Practice Guidance

Child Sexual Abuse

Version 2

April 2024

Hull Social Work Academy
Grow and thrive together

Hull City Council

Content

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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. Sexual abuse in the family is rarely an isolated occurrence and may go on for many years. Research tells is much abuse in the family remains unshared. Children may fear their abuser, not want their abuser to get into trouble, feel that the abuse was 'their fault', and feel responsible for what will happen to their family if they tell. Disabled children and some black, Asian and minority ethnic children face additional barriers.

Practitioners may 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. We need to be mindful that practitioners from other agencies will need support and guidance from ourselves.

Families will want to know what we expect from them, and this will include a clear time line of intervention and support. Hull adopt the Signs of Safety model, whereby a timeline is shared with each family.

The Timeline.

How would you explain a timeline to a family?
A timeline explains what work the family can expect to be done with them and over what period of time
You will need to put a start date and the target number of weeks for completion
What are the benefits of having a timeline?
Having a clear process to share with the family and other professionals involved
Open and honest approach to working with families
Brings hope and energy
Creates greater clarity/transparency
Creates professional accountability (to our families, supervisors, leaders)
Minimizes drift and delay- best interest of the child being paramount
Skilful use of authority- families and their networks more accountable
Helps everyone to review progress
What are the three phases of the timeline?

Preparation phase, safety planning phase and monitoring phase

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).

How many children experience sexual abuse ?

We don't know exactly how many children in the UK experience sexual abuse. However, research with 2,275 young people aged 11-17 about their experiences of sexual abuse suggests around 1 in 20 children in the UK have been sexually abused (NSPCC February,2024) For more information the statistical briefing can be accessed here: Child sexual abuse: statistics briefing (nspcc.org.uk)

The Child Safeguarding Practice Review Panel continue to work on a national review about sexual abuse in the home- once published Hull's guidance will be updated.

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.

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.

The scale and nature of child sexual abuse: Review of evidence
by Kairika Karsna and Professor Liz Kelly 2019

- The report estimates that at least 15% of girls and 5% of boys experience child sexual abuse before the age of 16. The majority of child sexual abuse is hidden; never reported or uncovered by an official agency.
- Two thirds of child sexual abuse take place within the family environment or the close circle around it;
- Sexual abuse involving child siblings is thought to be the most common form of intra-familial child sexual abuse, perhaps up to three times as common as sexual abuse of a child by a parent (Krienert and Walsh, 2011; Stroebel et al, 2013)
- 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 because 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.

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 share with adult's when the abuse is by a brother or sister. Often the children have experienced maltreatment or neglect, so we need to ensure we are professionally curious. We also know that adolescents who display harmful sexual behaviour usually do so first within their family (Miranda and Corcoran, 2000).

There are many barriers to children sharing their experiences of sexual abuse and it simply isn't likely that a child will feel able to tell professionals directly what is happening or recognise that what is happening to them is abuse. Instead, children may show other emotional, behavioural, and physical signs.

All professionals need the knowledge, skills, and confidence to recognise when children might be showing them that something is wrong and understand the potential indicators of sexually abusive behaviour in those who may be abusing them. There are also factors within the family or environment which can increase opportunities for abuse to occur, so a professional understanding of these is also really important in order to reduce risks and build strengths. The Centre for expertise on CSA has produced a *Signs and indicators template* which is designed to provide a common language amongst professionals to discuss, record and share concerns that a child is being, or has been, sexually abused. The template can be accessed here.

Signs and indicators of child sexual abuse | CSA Centre

Often children and young people do not tell anyone when they experience abuse and there are various complex reasons for this. But when the person hurting you is a family member it becomes even more difficult for children to tell due to loving the abuser and wanting to protect him/her.

When people abuse children, they rely on secrecy and try to silence the child and to build trust with adults such as us 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 and by recognising possible signs that child may be showing. (Adapted from Wrench 2016)

We know that professionals often struggle to name CSA and record their concerns so concerns are not addressed. The template aims to build confidence helping practitioners to record and state what they are seeing and what they aim to do to gain a bigger picture. Below are some examples from Social Care Institute Excellence (SCIE)

https://www.scie.org.uk/social-work/recording
https://www.communitycare.co.uk/2017/06/07/tips-social-workers-case-recording-record-keeping/

I am/Jane is concerned that X and Y may be being sexually abused. This is because of the following:

- List potential indicators

These may be signs of other factors in X and Y's life, however in order to explore this hypothesis, I will/Jane has agreed to:

- List actions that you have identified with Jane, e.g. Jane to ask step-dad about previous family and check records in other LA.

4.Practice Principles

Practice principles when working with child sexual abuse.

No Further Action (NFA) by police does not mean Social Care should automatically cease intervention and support. 90% of sexual offences reported to the police concerning offences within the family will result in NFA.

Our thresholds Vs Police differ

Police threshold for evidential burden of proof is - ***Beyond Reasonable Doubt***
Children's Services - Evidential Burden of Proof - ***Balance of Probabilities***

Assessment or intervention in cases of intra-familial CSA needs to take account of **all family members.**

Intra-familial CSA does not happen in a vacuum – 'NEED the WHOLE FAMILY CONTEXT' (statutory guidance advises this approach)

- •Risk Assessment – Must consider all family members.
- •Risk changes over time
- •Consider what is happening in the family to stop children from telling.

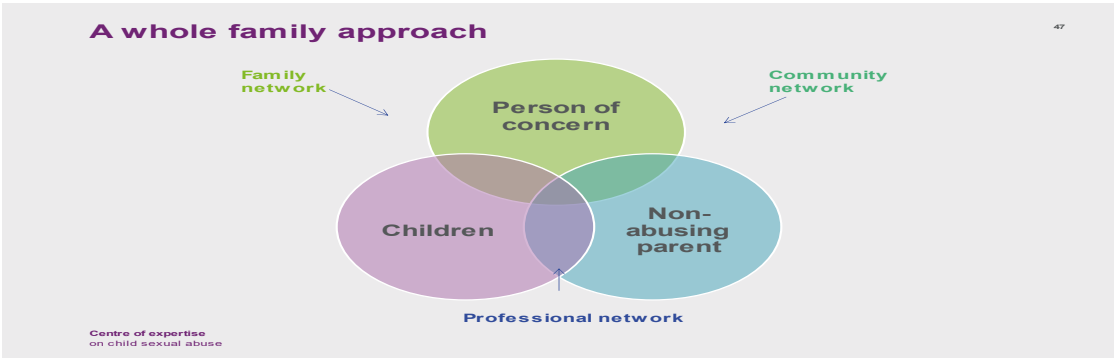
Examples

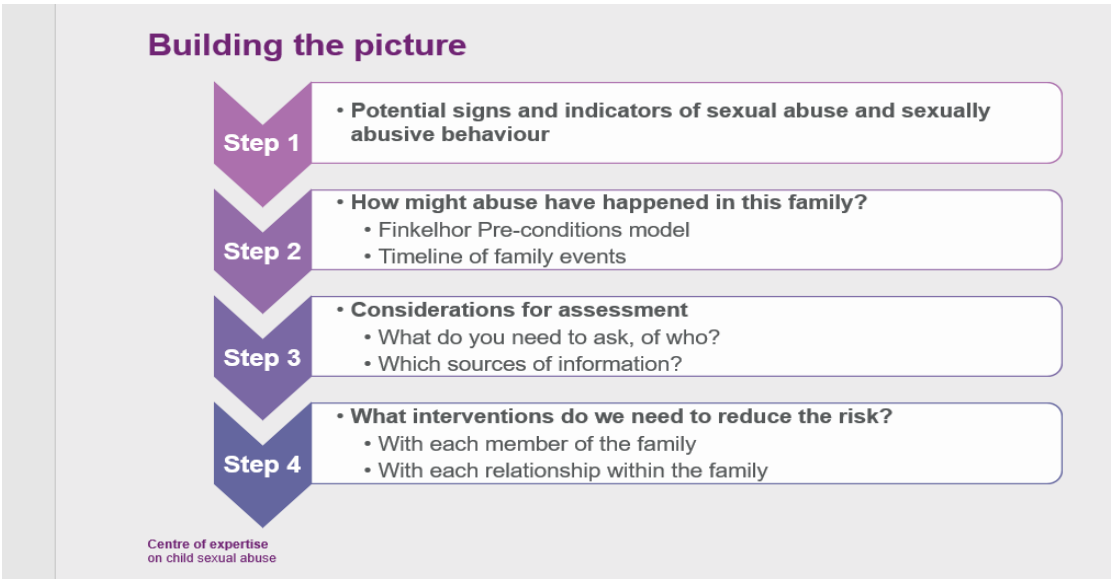
Alleged abuser high risk – Non-abusing parent/s protective, robust and have minimal vulnerabilities and recognise the risks – Children are confident and have a strong relationship with non-abusing parent – Consequently the risks may be manageable in this scenario, but needs to be assessed and evidenced within the assessment period or planning phase.

