

A Real Safe Space

How Rape Crisis Centres Support Children
and Young People Who Have Experienced
Child Rape and Sexual Abuse (CRaSA)

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Foreword

Almost ten years ago, the Independent Inquiry into Child Sexual Abuse (IICSA) was established to look at how institutions failed to identify, prevent, respond to and protect children being subjected to rape and sexual abuse. The Inquiry heard from over 7,000 victims and survivors whose testimony and experiences helped to shape the subsequent Final Report and its 20 recommendations. It is impossible to underestimate the courage and significance of those victims and survivors' contributions.

One particular recommendation (recommendation 16) related directly to the work of Rape Crisis member centres and led us to write this report: "...the UK government and Welsh Government introduce a national guarantee that child victims of sexual abuse will be offered specialist and accredited therapeutic support".

It seems self-evident that such support is vital for any adult or child victim or survivor of rape or sexual abuse. Countless survivors expressed the value of receiving this, and have described it as both life-saving and life changing. In one young survivor's poignant words, as a result of receiving specialist support from a Rape Crisis centre: "I stand taller, I think deeper, and I breathe easier".

The former government replied to the Inquiry's final report, stating "We recognise the importance for child victims of high-quality, timely therapeutic support and accept there is more we can do to ensure that those who have suffered get access to the provision they need to help them recover and rebuild their lives. We will elicit views on the future of therapeutic support, including possible systemic changes to provision". And yet, despite 1.5 years since this response was published, there has been disappointingly little engagement on the issue.

Despite the known benefits of accessing specialist counselling and therapy, this report exposes a stark reality – that the specialist Rape Crisis centres which have the skills to support children and young people subjected to rape and sexual abuse, face simultaneous overwhelming demand alongside severe and chronic underfunding. Meanwhile, and for reasons outlined in this report, statutory and non-specialist services are unable to meet the particular needs of victims and survivors.

The women's sector was the first to identify child rape and sexual abuse as a systemic and societal equalities issue, and Rape Crisis Centres were some of the very earliest organisations whose services were created by and for survivors of rape and sexual abuse. This year – the 50th of the Rape Crisis movement – is a key reminder of why we exist, which is at its heart, to support survivors of rape and sexual abuse, offering services when they need them, how they need them, and for as long as they need them.

So to policy-makers and commissioners, we say this: thousands of survivors have already told you what they need: access to specialist sexual violence and abuse services. So let's work together to make IICSA's vision for specialist therapeutic support for all children affected by rape and sexual abuse a reality.

