 2013
This report by the NSPCC and Metropolitan Police describes victims accounts of abuse by the TV personality Jimmy Savile, the police investigation Operation Yewtree and gives some learning from the cases.

Sexual Violence against Children and Vulnerable People National Group
Source: Home Office
Published: 2013
The Sexual Violence against Children and Vulnerable People National Group (SVACV) is a Home Office panel to implement the learning from recent inquiries into child sexual abuse and sexual violence prevention. They published a progress report and an action plan in July 2013.

*Practice advice and good practice examples*

Sexual abuse: signs, indicators and effects
Source: NSPCC
Topic page covering the signs a child may have experienced sexual abuse and the effects that sexual abuse can have.

Seen and Heard
Source: Department of Health. Published: 2016
E learning course to help staff spot the signs of child sexual abuse and exploitation

Hidden men: learning from case reviews – summary of risk factors and learning for improved practice around 'hidden' men
Source: NSPCC
This briefing is based on case reviews published since 2008 which highlighted the issue of professionals not identifying and/or assessing key men, such as fathers, mothers' partners, involved in the care of children who died or suffered harm. In these case reviews, children died or suffered serious harm through physical or sexual abuse by the mother's partner or were killed by a father with mental health problems. The review looks at the risk factors posed by hidden men and learning from these cases.

Protecting disabled children from abuse
Source: NSPCC - Published: 2014
Disabled children are at greater risk of abuse, including sexual abuse. This report looks at why disabled children are particularly vulnerable and considers what we know from research and reviews of service delivery. It examines the policy context and current state of safeguarding services in the UK and makes recommendations to improve the protection of disabled children.

Online abuse: learning from case reviews
Source: NSPCC
This briefing is based on case reviews published since 2008, where online abuse was a key factor. It pulls together and highlights the learning contained in the published reports. In these case reviews, children died or were seriously injured following cyberbullying, there was online grooming leading to sexual abuse and exploitation, vulnerable parents were targeted by abusive adults via dating websites and social networking sites or children were sexually abused in order to share images of child sexual abuse online.

Therapeutic services for sexually abused children and young people: scoping the evidence base: summary report
Source: NSPCC. Published: 2012
This research review examined the types of therapy which are effective in helping children and young people who have been sexually abused. It explored the evidence in relation to talking therapies (including counselling, cognitive behavioural therapy (CBT), group therapy, transactional analysis (TA) and eye movement desensitisation and reprocessing (EMDR)), and creative therapies (including play therapy, drama therapy and art therapy). It also considers the literature around the impact of sexual abuse on children; resilience factors; and what children and young people say about therapy.

A meta-review of interventions to support children and their families in the aftermath of child sexual abuse
Source: Action for Children. Published: 2009
This review gives an overview of the results of research reviews that have evaluated and summarised the effectiveness of interventions offered to children and families affected by sexual abuse. It forms one part of an evaluation conducted by Canterbury Christ Church University in partnership with a UK network of Action for Children projects which focused on child sexual abuse.

*Research and statistics*

Child sexual abuse and exploitation: understanding risk and vulnerability
Source: Early Intervention Foundation and Coventry University - Published: 2016
An assessment of the best evidence for identifying and appraising risk indicators.

Seminar series on child sexual abuse
Source: Child Protection All Party Parliamentary Group and NSPCC. Published: 2014
Report summarising a series of seminars on child sexual abuse held by the All Party Parliamentary Group on Child Protection and NSPCC. Sets out recommendations made to the government to better protect and support children from sexual abuse.
Social workers' knowledge and confidence when working with cases of child sexual abuse: research with social workers, managers and local safeguarding children boards chairs exploring issues and challenges
Source: Coventry University and NSPCC - Published: 2014
NSPCC commissioned Coventry University to undertake research in six local authorities in England. This report highlights issues around training, peer and managerial support and supervision, experience of managing cases and direct work with children.

Child sexual abuse: an NSPCC research briefing
Source: NSPCC. Published: 2014 - This short research briefing describes the characteristics of child abusers, including sexual abusers, based on research findings and statistical evidence. It covers the relationship between abusers and their victims; the gender, sexual orientation and age of abusers; how many people abuse children; and risk factors associated with child abuse

No one noticed, no one heard: a study of disclosures of childhood abuse
Source: NSPCC. Published: 2013
Researchers interviewed 60 young adults (aged 18-24 years) who had experienced high levels of different types of abuse and violence during childhood. The young adults were asked whether they had tried to tell anyone about what was happening to them, and what had happened as a result of their disclosures. Although much research suggests that few children disclose sexual abuse, in this study over 80% had tried to tell someone about the abuse.

How safe are our children? Analysis of how many children are being abused and neglected
Source: NSPCC. Published: 2014
The report compiles child protection data that exists across the four nations in the UK for 2014. The report sets out 20 different indicators of child safety. It also includes a section summarising the factors that influence a child's risk of abuse or neglect and a spotlight on the criminal justice response to child sexual abuse.

Lost in Care – Report of the tribunal of inquiry into the abuse of children in care in the former county council areas of Gwynedd and Clwyd since 1974 (Waterhouse inquiry)
Source: Department of Health - The 1996 inquiry, led by Sir Ronald Waterhouse QC, into to allegations of child abuse in care homes in former county council areas of Clwyd and Gwynedd between 1974 and 1990.

Macur review of the Waterhouse inquiry
Source: Department for Education
A review of the Waterhouse inquiry to see whether its scope should have been broadened, following accusations that there were other abusers involved at the North Wales homes including businessmen, politicians and police officers.

NSPCC archive of serious case reviews 2013 to 2015

Peter Wanless and Richard Whittam QC review
Source: Home Office. Published: 2014
A review into Home Office handling of child sex abuse allegations from from 1979 to 1999 and the way police and prosecutors dealt with any information given to them, led by NSPCC chief executive Peter Wanless It followed a previous review by the permanent secretary of the Home Office which found there was no record of specific claims of abuse by prominent public figures but that 114 files were said to be missing.

Statistics on the characteristics of children in need
Source: Department for Education. Updated: 2015
These statistics include the number of children who were the subject of a child protection plan by initial and latest category of abuse and by factors identified during assessments, including sexual abuse.

NSPCC child sexual abuse statistics
Statistics about child abuse gathered from a range of sources by NSPCC.

### iv. Resources available from Parents Protect!

www.parentsprotect.co.uk was created by the child sexual abuse prevention campaign, Stop it Now! UK and the Lucy Faithful Foundation.

There are a range of leaflets, posters and other resources for children on keeping safe, boundaries and sex education. Also available is a family safety plan template.

### 28. Other references

'Key messages from research on intra-familial child sexual abuse' McNeish and Scott, Centre of expertise on child sexual abuse – see list below

Intra-familial child sexual abuse: Risk factors, indicators and protective factors Practice Tool, Research in Practice (2018)

Creative Ideas for Assessing Vulnerable Children and Families, Wrench (2018) London: Jessica Kingsley Publishers

Helping Vulnerable Children and Adolescents to Stay Safe. Creative Ideas and Activities for Building Protective Behaviours, Wrench (2016) London: Jessica Kingsley Publishers

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