A**lleged abuser relatively low risk of harm** – **BUT** Non-abusing parent has multiple vulnerabilities, cannot recognise the risks and struggles to keep children safe - Child/ren also have vulnerabilities, poor relationship with their non-abusing parent. – Consequently, the risks may be much harder to manage.

To **reduce risk**, we need to think about all family members –

- •What are the vulnerabilities of the non-abusing parent/carer;
- •What are the vulnerabilities of the child; and
- •How has the alleged offender manipulated these in order to abuse the child
- •Remember professionals and communities can be groomed and manipulated as well.

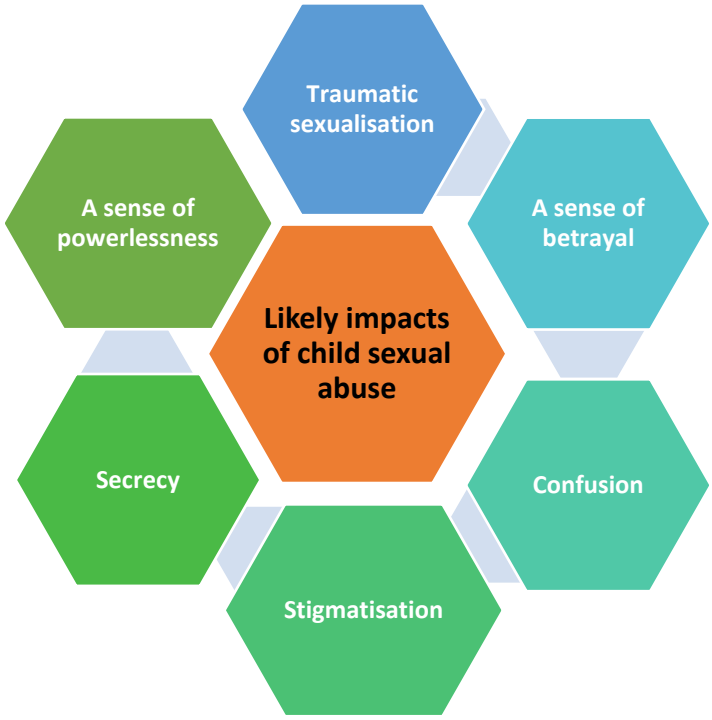




Additional principles below are aimed at supporting practitioners in their work in this area.

Build a healthy, high support, high challenge and communicative relationship with the family as families who trust us will feel they can talk to us and engage with us	Understand that each member of the family will have a different experience, a different story and potentially a different way of managing their feelings	Build effective relationships with other relevant agencies
We do not need to become more authoritarian when we feel less confident	Seeking a disclosure is not your end goal	Your primary focus should be to secure safety for the child
Be more creative in engagement and assessment work; Work with what you can observe – not just what you hear; unpick what you hear with what you see; have a toolkit ready to use	Have an understanding of the impact of trauma on child development, on family systems and communities	Don't assume the family will need services – we can support them to be a healthy system – tap into support. The most powerful healing tool for a child is a protective parent

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 are:

- *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

Sexual abuse can be difficult to think about and to talk about: it can feel complex, emotional, and even scary. You might worry about 'getting it wrong', having to have difficult conversations, 'opening a can of worms', and not knowing what to say or how to respond. You might also worry about 'contaminating evidence' – saying the wrong

thing to a child by asking a leading question which may jeopardise a criminal trial. However, it is important to recognise that you can talk to a child in many ways without fear of affecting a criminal trial – and to remember that the child's welfare should be the paramount consideration. Fear of getting it wrong can prevent you from asking children anything at all, yet research shows that they need 'help to tell'.

The guide below aims to help you communicate with children in relation to child sexual abuse, including when you have concerns that such abuse is happening. The guide brings together research, good practice guidance, and expert input from professionals and survivors of abuse.

Communicating with children

The Centre of expertise on child sexual abuse (CSA Centre) has published a guide for professionals on communicating with children who have, or may have, been sexually abused. The guide helps those working with children know how to respond to concerns about child sexual abuse, including best practice for what to say and do in conversations with children and provides an understanding of the professional behaviours that can give children the confidence to tell.

It's vital that anyone who works with children has the knowledge and confidence to talk to them about their experiences; knows how to recognise what is happening and understands how to help the child to have that conversation.

Full guidance can be found with the Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and guidance on Using Special Measures January 2023.

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.

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;

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. 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?'.

It is not generally permitted to put leading questions to a witness. A leading question is one which either suggests the required answer, or which is based on an assumption of facts that have yet to be proved. Thus 'Daddy hurt you, didn't he?' is an example of the first type of leading question, and 'When did you first tell anyone about what Daddy did?', put to a child who has not yet alleged that Daddy did anything, is an example of the second type.

Don't promise confidentiality – You can't promise to keep the allegation 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 and seek supervision.

The Cleveland Report forms Achieving Best Evidence:

Disclosure- Only when proved to be true or accepted as truth. Using disclosure is saying that you are starting at a point of where you assume abuse has occurred.

Allegation- Despite your personal beliefs you are showing you are prepared to consider all the evidence before you give your view.

Case Recording- For the sake of simplicity

• The (child/young person) told me….

• Has said that….

• … Told their mum/dad/teacher/social worker that…

We use the term 'conversation' when referring to professionals communication with children.

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

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 the assessment

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.

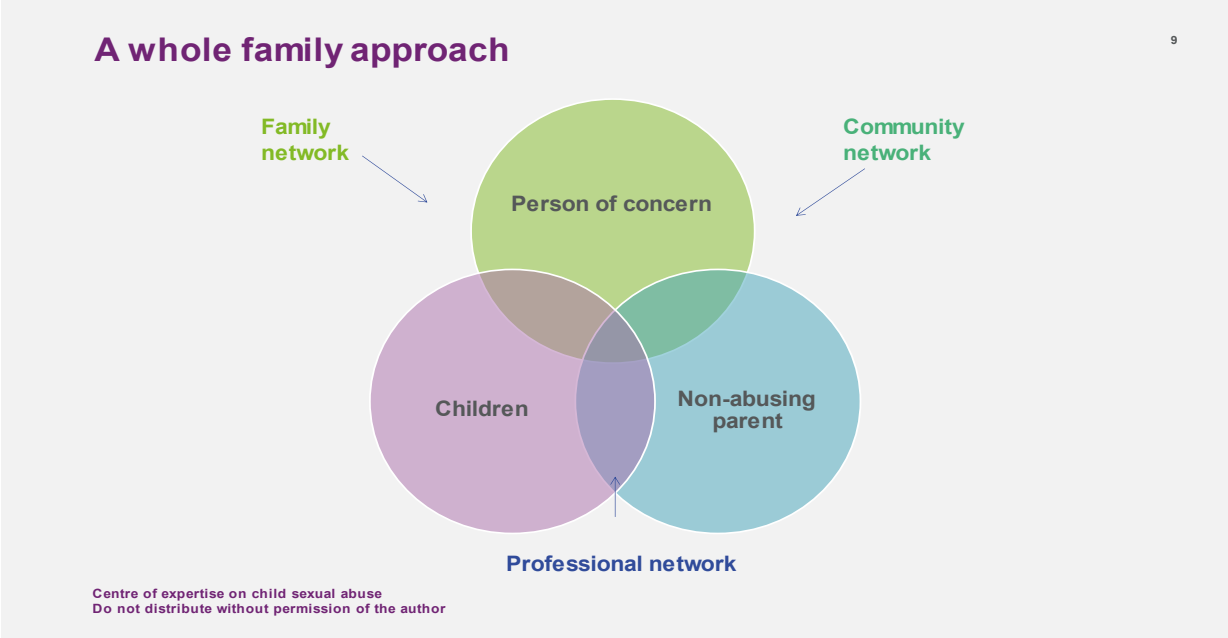
It may be necessary for the 'high energy' child to expend energy, and in this case, introducing some kind of movement can be helpful. This might include a bounce on the trampoline outside in the garden or doing star jumps, going for a fast, marching walk outdoors, or if they are a young child playing 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. Families First – Whole family focused intervention



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).

When a child shares, they have been sexually abused this can be 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 tell to their non-abusing parent than to anyone else (Warrington et al, 2017) and the way a non-offending parent responds to what the child shares 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).

- 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.

- There may 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.

Areas for Intervention when adult is felt to be a risk.

Our aim is to reduce risks and vulnerabilities and build strengths, possible areas may be

- Address individual and relevant risk factors-e.g. alcohol/drug use or mental health
- Relationships
- Family communication
- Address individual needs e.g. supportive & therapeutic intervention
- Education
- Safety planning

To support parents in their ability to protect, a program has been designed for practitioners to undertake with the non-abusing parent, carer or relatives to increase their knowledge and confidence. This can be accessed via Hull City Council's Learning and development and is called 'Increasing Parent Ability to Protect'.

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. It is a bottom line in Hull that the family need to find a network of people who know about the worries (informed).

Regular family network meetings should be held to consider care for children, identify what safety looks like, who in the network will support safety to continue so that children and family can safely remain together, where possible. Family Network meetings should be held regularly to agree the safety plan that the family should follow and identify who will do what to help. They key messages from the plan should be transferred to words and pictures for all.