Ciara Bergman

CEO, Rape Crisis England & Wales

Glossary of Terms

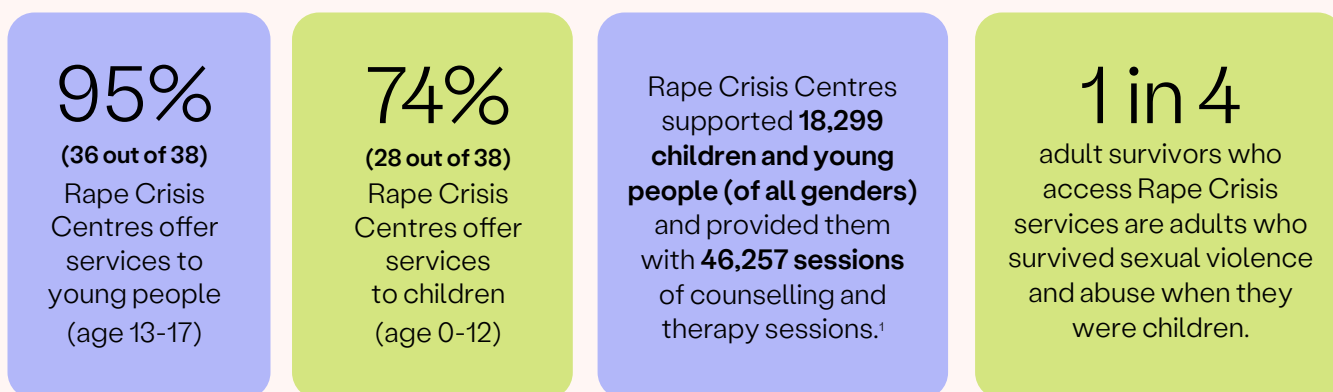
Child and Adolescent Mental Health Services (CAMHS)	Child and Adolescent Mental Health Services (CAMHS) are NHS services that assess and treat children and young people with emotional, behavioural and mental health difficulties.
Child Rape and Sexual Abuse (CRaSA)	Rape Crisis England & Wales (RCEW) use the term Child Rape and Sexual Abuse (CRaSA) to ensure that rape is neither minimised nor sanitised (either advertently or inadvertently) by euphemisms such as 'exploitation', 'assault', 'behaviour' or 'activity'. There is sometimes discomfort about use of the term 'rape' in respect of behaviours which nonetheless constitute it; however, we believe that avoiding its use is problematic, and frames rape as somehow 'different' when it is perpetrated against a child. RCEW believe that not naming rape, sexual violence and abuse for what they are contributes to the silence, concealment and taboo which children and adults alike so often report to be barriers to disclosure.
Child Sexual Abuse (CSA)	Child Sexual Abuse (CSA) is defined by the Government as: '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. These 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'. (Department for Education, 2018). RCEW prefer the term 'Child Rape and Sexual Abuse' (CRaSA) (see above).
Child Sexual Exploitation (CSE)	Child Sexual Exploitation (CSE) is a form of CRaSA, defined by the Government as 'a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology' (Department for Education, 2017).
Harmful Sexual Behaviour (HSB)	Harmful Sexual Behaviour (HSB) is defined as: 'Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult' (Hackett, 2014). This term was created to avoid labelling CYP as sexual offenders, though it is controversial. As set out in this report, some Rape Crisis Centres avoid the terminology as they do not believe that CYP should be seen as harmful.
Improving Access to Psychological Therapies (IAPT)	Improving Access to Psychological Therapies (IAPT), also known as NHS Talking Therapies, is an NHS service which was introduced with the aim of increasing accessibility to psychotherapy for children and young people (CYP-IAPT) experiencing depression and/or anxiety. Rather than establish a separate 'Talking Therapies' service for CYP, CYP-IAPT was integrated into existing CAMHS services.
Independent Sexual Violence Adviser (ISVA)	An Independent Sexual Violence Adviser (ISVA) provides emotional and practical support and information to victims and survivors of sexual violence and abuse who have reported – or are considering reporting – SVA to the police. The ISVAs we talk about in this report are independent from the police and other statutory agencies, and work within Rape Crisis Centres. Some Centres employ specialist Children and Young People's Independent Sexual Violence Advisers (CHISVAs).

Integrated Care Board (ICB)	Integrated Care Boards (ICBs) are statutory NHS organisations responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area. ICBs were established in 2022 and resulted in Clinical Commissioning Groups (CCGs) being closed down (NHS England, no date).
Integrated Care System (ICS)	Integrated Care Systems (ICSs) are organisational partnerships that come together to plan and deliver joined up health and care services which: • Improve outcomes in population health and healthcare • Tackle inequalities in outcomes, experience and access • Enhance productivity and value for money • Help the NHS support broader social and economic development. Following the passage of the Health and Care Act (2022), 42 ICSs were established across England on a statutory basis on 1 July 2022 (NHS England, no date).
Police and Crime Commissioners (PCCs)	Police and Crime Commissioners (PCCs) are directly elected politicians who are responsible for securing an 'efficient and effective' police force for their area. The role was created in 2012 to replace police authorities. PCCs have several key functions, including appointing a Chief Constable, holding them to account, and - if necessary - dismissing them. PCCs are also responsible for bringing together community safety and criminal justice partners, to make sure local priorities are joined up. They are responsible for commissioning the majority of victim support services in each force area (UK Parliament, 2022). A PCC represents every police force area in England and Wales with the exceptions of London, Greater Manchester and West Yorkshire where the powers of the PCC are held by the elected Mayor/Deputy Mayor. There are also different arrangements in the City of London.
Rape Crisis Centres (RCCs)	Rape Crisis Centres (RCCs) provide holistic, trauma-informed and quality assured rape and sexual abuse recovery services for adults and children who have experienced sexual violence and/or abuse at any time in their lives. This includes wraparound support from the first point of contact, through to follow up care and advocacy. RCCs are highly specialist and have expertise in a broad range of sexual harms affecting women and girls including – but not limited to – rape, sexual assault, sexual harassment, child rape and sexual abuse (CRaSA) including child sexual exploitation (CSE), sexual violence within domestic abuse, and sexual violence and abuse that takes place within institutions.
Sexual Assault Referral Centre (SARC)	Sexual Abuse Referral Centres (SARCs) offer confidential medical and practical support to people who have recently been raped or sexually assaulted. As well as Forensic Medical Examinations, SARCs offer medical help for physical injuries, pregnancy and STI tests, emergency HIV medication and onward referrals to other services, such as counselling. There is usually at least one SARC in every police force area and they are usually open 24/7. SARCs are often commissioned by NHS England, but are sometimes co-commissioned by PCCs and police forces. Victims and survivors who choose not to, or are unsure whether they would like to, report to the police can still access SARCs. Any forensic samples collected can be stored by the SARC while a victim/survivor decides whether they wish to report to the police.
Victims and survivors	We describe individuals who have been subjected to sexual violence and abuse as victims and survivors. This is to acknowledge the different ways that individuals define themselves in relation to what they have been through, and how their experiences may shape their identities and lives thereafter.