10. Sibling sexual abuse

Sibling sexual abuse: A knowledge and practice overview is provided by CSA Centre and helps to inform decision making and interventions. As with cases where an adult is considered a risk, we still need to assess parents ability to protect children from sibling sexual abuse. (see section 18 Non abusing parent assessment)

Access the content here :

Sibling sexual abuse and behaviour | CSA Centre

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:

The nature of the relationships and the environment in which they develop, understanding the functioning of any family must extend beyond an understanding of how children are looked after by their parents/ carers. It needs to include how individuals within the family interact; their roles and statuses in different situations and contexts.

Sibling sexual abuse must be understood as a problem of and for the family as a whole, and not just a problem for or about an individual child

Assessments are best undertaken when emotional, physical and sexual safety are available to all of the children in the family. A number of studies have found common factors in the family backgrounds of children involved in sibling sexual abuse, such as domestic violence and abuse, extra-marital affairs, physical chastisement, poor sexual boundaries within the family home (e.g. witnessing sexual activity between parents), parent–child sexual abuse, and a lack of supervision (Adler and Schutz, 1995; Hardy, 2001; Latzman et al, 2011; Laredo, 1982; Smith and Israel, 1987; Worling, 1995)

In cases of sibling sexual abuse Family-focused interventions are likely to involve engaging parents in longer-term work to:

- identify family strengths and needs
- identify and address past and/or current parental trauma
- increase openness and emotional expressiveness within the family
- clarify, consolidate, or restore appropriate parent and child roles
- acknowledge and interrupt abusive family patterns

- increase parental skills, confidence, and competence in promoting accountable behaviour within the family and in handling negotiation and conflict
- enhance the parents' protective capacity, especially in relation to boundary-setting
- assist the parents to structure the young person's time and social activities
- re-negotiate family relationships in situations where it is not possible for the young person to return home, to clarify, maintain or improve contact with the family and enable the family to be a source of continuing support and significance (adapted from Duane and Morrison, 2004

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 & 2021) 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

Cloverleaf Advocacy is an independent advocacy service for adult and children who need support, or are entitled to support, to have their voices heard by health and social care professionals. You make a referral vis referrals@cloverleaf-advocacy.co.uk

13. Consider 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 share 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

Below is a summary of some reasons why it may be difficult for certain children to talk. Link for full report here See report - https://www.iicsa.org.uk/publications/research/child-sexual-abuse-ethnic-minority-communities

15. The role of Strategy Discussion/Meeting.

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 tell 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 when possible should consulted and involved. The strategy meeting should:

- Share available information; remember Safeguarding children is our priority alongside any potential criminal conviction. **Multi-agency response to child sexual abuse in the family environment: Joint Targeted area inspections (Ofsted, 2020) found** Practice in this area is too police-led and not sufficiently child-centred.
- Agree when / who will see the child alone – consider race / ethnicity / language / disability;
- Decide whether a Section 47 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 during the investigation period.
- If the child is in hospital, consider arrangements for contact between family.
- Consider the timing of any criminal investigation – Achieving Best Evidence.

- Agree who/how information will be shared with; Practitioners should be proactive in sharing information as early as possible to help identify, assess, and respond to risks or concerns about the safety and welfare of children. This may be when problems are first emerging (for example, persistent school absences) or where a child is already known to local authority children's social care. Sharing information about any adults with whom that child has contact, which may impact the child's safety or welfare, is also critical. Working Together to Safeguard Children 2023 A guide to multi-agency working to help, protect and promote the welfare of children December 2023
- Agree feedback on any outcomes.
- Tools which may help signs and indicators tool and a harm matrix

When requesting the Police information, you would need access to the full Police report including charges if any, case summary, report including key evidence, defendant interview, non-key evidence, visual evidence, injuries etc. Key Witness statements, any transcripts of ABE interviews.

Working Together to Safeguard Children 2023, states *the police will hold important information about children who may be suffering, or likely to suffer, significant harm, as well as those who cause such harm. They should always share this information with other organisations and agencies where this is necessary to protect children. Similarly, they can expect other organisations and agencies to share information to enable the police to carry out their duties.*

GDPR does not prevent any piece of information from being exchanged with social services or any other agency working MAPPA and child protection.

Hull City Council have additional guidance in terms of placing restrictions on the living /contacts arrangements of a parent with their children:

Whether a case is regarded as section 17 or section 47, it must be based on the definitions of those sections of the Children Act 1989, as amended by later legislation. This is clearly explained in the statutory guidance 'Working Together to Safeguard Children' 2023.

If extreme measures are considered necessary to protect a child: i.e. a parent needs to leave the family home and/or only have supervised contact, it is highly unlikely that the case can be anything other than s47. Of its very nature, such draconian action should only be predicated on the basis of a risk of significant harm.

During enquiries undertaken under s47, it may be appropriate to ask a parent/step parent/ partner to move out of the family home for a short period. However, even if a short period of time is proposed, it must be very clear that there has been discussion about the voluntary nature of this arrangement.

There must also be clarity about what steps the Local Authority will take if this does not happen. It is not sufficient at any stage to state that the Local Authority will 'seek legal advice.' The next steps must be stated explicitly within the contingency plan.

Where the threshold for s47 is met, it is inappropriate to suggest to parents that the case can remain at s17 as long as they comply with what is being requested of them. Progressing to a Child Protection Conference should not be used as a 'threat' if there is non-compliance: this is not only contrary to the principle of working together with families, but also suggests that working under a Child Protection Plan means that the Local Authority has additional powers in regard to imposing the restrictions required, which it does not.

The key consideration is the impact on the child, not the compliance or otherwise of the parents.

16. Effective use of child protection intervention and support.

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 share what has been happening to them. 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.

The lead practitioners, Social Worker and the Conference Chair will need to work together to ensure that the meeting is effective and safe for the child. Be curious if the investigation has been NFA by police it does not mean that the offence did not happen.

Over the last 25years we have seen a drastic decline in children being placed on child protection plans under the category of sexual abuse. If there are concerns we need to name it and address concerns by way of our danger statements and safety goals.

17. Child Protection Medical

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. Sexual assault referral centres offer medical, practical and emotional support to anyone who has been sexually assaulted or raped. They have specially trained paediatrician / Forensic Nurse Examiners (FNE) When child sexual abuse is shared or suspected medical examinations can have wide benefits, including: identifying forensic and evidential findings and providing a holistic assessment of the health and wellbeing of children who have experienced sexual abuse. It's important that professionals who engage with children prior to a possible referral for medical examination have the knowledge and confidence to provide information and advice to children and non-abusing parents and carers.

Guidance can be accessed here:

The role and scope of medical examinations when there are concerns about child sexual abuse: A scoping review (csacentre.org.uk)

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 2023.

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 and Plan

When planning for assessment with cases involving sexual abuse, think about how to gather information using different methods. Information from the police will be crucial and should you have any difficulty accessing this then this needs to be escalated through your manager and if needs be, challenged using the Escalation and Resolution policy available on Hull Safeguarding Children Partnership website.

There will be different assessments undertaken on members of the family and this can be a lengthy process. Whilst full assessments are being completed access Research In Practice Intra-familial child sexual abuse: Risk factors, indicators and protective factors tool , specifically section three page 20 to help decide immediate plan until further information can be obtained.

The Person Posing Risk Children assessment (see Appendix 1)

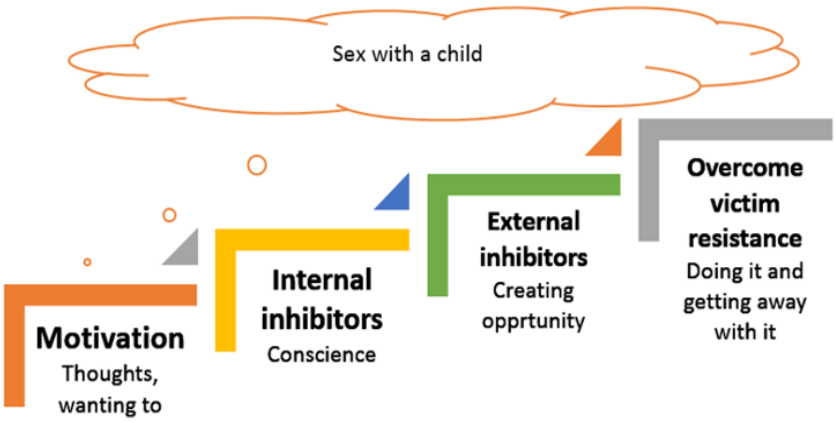
The term used here will be Person Posing a Risk (PPR) to children. An assessment must be carried out on any PPR who may or may not be convicted of an offence relating to the area of risk when a decision needs to be made about whether it is safe for them to have contact with or to live in a household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

A PPR to children assessment should be carried out whenever a social worker or 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).
When completing this assessment, it will be useful to be familiar with Finklehors **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

Information from police will be crucial here to help us identify how children were groomed and opportunities created to sexually abuse child. This will help you complete section 2 of PPRC assessment.

- Section 3 it will be helpful to consider how the information collected relates to Ward and Beech Etiology of Risk 2004.Belwo is a list of relevant factors
- History of offending, including sexual
- Relationship history (intimacy deficits – emotional or sexual) Emotional self-regulation/ management (e.g. mental health, substance misuse, anger, stress)
- Sexual self-regulation/management (e.g. sexual preoccupation)
- Congruence with children (for males)
- History of childhood trauma, abuse, attachment difficulties
- Issues of power and control (e.g. violence/aggression)
- Sexual interest in children
- Distorted scripts/views of sex and children (gender, sexual entitlement)
- Social isolation/difficulties in social relationships
- Previous intervention or treatment
- What's changed? (in relation to historical allegations)

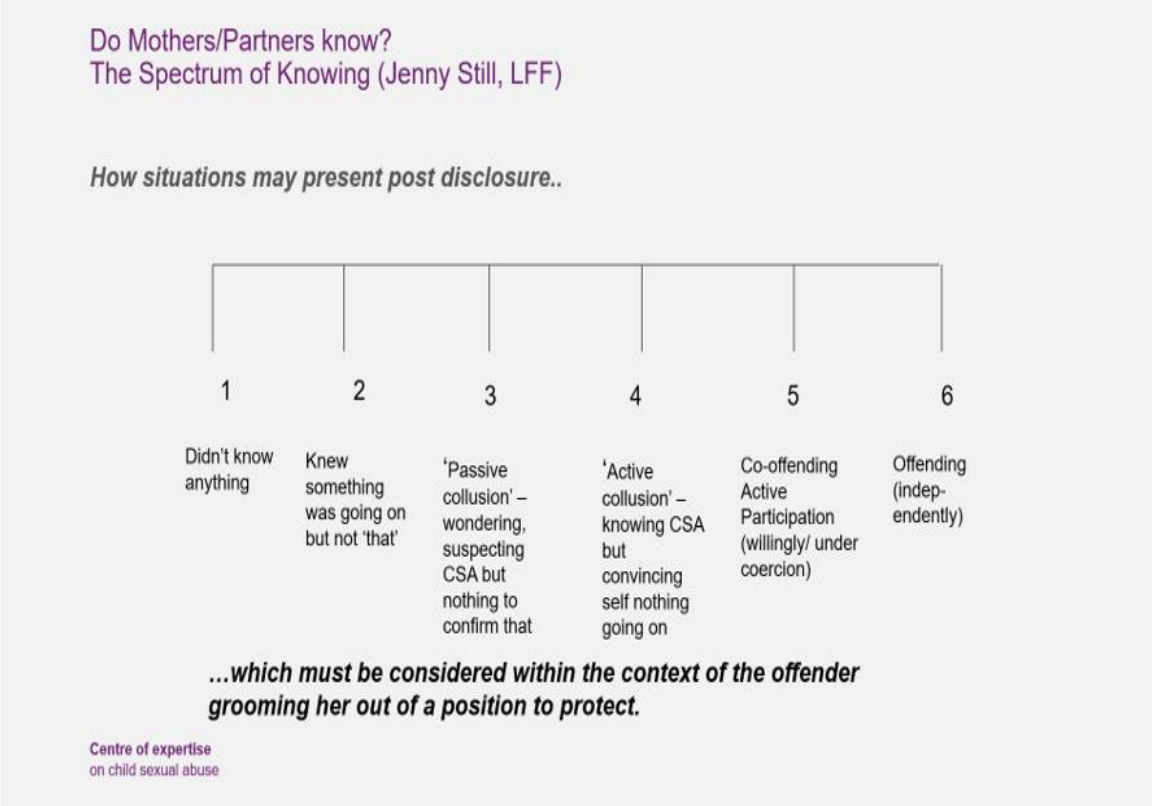
Section four asks to worker to consider child/children in the family and information gained from Non abusing parent ability to protect assessment. (NAP)

It is important for those undertaking PPRC 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 PPRC 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 PPRC 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.

When looking at the protective adult it is important to first have considered Jenny Stills Spectrum of knowing.



1 – didn't know anything

A number of non-abusing parents will say at the start of our work with them they didn't know anything at all was going on. They may be frightened to say to someone in authority that they had moments where they thought something was strange as they may worry we will see them as failing to protect**.** In reality, as we have already seen, it is very hard to know sexual abuse is going on, however they may well have thought something was wrong, just not that - however, saying that out loud will be hard. If you work openly and non-judgementally with them, they may well be able to say over time 'I knew something wasn't right, but not that'. If they have picked up absolutely no signs of concern (and this is true), then there may be issues in relation to the extent to which they are attuned to their child (as a result of e.g. being too busy with work or other children; struggling with mental health or substance misuse; poor relationship with child).

2 – Knew something was going on, but not that.

As noted above, it is likely that **parents (who have some attunement with their children)** do pick up something is wrong but have not considered sexual abuse. For example, they may say that they thought their mood was about difficulties at school or with friends. Remember too that as part of the grooming process the abuser may have manipulated the situation so, for example, if non-abusing parents has discussed with them that they are worried about the child, the abuser may have encouraged them to think their concerns are based on other events or issues.

3 - 'Passive collusion' – wondering, suspecting CSA but nothing to confirm that

It will be very difficult for a non-abusing parent to tell anyone that there were moments when they thought sexual abuse was happening, but they put it out of their head or **persuaded themselves that there was no evidence for it. However, where they have had previous thoughts like these that weren't acting on, they will be struggling with additional guilt about what happened.** As far as possible it is useful for the worker to engage openly and non-judgementally with questions such as "other women I've worked with have had moments when the possibility of sexual abuse entered their heads, but they dismissed it as they believed it couldn't be true, or it was just them 'going mad'. Is this something that happened with you?" The purpose of this is to be able to help them with feelings of guilt, and also to get more information to help understand how the abuse took place and what the child experienced.

Survivors of sexual abuse

- They may see themselves as damaged in some way by the abuse and that so if they are seeing things of concern sexually, then it must be their 'damaged head' that is seeing things that aren't there;
- If the abusing person knows they have been abused, they can manipulate their experiences, i.e. 'you see sexual abuse everywhere'.

4 – Active collusion - knowing CSA but convincing self-nothing is going on

This is similar to point 3, though may be a more active process of convincing themselves nothing is going on. It may also be for some (who have their own sexual abuse histories) that they can 'disassociate' from the situation in order to cope with it.

5 – Co-offending Active Participation (willingly/ under coercion)

There is a distinction to be made between those who willingly co-abuse and those who do so under coercion. While the child will experience sexual abuse from this person in both situations, if, for example, they have watched their mother be coerced into doing it through violence, then there may be an option that future contact could happen. If the mother has been doing it willingly, then there is unlikely to be an option for future contact.

6 – Offending independently

Some mothers may abuse their children independently of anyone else.

It may be worthwhile completing **Increasing parents' ability to protect** work first to help strengthen knowledge and understanding of CSA before assessment. You can then refer to this as you go through the assessment to see if there has been any transfer of learning. **OR** You may identify after the assessment that this is an intervention that may be appropriate to develop strengths.

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.

The template can be found in Appendix 2

It is important to recognise that many NAP will go through a period of denial.

It is not uncommon to see the mother in a state of confusion and ambivalence, swinging on a pendulum between believing the child completely one minute and not the next, or believing some but not all of it: 'I can believed this, but I cannot believe that'." (Still, 2016:19)

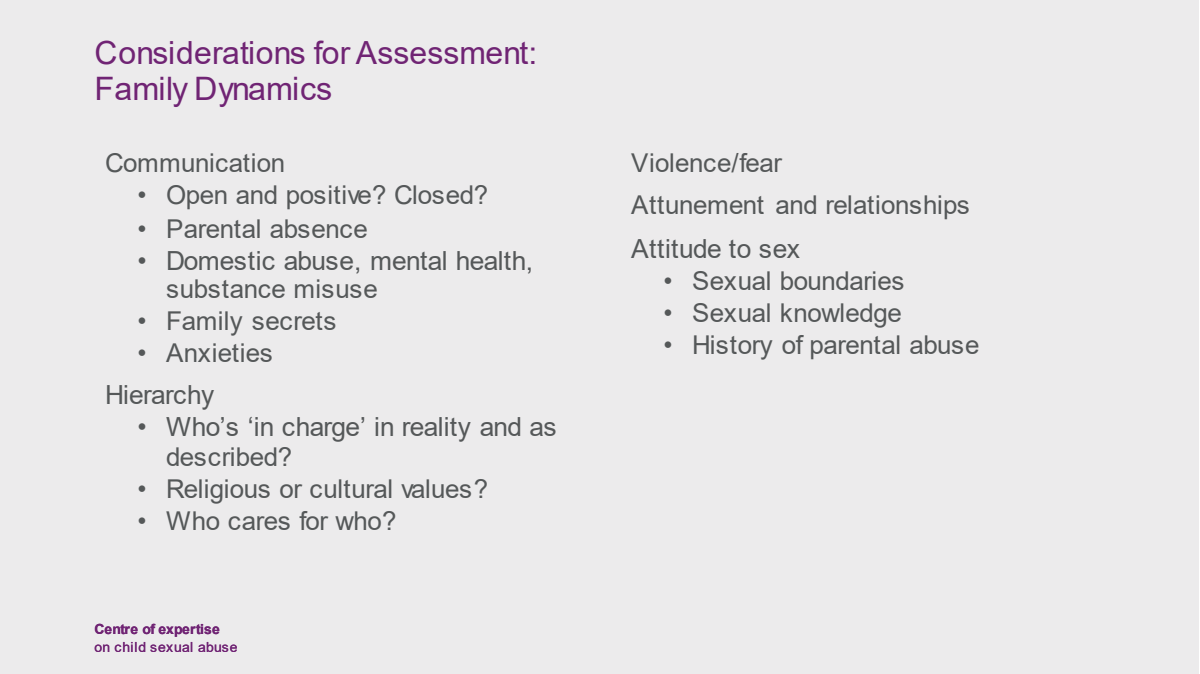
A normal and functional defence that allows us to protect ourselves against something that is painful and distressing. (The American Psychiatric Association,1994)