Despite the overwhelming and sustained need for community-based, specialist services for the estimated 1 in 10 (Kairika, 2022, p41) children and young people (CYP) who have experienced child rape and sexual abuse (CRaSA), decades of chronic underfunding and poor commissioning practices have left a significant gap between demand and availability. Where therapeutic support is available to child victims and survivors, it is frequently offered by non-specialist services that are ill-suited to work with the specific trauma they have experienced.

Independent Rape Crisis Centres (RCCs) have decades of experience and expertise in providing specialist life-changing, and in some cases life-saving, support to victims and survivors of CRaSA. Yet they are often overlooked by commissioners and unable to provide the services that they are uniquely positioned to offer.

Rape Crisis Centre Snapshot figures (2022/23)



Statutory services, such as Child and Adolescent Mental Health Services (CAMHS), and other generic CYP services can and do have an important role to play in the response to – and care of – victims and survivors of CRaSA. However, their stringent eligibility criteria, lengthy waiting lists, relatively short intervention duration, and focus on clinical and medicalised models of trauma and recovery are often inappropriate and ineffective in meeting the needs of most victims and survivors, meaning they should not be seen as the primary referral route for this young cohort of victims and survivors.

In October 2022, the Independent Inquiry into Child Sexual Abuse (IICSA) published its final report, making a crucial recommendation:

“...the UK government and the Welsh Government introduce a **national guarantee** that child victims of sexual abuse will be offered **specialist** and accredited therapeutic support. There should be **sufficient supply** of these services so that children in all parts of England and Wales can access support in a **timely** way. These services should be **fully funded**. Responsibility for commissioning these services should be given to local authorities.² There must be **no eligibility criteria** for children to access these specialist therapeutic services other than having been a victim of child sexual abuse.” (IICSA, 2022) (Emphasis added).

¹ Note: This data was provided by Rape Crisis Centres to the Ministry of Justice for the 2022/23 financial year, in Rape and Sexual Abuse Support Fund monitoring reports. These figures exclude advocacy, prevention work, and other provision, as separate from counselling and therapy.

² NB: RCEW does not agree that commissioning responsibility should be given to local authorities, but is in full support of the remainder of this recommendation.

This report advocates for the implementation of this recommendation, underscoring the necessity of specialist, accredited, fully funded therapeutic services for young victims and survivors of CRaSA. Through an analysis of the current commissioning landscape, and the services offered by RCCs, this report argues that independent sexual violence and abuse (SVA) services, such as RCCs, are uniquely positioned to provide the most effective support for children affected by CRaSA.

Drawing on insights from 11 interviews with staff from 10 RCCs, feedback from victims and survivors who have utilised RCC services, and extensive external research, we submit that RCCs offer a level of support that is uniquely and necessarily:

1. Flexible
2. Holistic
3. Expert/specialist
4. Rooted in a child-centered empowerment model
5. For life

The benefits of specialist trauma-informed support, such as that provided by RCCs, are well-documented. Evidence shows that those accessing these specialist services benefit from significant improvements in self-worth, social isolation, and overall recovery (Chouliara et al., 2011; Adisa et al., 2023; Gekoski et al., 2020). Feedback from victims and survivors who have accessed RCCs consistently highlights the value they find in speaking to specialist SVA professionals who understand the trauma they have experienced, and are able to offer a person-centred approach to working through that trauma.

Recent estimates suggest that over 55,000 children affected by CRaSA are on waiting lists for support services across England and Wales (Parkinson and Steele, 2024). However, despite the high volume of referrals into specialist RCCs both from CYP and their families, and from various statutory agencies, RCCs remain underfunded and undervalued by the commissioners tasked with providing therapeutic CRaSA services. The Ministry of Justice has acknowledged the insufficiency of specialist provisions for CYP affected by CRaSA (IICSA, 2022), yet there remains a lack of concrete plans to address this gap, even after the publication of IICSA's recommendations almost two years ago.

In order to ensure that CYP can access the support they both need and want in the aftermath of CRaSA, to commence and sustain their recovery from these experiences, rebuild their lives, and restore confidence and autonomy over their embodied lives and experiences, we are calling for a whole-system approach to ensuring that specialist support is available, and that this support is adequately resourced. We want that support to be comprehensive and coordinated.