From a trauma processing perspective, features such as denial, unfocussed anger, minimisation of the problem and ambivalence toward both the alleged victim and abuser would be considered part of the course, rather than evidence of toxic parenting or deep seated psychopathology. (Chaffin, 1996)

It will be helpful to discuss this with the NAP and to give them time to process information this will also help establish trust in the relationship.

Often workers find that the NAP knowledge of sexual abuse is not where we would want it and then recommend undertaking Increasing parents ability to protect program, so it may be helpful to do this program first with the Nap and then undertake an assessment of ability to protect.

Family Dynamics also need to be assessed this may have been covered in PPRC and NAP assessment. This information should be gained through work individually with all family members.



Getting the Family Sexual Script (Appendix 3)

The family sexual script is the unwritten code by which the family understand what acceptable and unacceptable ways are of interacting with each other and those outside the family. It covers privacy, intimacy, and access to sexual information as well as sexual behaviours. This helps to understand the messages the child has been given about these different aspects.

Direct Work with children to help compete whole family approach assessment and decision making.

Information should be gained from undertaking direct work with children regarding their understanding of why social care are involved, their ability to recognise ok/not ok behaviours (you may want to complete protective behaviours work with children to help increase their understanding but this is not about giving children responsibility for their safety adults keep children safe) , input from school and additional information regarding any vulnerabilities.

Analysis of information and planning

7.Building a trusting relationship with the child

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

Not until we have completed the above can we start to think about making decisions and future plans.

19 Family Safety Plans

How would you help a family to understand what you mean by effective safety planning?
What are the essential elements of safety planning?
Created together with the parents, carers, child/young person and key members of the support network
Give family every opportunity to come up with and apply their own solutions before the professionals impose theirs

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. Signs of Safety knowledge bank has good examples to access and the Signs of Safety work books.

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

Safety planning practice and process;
What is the safety planning journey?
Road map, danger statement, safety goal, safety scales… what makes a good one?
It's a journey
Always involves parents together with support people
Often start with an immediate safety plan after the case opens
A safety plan is about behaviours and actions and creates the detail of who will do what so if and when problems happen the child is always safe.
Preparation for each session is essential

Safety Planning Elements- Bottom Lines;
What are bottom lines?
Professional bottom lines are the MINIMUM that must happen and cannot be compromised on for the safety plan to work
What should always be included in bottom lines?
1. Family need to find a network of people who know about the worries (INFORMED)
2. The parents, together with their network (with the support of the worker) create a safety plan with simple rules to show everyone how they will keep the child/ren or young person safe
3. Words and pictures to explain to the children why everyone is worried and what they are doing to try and get these sorted out
Where else would you find these?
Draft safety goal

Words and Pictures
Why do we need words and pictures completing when safety planning?
Child abuse is a syndrome of secrecy
Builds stronger relationships and empathy between the worker and family (also helps the worker to understand what they know or need to find out, not assuming they know)
Over 50% of safety planning; helping families to talk about the difficult issues
Not a shaming document
Builds lasting safety after services no longer involved
What are the various versions of words and pictures, what version would you need at an early stage?
1. Short versions- using it to explain why you are involved
2. 6 frames - incorporating immediate safety planning
3. Words and pictures story board;

- *Making sense of past and present events is important for a child's development*
- *Sometimes those events are hard for the adults to talk about- what to say and how to say it?*
- *Words and pictures is a way of finding the right words to explain the events*
- *Child needs to know their story to understand the SAFETY PLAN*
- *Primarily for the child, but hugely beneficial for the parents*
- *One story from different perspectives*

- *Parents can control the story telling rather than it being 'leaked' from another source*

4. Words and pictures safety plan; explain the rules of the plan, as long as necessary to cover all of the worries

How does three houses feed into words and pictures?

The issues and problems

Three houses- an opportunity for child to talk about issues and problems- a powerful tool to then share with parents

Words and pictures produced by parents lets the children know what people are doing to alleviate the worries and problems

Example of 6 frames or so

Family Meetings

If you are concerned about keeping a child safe from sexual abuse, a family meeting is your chance to create a safer environment and a support network for everyone in the family. Children and young people are immediately safer when parents and caregivers take the time to learn about sexual abuse and its warning signs.

We talk about risk factors – what puts someone at risk to sexually abuse a child but we must also talk about protective factors – the things a family can do to keep the family safer. Protective factors are the building blocks of the family.

Parents and caregivers who make a commitment to speak up as soon as they have a concern, instead of waiting for certain evidence of harm, play an even more crucial role in a child's safety. Here are some things that you and your family can do to protect children from sexual abuse:

20. Recognising what can influence the assessment

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: **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: **A belief that the carer's initial disbelief that abuse can have taken place will remain and cannot be worked with e.g. 'She is a hopeless case, she'll never believe the child, the child is best out of there'**	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 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 Harmful Sexual Behaviour Tool and Training

Harmful Sexual Behaviour tool and training Aims checklist and section on sibling sexual abuse and decision making.

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

"Sexual behaviours expressed by children and young people under age of 18yrs that are developmentally inappropriate, may be harmful, to self or others or be abusive towards another child or adult"

Hackett , Branigan 2019

Normal Inappropriate Problematic Abusive/violent

The continuum above has been developed by S. Hackett.

Technology assisted HSB Technology-assisted harmful sexual behaviour (TA-HSB) is when children and young people use the internet or other technology to engage in sexual activity that may be harmful to themselves and others. TA-HSB covers a

range of behaviour including the developmentally inappropriate use of pornography, online sexual abuse, grooming, sexting

Practioners can have difficulty in defining and agreeing what constitutes harmful sexual behaviour. To help with consistency and understanding the AIM Checklist Tool is recommended and can be accessed via the Aim Project website. The AIM Project – The AIM Project

Around ¼ of sexual abuse is perpetrated by children or young people under the age of 18 (Hackett 2004).

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. We need to ensure we have a protective adult in the home.

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. Some practioners have been trained in AIM 3 so will be able to carry out this assessment. We also have access to Hull CAMH who offer a HSB service. The information below from their website helps explain who can access service and when.

The service that offers support to young people under the age of 18 who display mental health difficulties, neurodevelopmental disability or have experienced significant trauma that have engaged in harmful sexual behaviour. We provide both indirect support to professionals and direct support to young people and their families/carers. The service is made up of two part time Forensic Psychologists, a part time Advanced Practitioner and access to generic CAMHS psychiatric support. Who can refer? Any professional working with young people in the Hull area can refer by emailing hnf-tr.hsbcamhs@nhs.net We require that cases are held by a case-holder or co-coordinator at the point of referral and throughout service involvement. What do we do? Consultation Services Formal consultancy support can be provided to professionals in the form of guidance, advice and/or the provision of materials. You'll be provided with written documentation following the consultation including

recommendations. In other incidences we may become involved in more complex multi agency planning.
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.

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

Young people and new technologies add info
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.
Problematic behaviours online 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.
Considerations as to whether behaviour is problematic/harmful will need to look at the following:

- What age did young person begin to view pornography?
- What is there background?
- How much time is spent accessing ?
- What is the content?
- Were others involved influencing or facilitating?
- What appears to be the function of the behaviour?
- Were the images self-generated or was the young person in possession of CSA from another source
- If accessed on line how were the images obtained (what sites were accessed/ search terms used?)
- If self-generated what was the motivation behind obtaining the image?
- Were Peer –Peer sites used ie Xbox ect is there any suggestion of grooming/
- What are the characteristics of the children in the images, are adults involved?

When thinking about "Sexting" the Exchange of Sexual Messages, Photos or Videos we will need to consider the following:

- Sent Image of self
- What did the image depict
- What was the intention/ motivation for taking sending the image

- Who did they send it to
- Could this behaviour indicate child has been groomed/coerced.
- Received image.

Consider
Did the young person incite the image from other child or was it shared consensually
Is there evidence of grooming/coercion.
Has the image been shared?
If so what steps have been taken to contain spread of image
How old is the child involved.
Dors the child understand the implications of sharing images

A two day training course is ran via learning and dveleopment regarding recognsing and responding to HSB in children and sibling sexual abuse.

23 Abusive images of children

More and more families are coming to the attention of CSC due to adults accessing child sexual abuse material online. The CSA centre has published guidance Managing risk and trauma after online sexual offending A whole-family safeguarding guide.

The resource is for social work practitioners and managers. It has been designed to aid their thinking and decision-making when assessing and supporting a family where a parent is under police investigation for accessing child sexual abuse material.
Language is important. We use the term child sexual abuse material 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.

There may be additional considerations when thinking about family time where a child has spoken about being sexually abused or there is concern or suspicion:

- Is there an on-going police investigation where a child has shared there has been 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.

24. Training to accompany guidance available via Oracle
Working with families were there are concerns of child sexual abuse
Recognising and responding to harmful sexual behaviours and sibling sexual abuse.
Protective behaviours work with children and young people.
Increasing parents ability to protect work

Appendix 1 PPRC assessment template

Introduction and guidance notes:

A Home Office Review of Schedule 1 in 2004 identified that the term Schedule 1 Offender is ill defined and to a certain extent unhelpful since it defines people by their offending history rather than any risks they may pose. The Home Office has therefore concluded the term Schedule 1 Offender should be replaced with 'Risk to Children' (RTC). This clearly indicates that the person has been identified as presenting a risk, or potential risk, to children This tool is designed to provide a framework for assessing the risk posed by such individuals, who may or may not be convicted.

For convenience they are referred to as PPR (Person Posing Risk/potential risk to children) throughout this document It is intended for use as a framework for discussion with the PPR and other members of the household, (not a form to be completed) when social workers become aware of such an individual living in a household with children or having contact with a household with children.

The headings below can be used as appropriate for individual sections of a written report containing information and an analysis of that information. The information is obtained by a series of planned interviews, by associated observation of the household interaction, and by information from other agencies.

The bullet points in the following framework are intended as a checklist guide to the areas to be covered and the framework should not be used as a form to be completed. The task is to assess the degree of risk and consider whether it is acceptable/manageable in the light of other factors. However, Service Managers must bear in mind the PPRTC assessment takes several weeks. They 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 such an assessment.
When planning the PPRTC assessment social work managers should consider whether the worker conducting the assessment should be independent - i.e. not directly involved in working with the family in question.
The PPRTC assessment should be conducted openly with the individual concerned, 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. When the report is completed, the PPR is entitled to receive a copy of the sections that refer to him. On completion of the information gathering, interviews and observations, the written assessment is then compiled for submission to the Service Manager, who will decide whether the children are sufficiently safeguarded for the plan to be endorsed.
It is important for those undertaking PPRTC assessments to bear in mind the importance of the following factors:

- Consulting other professionals 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
- Cultural factors

Section 1 Introduction

• Name, date of birth any alias of PPR, current address
• Name, date of birth, address of child
• Reason for the assessment eg, request for contact with a child, wishes to live in household with a child
• Agencies contacted during the assessment of the PPR: Police, Prison, Probation, CYPS, Housing, G.P, Community Mental Health, Other (please state)
• Frequency of contact with the PPR
• Agencies contacted during the assessment of the child and their family G.P, H.V, Nursery, E.W.O, School, Community Mental Health, Community Paediatrician, Dentist, YOT, Police, School Nurse, Other (Please state)
• Has the child been seen alone (if age appropriate)
• Frequency of contact with the child and family

Section 2 The PPR behaviours of concern

Details of offences, suspected offences against children, convictions, cautions, findings of fact, allegations, generalised concerns
Details of any current orders in force, e.g. Probation Order, Registered Sex Offender, Notification Order, Sex Offenders Prevention Order, Risk of Sexual Harm Order, License
• What information is known about other families that the PPR has been involved with
• Number, ages, gender and characteristics of victims, and their relationship to PPR
• Evidence of planning and or involvement with other PPR's
• Offences against adults
• Has the PPR shared concerning information/images with other PPR's, eg, shared photographs, made videos, via the internet
• If there are concerns that the PPR has been involved in non-contact offences, for example, accessing images on the internet, have the risks been increased by his use of more than one computer, his dishonesty in respect of his access to computers, etc
Personal responsibility for the behaviour of concern:
• Does the PPR blame the victim, partner, external factors, personal history, substance misuse etc
• What degree of personal responsibility is shown
• Can the PPR see things from the victim's point of view Attitude to victims:
• What is the PPR's view of the victims
• What is the PPR's opinion about what it was about that child/those children that led to the offences? Openness:
• Does the PPR engage and co-operate with the assessment and volunteer information
• Does the information given check out against police/probation information
• What information have they provided to the child's main carer. Is this accurate
Therapeutic input:
• Has the PPR taken part in any treatment programme since the offences
• Give details of this and his level of level of compliance/ co-operation/involvement
• If not, would PPR be willing to participate
• Has there been any risk assessments already completed in respect of the PPR. If so, what were the details/recommendations of these? How relevant do you feel the recommendations of these assessments are in relation to this risk assessment

Section 3 Family and environmental factors of the PPR

Factors that may impact of the PPR's behaviour:
• Mental illness/learning disability
• Physical disability
• Poor experience of being parented, childhood abuse, living outside the family unit or care history
• History of violence
• Past or current involvement in drug misuse
• Past or current alcohol abuse Family history, relationships , sexual history (See Appendix 4)and well being:
• PPR's description of his family history, past and current relationships with extended family
• Experience at school, including relationships, attainment, value of education
• Historical involvement in criminal behaviour/antisocial behaviour
• Historical and current employment status
• Impact of any problems experienced by other family members, for eg, illness, bereavement or loss • What friends and social contacts does he have
• How does the PPR describe himself. What is his self- image and self-esteem
• How stable is his lifestyle
• What hobbies and pastimes does he have

Section 4 The Child and their family

Name and age of the child the PPR intends to have/has contact with
• Are they known to CYPS. If so why • Details of who they live with and their wider family network
• The PPR's status/relationship to the child
• Any welfare or developmental issues in respect of the child vulnerability/capacity to protect themselves
• The level of involvement by the PPR with the child – frequency, where taking place, who else present, purpose of contact etc.
• The wishes and feelings of the child in relation to contact with this person (If the child is preverbal state what you think the child would want)
• Include a view about whether you think the child's views are freely given or whether they may be under pressure, e.g. from mother wanting a relationship with the PPR Information about the main carer of the child:
• Name, date of birth
Are they known to CYPS If so, why
• What is your assessment of their parenting capacity to protect from harm. (Please refer to the dimensions of the core assessment framework)
• Are there any factors which impact on the parents/'carer's capacity to protect from harm, for example, physical/mental illness, disability, poor experience of being parented, care history, childhood abuse, history of violence, alcohol, substance misuse. Please refer to the dimensions of the core assessment framework
• Relationship to the PPR, length of contact
• Attitude to PPR's previous offences/history
• Consideration and practical arrangements for safeguarding the child
• Social support network of the main carer

• Social support network of the child within the family
• Social support network of the child outside of the family, including professional contacts

Section 5 Support and monitoring systems

• Describe the proposed support and monitoring arrangements for this family i.e. the child, the PPR, and the non-abusing parent; include frequency of proposed professional contact
• Give details of the process that will be used for sharing relevant information with other professionals involved with the family

Section 6 Analysis

• Risk factors
• Protective factors
• Detailed recommendations based on balancing the risk factors against the protective factors

Section 7

Name and contact details of social worker completing the assessment
• Signed and dated
• Comments/endorsement by social work manager
• Signed and dated