Currently, multiple different commissioners have overlapping responsibilities for providing services to CYP who have experienced CRaSA, including Police and Crime Commissioners, NHS England, local authorities, and Integrated Care Boards (formerly Clinical Commissioning Groups) and the Ministry of Justice. However, there is minimal, if any, cooperation or joint working in some areas, which has led to a confusing, fragmented and often underdeveloped support offer, with specialist services having the expertise but not the resource required to meet this need.

Section 13 of the Victims and Prisoners Act 2014, when fully enacted, will place a new duty on commissioners to work together to provide support to CYP who have experienced CRaSA and we hope that this new statutory duty, in combination with recommendation 16 from IICSA, will act as a catalyst for meaningful change in the commissioning of support for victims and survivors of CRaSA.

This report aims to showcase the work of RCCs as specialists in this area, and makes recommendations for change, so that all CYP (and their families/support networks) affected by CRaSA can access the specialist services they need and deserve. Whilst the focus of this report is on therapeutic support, as covered by Recommendation 16 from IICSA (above), we also discuss the holistic support that RCCs can and do offer, outside of therapeutic work, such as Independent Sexual Violence Adviser (ISVA) support and movement-building and/or activism-based groups. These services provide a wraparound support offer to CYP, which many have found invaluable for regaining the sense of autonomy and power that has been forcibly removed from them through the experience of CRaSA.

Rape Crisis Centres (RCCS) are...

1.	2.	3.	4.	5.
Flexible	Holistic	Expert and specialist	Rooted in a child-centred, a empowerment model	For life
RCCs are independent from the state. They are able to develop in response to client's needs, quickly adapt to address gaps in local support pathways, avoid complex statutory referral pathways and strict eligibility criteria, work flexibly with CYP and their families/ support networks and effectively engage with their local communities.	RCCs recognise that the impacts of CRaSA can permeate several different areas of a victim/survivor's life, and that, in order to recover, victims and survivors often need support with more than one issue at a time. RCCs therefore ensure that a number of services are available to CYP, to provide holistic wraparound support, including: therapeutic support for victims and survivors and their non-abusing family members (including counselling, play therapy and group work), practical and emotional support, advocacy, and support through the criminal justice system.	RCCs are specialist because sexual violence and abuse (SVA) is their primary focus, unlike other generic/statutory services. Staff have a deep understanding of SVA and its impacts and decades of experience of supporting victims and survivors of all ages and backgrounds. RCCs hold technical and local expertise that cannot usually be found in generic/ national services.	All RCCs are accredited to the Rape Crisis National Service Standards which centre an empowerment model. Victims and survivors are supported to take control of their own lives and recovery. RCCs provide the necessary political and societal context to allow victims and survivors to unpick the shame and stigma they may feel. All support is trauma-informed and pathologising clinical models of support are avoided.	RCCs know that victims and survivors are not 'recovered' after a set number of support sessions. Recovery is not linear and is rarely final. RCC staff know that trauma can impact victims and survivors across their lives, triggered by certain life events and experiences. RCCs are there for victims and survivors throughout their lives. There is no need for a 'transition' from child to adult services at 18, and nothing to prevent individuals returning for support when they need it.

Methodology

RCEW staff conducted 11 interviews with staff from 10 different Rape Crisis Centres who currently offer services to children and young people (CYP) who have experienced CRaSA. Centres were interviewed about their current and past work with CYP, barriers to providing these services, the commissioning and funding landscape in their localities, their relationships with other services, whether they feel valued for their work with CYP, their hopes for the future and other related topics. Centres from across the country were interviewed to gather as broad a national picture as possible.³ Quotes from these interviews are used throughout the report to illustrate the passion, expertise and creativity of Rape Crisis professionals and the services they offer to CYP.

RCCs also shared with us feedback from some of the young victims and survivors they have supported, to demonstrate the value they find in the specialist support offered by RCCs. Extracts of this feedback are also included in the report.

3 Rape Crisis Centres in the following areas were interviewed: North East (2), North West (1), East (3), South East (2), London (1), West (1).

Part 1: Context

Rape Crisis England & Wales

Rape Crisis England & Wales (RCEW) is a national charity supporting a network of 38 independent Rape Crisis Centres (RCCs). We campaign and influence on behalf of victims and survivors to improve practice and policy responses to sexual violence and abuse (SVA). Our website and 24/7 Support Line provide specialist information, support and onward referral to all those in England and Wales affected by any form of sexual violence and abuse, including child rape and sexual abuse (CRaSA).