Section 8 Decision of Service Manager

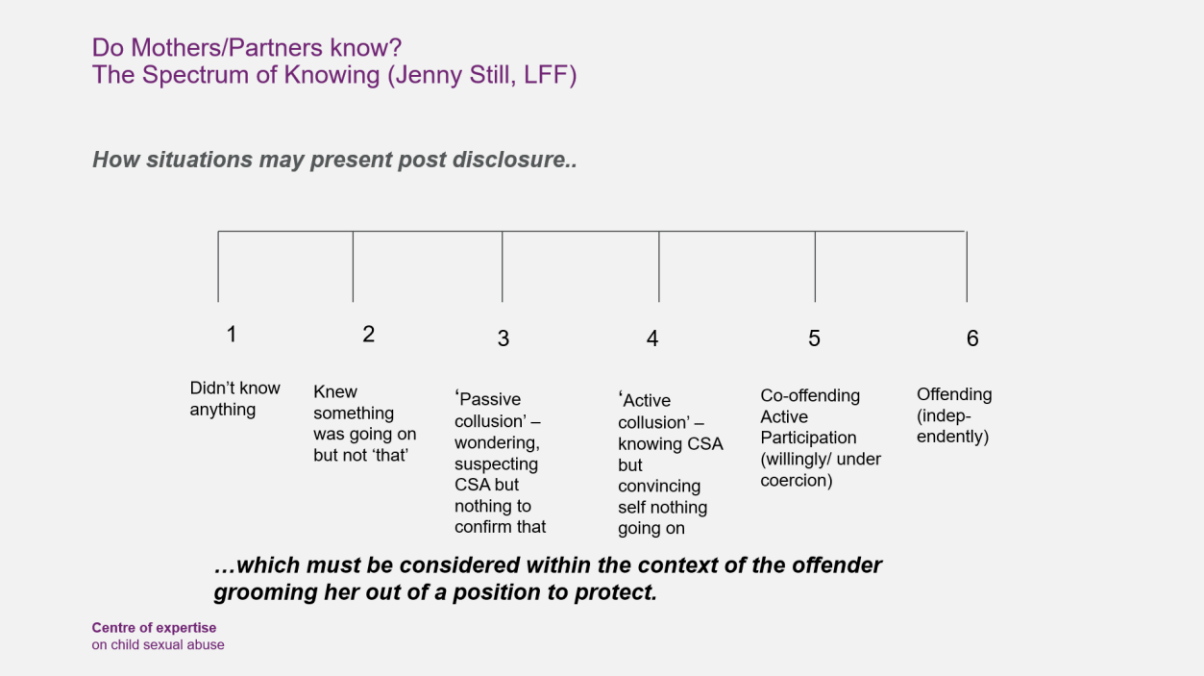
Decision
• Comments
• Any further information needed
• Monitoring/ reviewing arrangements

Section 9
• Name and contact details of Service Manager
• Signed and dated

N.B. For additional information and in order to weigh the significance of risk factors and protective factors, staff assessing PPRs should refer to:
• Risk Assessment and Risk Management Code of Practice and Guidelines – Trevor Owen 1999
• Schedule 1 PPRs – Offences against Children – Guidance and Definitions – Trevor Owen July 2005
• Department of Health (2000) Framework for the Assessment of Children In Need and their Families. London: The Stationary Office Available from the Child Protection Unit Children and Young Peoples Directorate

Appendix 2 Non abusing parent assessment.

Reason for the assessment
Set out the reason for the assessment, for example: Care proceedings, formal pre-proceedings. Give a brief outline of the Local Authority concerns.
Consider Jenny Stills Spectrum of knowing, before beginning.



This is a very useful spectrum to show to participants to help them think about the differences between non-abusing partners and where they may sit in relation to the extent of what they knew was going on. It is not a tool to use with non-abusing parents, but a good one to aid thinking in cases.

1 – didn't know anything

Many non-abusing parents will say at the start of our work with them they didn't know anything at all was going on. They will be frightened to say to someone in authority that they had moments where they thought something was strange as they will worry we will see them as failing to protect.
In reality, as we have already seen, it is very hard to know sexual abuse is going on, however they may well have thought something was wrong, just not that - however, saying that out loud will be hard. If you work openly and non-judgementally with them, they may well be able to say over time 'I knew something wasn't right, but not that'. If they have picked up absolutely no signs of concern (and this is true), then there may be issues in relation to the extent to which they are attuned to their child (as a result of e.g. being too busy with work or other children; struggling with mental health or substance misuse; poor relationship with child).

2 – Knew something was going on, but not that.

As noted above, it is likely that **parents (who have some attunement with their children)** do pick up something is wrong but have not considered sexual abuse. For

example, they may say that they thought their mood was about difficulties at school or with friends. Remember too that as part of the grooming process the abuser may have manipulated the situation so, for example, if non-abusing parents has discussed with them that they are worried about the child, the abuser may have encouraged them to think their concerns are based on other events or issues.

3 - 'Passive collusion' – wondering, suspecting CSA but nothing to confirm that

It will be very difficult indeed for a non-abusing parent to tell anyone that there were moments when they thought sexual abuse was happening, but they put it out of their head or **persuaded themselves that there was no evidence for it. However, where they have had previous thoughts like these that weren't acting on, they will be struggling with additional guilt about what happened.** As far as possible it is useful for the worker to engage openly and non-judgementally with questions such as "other women I've worked with have had moments when the possibility of sexual abuse entered their heads, but they dismissed it as they believed it couldn't be true, or it was just them 'going mad'. Is this something that happened with you?" The purpose of this is to be able to help them with feelings of guilt, and also to get more information to help understand how the abuse took place and what the child experienced.

Survivors of sexual abuse seem to be over-represented in this group and there are a number of possible reasons for this which will be explored later, however for the purposes of this slide, it is worth considering these 2 points:

- They may see themselves as damaged in some way by the abuse and that so if they are seeing things of concern sexually, then it must be their 'damaged head' that is seeing things that aren't there;
- If the abusing person knows they have been abused, they can manipulate their experiences, i.e. 'you see sexual abuse everywhere'.

4 – Active collusion - knowing CSA but convincing self nothing going on

This is similar to point 3, though may be a more active process of convincing themselves nothing is going on. It may also be for some (who have their own sexual abuse histories) that they can 'disassociate' from the situation in order to cope with it.

5 – Co-offending Active Participation (willingly/ under coercion)

There is a distinction to be made between those who willingly co-abuse and those who do so under coercion. While the child will experience sexual abuse from this person in both situations, if, for example, they have watched their mother be coerced into doing it through violence, then there may be an option that future contact could happen. If the mother has been doing it willingly, then there is unlikely to be an option for future contact.

6 – Offending independently

Some mothers may abuse their children independently of anyone else.

It may be worthwhile completing **Increasing parents' ability to protect** work first to help strengthen knowledge and understanding of CSA before assessment. You can then refer to this as you go through the assessment to see if there has been any transfer of learning. **OR** You may identify after the assessment that this is an intervention that may be appropriate to develop strengths.

Summary of the areas to be assessed

Internal capacity to protect, ability to protect and likelihood of protecting.

Internal capacity to protect

Adverse Childhood Experiences,
NAP childhood is there any evidence of ACES how have these been understood /resolved, how have these shaped the parent, what learning has she taken from these, what coping strategies did she use at the time, what is her definition of good enough parenting, does she over regulate her emotions, has she developed a passive, fatalistic attitude, consider her attachment style (Rip have a good guide)

Cognitive Impairment

Anti-sociality
Attitudes towards authority, rules, regulations, and those who impose them ie police, any anti-social behaviours, attitudes or risky behaviours.

Sense of Self
How has her childhood influenced her view of self, life, self-esteem what does she see as her strengths, weaknesses what would others say, have they said.

Relationship History
Is there evidence of parent living independently or being assertive within relationships, healthy relationships, are there levels of dependency, previous abusive relationships.

Coping & Resilience
Coping strategies refer to the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimise stressful events. Maladaptive coping strategies do not increase our functioning. Rather, they temporarily reduce the symptoms while maintaining and strengthening the disorder in a short term.
Examples of maladaptive behaviour strategies include avoidance, self-harm, dissociation, and escape (including self-medication/substance misuse).
A parent who struggles to manage or adaptively cope with stressful life events may find supervising a PPR or responding to the needs and behaviours of a child at risk significantly challenging.
Resilience is the ability to manage and bounce back from all types of challenges that emerge in every family's life.

Assessors should consider how the parent has responded to problems and stress in her life.
Has the parent resolved their own trauma to cope with the present day without resorting to previous mal-adaptive methods of coping.
How does she manage day to day life challenges such as financial pressures, children or juggling her various responsibilities.

Use of positive support networks
A parent's relationship with their wider family, friends, neighbours and colleagues can be a valuable resource to provide practical, informational and emotional support.
Not just having social & family connections.
It is the willingness of the parent to seek that support, advice or support provided which impacts on the quality of the parenting.
Capacity to connect. For some NAP's there may be significant challenges for them in emotionally connecting with another person.
A 'disclosing environment' A parent may face personal and practical barriers to acknowledging the abuse as their lives are often intertwined with that of the PPR.

Substance Use

Mental and Physical Health
Parental mental health difficulties do not necessarily have an adverse impact on a child's developmental needs.
However, anxiety disorders, depression and some psychotic illnesses may reduce parents' ability to be reciprocal, involved and encouraging with their children.
Mental health problems often co-exist with other difficulties: nearly half of those attending mental health services report alcohol or drug problems.
Physical disabilities or any condition including depression and low self-confidence which isolates a parent from independent help, may also increase the possibility of exploitation and/or reduces her available options if she has concerns.

<u>Ability to protect.</u>

Response following allegation
If there is no allegation but a high index of suspicion of sexual abuse, how far is the NAP open to the possibility that sexual abuse may be the most likely explanation for the child's presentation?

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.

Insight into person of concern

- If they do not accept that the PPR poses a sexual or violent risk of harm, how have they come to that conclusion?
- If they do not accept a risk do they acknowledge that the safeguarding agencies have a valid concern and are they willing to engage in managing the concerns of these agencies?
- Do they have a good understanding of what precipitated the PPR''s past sexual or domestic abuse or do they continue to justify or externalise responsibility for the abuse?

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.

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.