RCEW is the national membership organisation for a network of 38 independent RCCs. Much of this report is based on the work of these member Centres, of which:

- 95% offer services to young people aged 13-17
- 74% offer services to children aged 0-12

The services offered by these member Centres vary by area, according to local need and different funding and commissioning criteria. Most Centres offer therapeutic services, such as counselling and/or play therapy, to children and young people (CYP) who have experienced CRaSA. Some also offer wider services, such as therapeutic support for family members of victims and survivors, a specific CYP Independent Sexual Violence Adviser (ISVA) service, prevention/education work in schools, activism groups, and work with CYP who are exhibiting 'harmful sexual behaviour' (HSB) – though many Centres will use this terminology carefully, in recognition that children using these behaviours are often the victims and survivors of trauma and violence themselves.

Whilst the focus of RCCs work is on the disproportionate perpetration of male violence and abuse against women and girls, RCCs provide support to all genders. However this differs by area due to different funding and commissioning arrangements.

To become accredited by RCEW, Centres must meet a robust set of specialist quality standards – the Rape Crisis National Service Standards (RCNSS). RCCs undergo a rigorous process of

assessment to ensure that they are independent, community-based and work from a trauma-informed perspective to provide confidential, specialist services to victims and survivors of all forms of SVA. RCNSS accreditation demonstrates quality and specialism in every aspect of a specialist Rape Crisis Centre's service provision.

Prevalence

Due to under-reporting, we may never know the true scale of CRaSA in England and Wales. However, it is estimated that at least 1 in 10 children in England and Wales are sexually abused before the age of 16 (Kairika, 2022, p41) and research has shown that children are disproportionately likely to be the victims of sexual offences relative to adults:

“...while they [children] make up only 20% of the population in England and Wales, they account for 40% of all sexual offence victims”. (Kairika and Bromley, 2024, p46)

The Crime Survey for England and Wales (CSEW) is perhaps the best available indicator of prevalence, since it (anonymously) asks adults about their experiences of sexual violence and abuse (SVA) when they were under 16. This said, the survey does not ask about experiences of SVA at ages 16 and 17, so even these figures are likely to underestimate prevalence of CRaSA experienced by children (those aged under 18).

Most recent CSEW data estimates that:

- Approximately 3.1 million adults aged 18 to 74 years experienced sexual abuse before the age of 16 years. This is equivalent to 7.5% of the population aged 18 to 74 years.
- Around 4 in 10 adults (36%) who were sexually abused before the age of 16 experienced more than one form of non-contact sexual abuse, rape or assault by penetration (including attempts), or other contact sexual abuse (Office for National Statistics, 2020).

The CSEW estimates that less than one quarter of adults who experienced CRaSA before the age of 16 reported it to the police (Office for National

Statistics, 2020). Therefore, the number of child sexual offences recorded by the police cannot be used as a reliable measure of prevalence. However, for completeness, it should be noted that the most recent data shows that the police recorded 103,055 CRaSA offences in 2021/22 – a 15% increase on the previous year (Karsna and Bromley, 2023, p7). Whilst this increase in reporting is promising, there is still self-evidently a lot of sexual violence and abuse that goes unreported. Indeed, many victims and survivors never report what has happened to them, or tell anyone else about it. Despite the very large number of survivors subjected to CRaSA, their needs continue to be severely marginalised by policy-makers and commissioners.

The Impact of Child Rape and Sexual Abuse (CRaSA)

The impacts of CRaSA can be far-reaching. 94% of participants who spoke to the Independent Inquiry into Child Sexual Abuse (IICSA) as part of the Truth Project reported that their experience of CRaSA had negatively impacted on them – 88% identified a negative impact on their mental health (IICSA, 2022, p68). The Inquiry's own rapid evidence assessment, which analysed over 200 pieces of research on CRaSA, found that impacts may be felt across an individual's lifespan, both in the short-term and for the long-term. The assessment found that the impact of CRaSA could be seen in every aspect of victims and survivors' lives, grouped into seven categories (Fisher et al., 2017):

1. Physical health problems (e.g., physical injuries, problems related to childbirth, unexplained medical problems)
2. Emotional/mental health problems
3. Externalising behaviours (e.g., substance misuse)
4. Interpersonal relationship issues (e.g., reduced relationship satisfaction and stability and issues with intimacy)
5. Socio-economic issues (e.g., lower educational attainment, higher unemployment, and financial instability)
6. Religious/spiritual beliefs (e.g., disillusionment with religion and faith as a coping mechanism)
7. Vulnerability to re-victimisation

These findings are consistently repeated in various studies. For example, a survey of 365 adult victims and survivors of CRaSA conducted by the All-Party Parliamentary Group for Adult Survivors of Childhood Sexual Abuse (2020) found that the sexual abuse individuals had experienced as children had

negatively affected intimate relationships for 90% of respondents, mental health for 89%, family life for 81%, career for 72% and education for 65% of respondents.

As well as impacting on victims and survivors themselves, it is frequently reported that CRaSA also has a wider impact on families and wider society. Research has found that the impact experienced by non-offending parents and siblings can mirror the outcomes for victims and survivors themselves, and has the potential to affect all areas of family members' lives (Fisher et al., 2017).

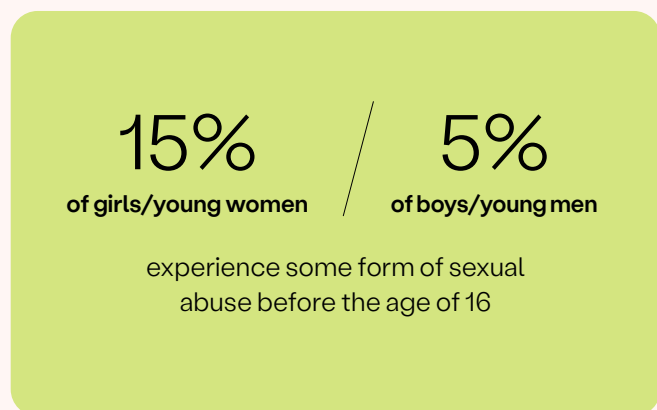
Further, it is estimated that contact CRaSA alone costs the UK around £10.1 billion per year (Home Office, 2021), predominantly through lost labour market productivity, but also due to the cost of health, criminal justice and social services utilised by victims and survivors and perpetrators.

In addition, research has found that when victims and survivors have a negative experience of support services, this can compound existing harm and serve as a form of secondary victimisation (Gekoski et al., 2013). Poor experiences of support services can also present a barrier to further service use. Research has found that victims and survivors of CRaSA who receive a poor response from services take longer to go on to access a new service, meaning they are without support for longer and may see a (further) decline in their mental health. Moreover, these victims and survivors often need to access services for a longer duration and utilise more services overall (Smith et al., 2015). It is so important then that victims and survivors receive the support that they need and deserve following an experience of CRaSA, at the point they wish to access it.

The effects of CRaSA inevitably vary from survivor to survivor and will differ according to socioeconomic status, race and ethnicity, amongst other important factors such as whether the child or young person has a disability or learning difficulty. In terms of Black and minoritised children and young people, important research from the Centre of Expertise on Child Sexual Abuse by Sukhwant Dhalwal explains that "The prevalence of sexual abuse of African, Asian and Caribbean heritage children in the UK is not known", and that there is a dearth of studies looking at "the long-term impacts of child sexual abuse on the physical and mental health of African, Asian and Caribbean heritage children - another under-researched area." (Dhalwal 2024, p7)

However, although not exclusively focused on CRaSA, Imkaan have produced important research looking at the experiences of Black and minoritised women's experiences of sexual violence and abuse (Thiara and Roy, 2020), covering access to services, responses from statutory agencies, and distinct issues pertaining to family and community.

Data suggests that:



Official data collated and analysed by the Centre of Expertise on Child Sexual Abuse (Karsna and Kelly 2021)

Current Policy

The need to provide comprehensive and specialist interventions for all CYP who experience CRaSA has been a longstanding feature of national and international policy efforts, as summarised below.

- Article 25 of the **Istanbul Convention**, which the UK recently ratified, sets out that: 'Parties shall take the necessary legislative or other measures to provide for the setting up of appropriate, easily accessible rape crisis or sexual violence referral Centres for victims in sufficient numbers to provide for medical and forensic examination, trauma support and counselling for victims'.
- Article 39 of the **United Nations Convention on the Rights of the Child**, ratified by the UK in 1991, states that: 'Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse'.
- **The National Institute for Clinical Excellence (NICE) Guidelines on Child Abuse and Neglect** recommend therapeutic interventions for children, young people and families after sexual abuse, as well as CYP having a choice of intervention (NICE, 2017).
- **NHS England's (2018) Strategic Direction for Sexual Assault and Abuse Services** acknowledges the complex landscape for support for both adults and CYP following sexual violence and abuse. It sets out the 'need for all commissioners and providers of services that support victims and survivors of sexual assault and abuse to work together to create a seamless approach that recognises individual needs and reduces fragmentation and gaps between services' (p10).
- The Home Office's (2019) **Child Sexual Abuse Commissioning Framework** is intended as a document to support commissioners to support children affected by 'broader' CRaSA, not just CSE, as is presently often the case. The Framework highlights the importance of specialist CRaSA services, 'in particular voluntary sector organisations [which] are often able to reach vulnerable groups of young people and adults who may avoid statutory services; have strengths in community outreach; and are able to provide bespoke, longer-term support to victims' (p8).
- **The Code of Practice for Victims of Crime in England and Wales (Victims' Code) (2022)** states that victims and survivors have the right to be referred to services that support victims and have services and support tailored to their needs.
- **The 2021 Tackling Violence against Women and Girls (VAWG) Strategy** states that the Government knows that 'in many ways the response to victims and survivors is not where it needs to be' (HM Government, 2021a, p50) and sets out how vital it is that women and girls can access quality, timely support. A number of commitments are made to improve support for survivors of VAWG.
- **The 2021 Tackling Child Sexual Abuse Strategy**, which separates CRaSA out from the Government's aforementioned VAWG Strategy, states that it is 'fundamental that child and adult victims and survivors have access to high quality, timely support through universal and specialised services that meet their varied needs' (HM Government, 2021b, p53), before going on to outline several initiatives that have/are to be taken by the Government.