Victim Insight

The parent should be invited to share her understanding of the impact of the abuse and the severity of harm upon the victim. What has influenced her decision making and how has she come to this conclusion?
What influence if any does the PPR have on her understanding of the victim's behaviour?

Engagement with Safeguarding Services

A parent who evidences that she is working 'with' as opposed to 'against' the agencies is more likely working in the best interests of the child.
Constructive working relationships between professionals and the NAP/family are central to effective practice in situations where children are at risk of abuse.

Parental Empathy
Parental empathy in this context refers to the responsivity of the parent to the needs and presentation of the child. The parent should demonstrate a genuine interest in the child's well-being and experiences, and a capacity for empathy with the child. Explore the parents understanding of the range of a child's needs generally; What is their sense of the child; how do they feel about assuming this role; what is the quality of the relationship between the NAP and the child (ren).

Parental Authority
Is there evidence of the parent holding authority within the family home.
Is there any evidence to suggest that the PPR is attempting to undermine the parents authority?
Is the PPR viewed as head of the household? How long has the PPR lived within the family before assuming a parental role.
Has the parent been witnessed by the child(ren) or directly involved the child(ren) in any breaches of safety plans?
What evidence exists that would suggest the parent can enforce and maintain boundaries?
Is there clear awareness of holding parental authority in the home. Evidences consistent parental authority through protective, authoritative and supervisory behaviours creating stability in family's behaviour

Perception of self as parent
Self-perception of parenting includes several possible characteristics such as a feeling of competence in the role of parent, involvement in caregiving, satisfaction from a caregiving relationship, and an ability to balance parenting with other roles in life.
Some parents may lack a confidence in their abilities to meet the child's needs and have little experience of positive parenting to challenge their own self-perception.
Some parents may present with little awareness of the expectations of the role.
Some may even hold an undisclosed resentment towards the role as they may see it as a burden that has to be endured.
Understanding the parents perception of parenting should include an exploration of their own experiences of being parented.
Does their parenting mirror their own parent/carer in childhood? What is their own view of parenting? What is their perception of their relationship with the child?

Parenting children with additional needs
Children with disabilities and special health care needs are 3.4 times more likely than others to experience abuse or neglect.
Parents face particular challenges when their children have health problems, disabilities, or emotional or behavioural difficulties.
The contribution of the PPR in the parenting of this child or any other child may well be very welcomed by a stressed and tired parent.

Likely to protect
Based on the above how likely is the parent to protect, challenge, supervise the PPR.

Appendix 3 Getting the Family Sexual Script

This information should be gathered separately from each adult member living within the household. This may highlight discrepancies in their views and help to identify who sets the rules and who enforces them and how.One of the key things that workers need to do is to find ways to feel comfortable in talking about sexual things, otherwise it will be difficult for them to put others at ease. The following is guidance on how to talk to parents/carers about the sexual script in a sensitive way. The suggestions for how to put questions are examples only. The workers will need to find a way, which is comfortable for their own style.

Talking with parents about the family sexual script

Begin the session by acknowledging that talking about sexual things can be embarrassing, but it is going to be necessary in order to be able to help the child and family. Tell them, as a worker, you will try and ask the questions sensitively.

Tell them what you will cover. This will help their anxiety about what you might ask them, for example, “Today we would like you to help us understand your view and your family’s view about boundaries around issues like privacy, being intimate with people, for example, hugs, sexual language, knowledge and information and about sexual behaviours.”

Begin with Privacy as it is less embarrassing or threatening.

Privacy

Put an open question first: “Tell me about your view on what should be kept private in relation to children and adults’ bodies, space and belongings.”

If they are stuck, use examples and supplementary questions.

“Tell me your views about what age is it appropriate for children to stop bathing a) with adults, b) with other children.”

If they are still stuck draw a line on a piece of paper with different ages marked off on it, and say would it be 3 or 4 or between 4 and 5, etc. Some people work better visually.

“Tell me about your views about when it is appropriate for children to sleep a) with adults, b) with a child of the opposite sex, c) with an older child.

Again if stuck use the age line from above.

“Tell me your view about adults walking around naked in front of children or nudity at home.”

“Tell me about your views about personal space, should it be respected?”

If the answer is yes, then follow up with “how should it be respected, give me an example.”

If they are stuck ask them to stand up with you. Stand away from them, tell them you are going to walk slowly towards them and they should tell you to stop when they first feel uncomfortable about how close you are to them. Put a piece of paper on the floor to mark the spot. Ask them to think if this mark would be the same for a family member and is there any variance between family members.

“Tell me your views on privacy of belongings; do adults and children have a right to have things that are just theirs and that no one should touch, take or read without their consent?”

If the answer is yes – ask for an example relating to an adult and one relating to a child.

At the end of each section ask if everyone in the family would have the same view about this as them. If they do not, who would not and what would they say.

Ask them how the children in the family learn these ‘rules’ or boundaries. For example, are they written down, verbally told and reinforced with sanctions or shouting?

Being intimate – physical touch, for example hugs/kisses (not sex)

“Tell me your view about intimate/physical touches between adults and other adults and between adults and children, when are they ok and when are they not ok; what makes them either ok or not ok?”

If this is too big a question, then try sub questions (you might already have these prepared on a sheet of A4):

Answer the following statements either yes or no:

In our family we hug each other yes no

In our family we kiss each other on the lips	yes	no
In our family we kiss each other on the cheek	yes	no
In our family we sit on each other's knees	yes	no
In our family we rub/massage bits of each others bodies	yes	no

You may be able to think of other relevant examples for the family

After answering each one, if they say yes, ask what makes it ok. If they say no, ask what makes it not ok.

Remember to ask about other family member's views and how the children would know these rules.

Sexual language, information/knowledge, materials

"Tell me your views about adults/ children using sexual language." If this is too big a question give a range of scenarios:

a) Is it ok for adults to use sexual language to other adults?	yes	no
b) Is it ok for adults to use sexual language to or around children?	yes	no
c) Is it ok for children to use sexual language to adults?	yes	no
d) Is it ok for children to use sexual language to other children?	yes	no

After answering each one, if they say yes, ask what makes it ok. If they say no, ask what makes it not ok?

"When do you think children should start learning about sex, what should they know, and does this change as they get older?"

If stuck use your age line again and ask them to mark on that.

"In your view, where do you think they should get their knowledge and information from?" (you could have this on your A4 sheet)

a) Parents	yes	no	
b) Other family member (specify who)		yes	no
c) School	yes	no	
d) Other children/ young people	yes	no	
e) Books, magazines, TV		yes	no
f) Pornographic magazines, DVDs		yes	no
g) Images on posters/calendars		yes	no

"Are there any limits on what the children can read, watch on TV/DVD or hear?"

Remember to ask about other family members' views and how the children would know these rules.

Sexual Behaviours

"Other than actual sexual intercourse, there are some behaviours often referred to as 'petting' behaviours (or foreplay) for example, kissing, touching breasts/genitals over clothing; touching naked breasts/genitals; masturbation of self and others. With regard to these behaviours at what age do you think it is appropriate for children and young people to engage in them and why?"

Do the age line again and ask them to mark on that.

"At what age do you think it is appropriate for children and young people to engage in actual sexual intercourse or other sex acts, for example, oral sex or anal sex and why?"

Use the age line again and ask them to mark on that.

"In your view is it harmful or educational for children to see adults having sexual intercourse?" Ask why for either answer.

Appendix 4 Exploring sexual history.

At what age did you become aware of sex?

What did your sex education consist of?

Who talked to you about sex?

What messages did you get from parents regarding sex, was it discussed openly?

how did your parents display affection towards each other, to the children?

Talk me through your sexual history from then to present.

At the time of sexual awareness and adolescence, how did the person relate to the opposite sex (prospective girl/boyfriend), and view themselves as sexual beings?

Number of casual sexual encounters

Number of adult relationships, and length of relationships

In these relationships who initiated sex?

How often do you have sex, think about sex, masturbate?

With your current partner who initiates sex?

How much time do you spend watching pornography? What types of pornography

Any signs of sexual deviancy or preoccupations: internet use, sado-masochistic tendencies; swapping or group sex

Any pattern of how person functions in relationships (submissive, avoidant, aggressive, domineering, violence

Appendix 5 Resources/references

The multi-agency response to child sexual abuse in the family environment - GOV.UK (www.gov.uk) 2020

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

https://www.stopitnow.org.uk/signs-an-abuser-might-display.htm

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

https://www.dcp.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Documents/ChildDevelopmentAndTraumaGuide.pdf

'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

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

https://www.nctsn.org/resources/coping-shock-intrafamilial-sexual-abuse-information-parents-and-caregivers

Sibling sexual behaviour: A guide to responding to inappropriate, problematic and abusive behaviour (csacentre.org.uk)

www.parentsprotect.co.uk
https://www.parentsprotect.co.uk/sexual-abuse-learning-programme.htm

https://www.theupstreamproject.org.uk/

www.stopitnow.org.uk

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

Managing risk and trauma after online sexual offending: A whole-family safeguarding guide (csacentre.org.uk)

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