- **The End-to-End Rape Review (2021)** sets out the Government's ambition that 'every victim of rape and sexual assault will have access to quality support, appropriate to their needs, when they need it' (HM Government, 2021c, p7).
- **The Government's Victim Funding Strategy (2022)** acknowledges that services for victims of crime are not always available and/or accessible. It sets out three strategic aims which will 'ensure victims are properly supported' (HM Government, 2022, p3). This strategy supersedes the 2018 Victim Strategy which stated the Government's intention to 'review the effectiveness and spending on services for victims of child sexual abuse, meeting one of the recommendations of the Independent Inquiry into Child Sexual Abuse' (HM Government, 2018, p23).
- **The VAWG National Statement of Expectations (2022)** sets out 'how local areas should commission effective services to ensure their whole system response to VAWG is as collaborative, robust and effective as it can be so that all victims and survivors, including children as victims in their own right, can get the help they need' (Home Office, 2022, p3). It highlights in particular the need for 'sufficient local specialist VAWG service provision' for CYP (p6).
- **The Serious Violence Duty (2022)** - the Home Office allocated grant funding for police force areas to deliver the Serious Violence Duty. The duty requires authorities to work together to prevent and reduce serious violence and the impact of it, which includes domestic and sexual violence (set out in the Police, Crime, Sentencing and Courts Act 2022).

Despite the number of commitments to improve support for CYP in the national (and international) policy arena over the past few decades, practical action has thus far fallen short. As set out in the body of this report, victims and survivors of CRaSA (and indeed other forms of sexual violence and abuse) are still unable to access specialist support in a timely manner in many areas of England and Wales. Where funding for CRaSA support services is available, it is often directed towards statutory mental health services and/or generic CYP support services, which are often unable to meet the needs of victims and survivors of CRaSA, rather than specialist SVA services.

Current Practice – Funding and Commissioning

Commissioning responsibilities

At present, in England, various commissioners hold responsibilities for commissioning support for CYP victims and survivors of CRaSA. These responsibilities are summarised in the table below (Home Office, 2019). The elements of therapeutic support (the focus of this report) are highlighted in **bold** on the following page:

Commissioner	Service responsible for
NHS England	- Sexual Assault Referral Centres (SARCs) providing forensic medical examinations, medical care/support and follow up services in collaboration with PCCs/police Child and adolescent mental health services Tier 4 (CAMHS Tier 4) - HIV treatment and care (including drug costs for HIV post-exposure prophylaxis following sexual exposure (PEPSE)) - Promotion of opportunistic testing and treatment for sexually transmitted infections (STIs) and - Patient-requested testing by GPs Long-term specialist mental health services - General Practice
Integrated Care Boards (formerly Clinical Commissioning Groups)	Mental health and Improving Access to Psychological Therapies (IAPT); services for depression and Post Traumatic Stress Disorder (PTSD) that understand the specific needs of victims and survivors of sexual assault and abuse, including the third sector - Non-sexual health elements of psychosexual health services - Secondary care services, including A&E - NHS 111 - Sexual health services for children and young people including paediatric care/support CAMHS Tier 3 Voluntary sector services (in some areas)
Police and Crime Commissioners (PCCs)	Grant funded to commission or deliver support services for victims of crime, including victims of child sexual abuse - Victim referral hubs – assessing need and onward referral to victims' services - Police 101 - In some force areas, PCCs and police lead on the procurement of SARC services (see above for NHS) - Violence Reduction Units – VRUs bring together local partners to understand, prevent, and tackle the drivers of serious violence in their area
Local Authorities	- Comprehensive sexual health services (excludes additional services commissioned from primary care) - STI testing and treatment, Chlamydia screening and HIV testing - Sexual health services, including young people's sexual health teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools such as school nurses and health visitors Voluntary sector services
Ministry of Justice (MoJ)	Contribute to some rape and sexual violence support services from the voluntary sector such as the Rape and Sexual Abuse Support Fund, and through the 24/7 Rape and Sexual Abuse Support Fund

Clearly, many responsibilities overlap and it is not clear who has overall responsibility for therapeutic support services, such as specialist sexual violence and abuse (SVA) counselling. In addition, these five commissioners come from a mixture of health, social care and criminal justice backgrounds and therefore have different priorities when providing services, yet there is no clear guidance on the aims of the services to be provided by each commissioner. Each commissioner is also responsible for different, sometimes overlapping, geographical areas. Furthermore, there is currently no requirement for these commissioners to work together, and anecdotal evidence suggests that most do not.¹

What this fragmented and confusing commissioning landscape most often translates to is the provision of the following services for CYP who have experienced CRaSA:

- CAMHS services (statutory generic mental health services), funded by NHS England and Integrated Care Boards (ICBs), available across England and Wales.
- In some areas, generic CYP voluntary sector support services, funded by PCCs and sometimes local authorities, which support CYP on a range of issues, not just CRaSA.
- In far fewer areas, specialist sexual violence and abuse (SVA) voluntary sector support services, such as Rape Crisis Centres (RCCs), are funded by PCCs and less frequently by local authorities and ICBs.

Where RCC services are commissioned, Centres report that funding for CRaSA-specific services is minimal and does not cover the full costs of service delivery. Most Centres seek additional funding from other sources – usually trusts and foundations, independent grant making bodies and individual donations, to cover the costs of running services which have huge demand from victims and survivors. Many Centres also report that they are unable to obtain any funding at all from health commissioners, despite receiving frequent referrals from health services to support CYP.

The All-Party Parliamentary Group (APPG) on Sexual Violence reported in 2018 (p15):

“Although CCGs have a vital role to play in the commissioning of mental health services, including for psychological therapies for adult and child victims and survivors of sexual violence, it is apparent this is not being realised in budgets. In 2018, just ten CCGs of over 200 provided funding to their local Rape Crisis Centre”.

CCG funding accounted for approximately 2.8% of the funding received by Rape Crisis Centres in 2018.

In our interviews with Centres it was clear that this position has not changed for at least five years, and despite the move from CCGs to Integrated Care Boards (ICBs). One RCC outlined the lack of knowledge or interest from health commissioners and the confusion felt around commissioning responsibilities in one area of the country:

“We have real challenges around our health bodies... commissioning anything from us as Rape Crisis and I know that's true for Centres up and down the country. It's always a miracle if you hear a Rape Crisis Centre got some NHS funding or has been funded through the Integrated Care Boards so we are... trying to make headway with that in our area. So as soon as the... CCGs were disbanded and the Integrated Care System came in I managed to locate the person who had a notion of responsibility because they have got a legal duty in the description around their joint forward plans to provide services for survivors in domestic abuse and sexual violence, children and adults. So I waved that in lots of people's faces until someone agreed to meet with me... the strategic lead in our area for the joint forward plan for Integrated Care Board did meet with me and it was really frustrating, it took a long time to meet with her... I tried to give her some context around the lack of health funding that we'd received to date, the fact that we've now got a dynamic where the PCC, [who] is... the core kind of victims service funder doesn't see therapeutic support as their responsibility, they see that as a health responsibility and yet the three key health bodies just argue between the three of them on a circular basis about who has responsibility. But it was a frustrating conversation that when I talked about the SARC she didn't know what a SARC was, when I talked about ISVAs she didn't know what an ISVA was”. (Rape Crisis Centre staff in East England)

Where funding for CRaSA support is available from any of the commissioners listed above, the focus has tended to be on Child Sexual Exploitation (CSE), which represents one narrow dimension of CRaSA. A 2018 survey of 400 adult survivors of CRaSA found that almost 70% of respondents had experienced CRaSA within their family, rather than outside of it (Smith et al., 2015). Nevertheless, the focus on CSE as a form of sexual harm which is perpetrated outside of the context of the family is over emphasised in policy and literature, an example of which is the Government's Tackling CSA Strategy, which largely ignores other prevalent forms of CRaSA, such as familial CRaSA.

¹ NB: s13 Victims and Prisoners Act 2024 introduces a duty on commissioners responsible for providing victim support services to collaborate with each other in the exercise of their functions. However, at the time of writing this provision of the legislation was not yet in force.

A recent joint inspection (Her Majesty's Inspectorate of Probation et al., 2020) into the response to CRaSA in the family has echoed concerns about an over-emphasis on CSE and stated that familial CRaSA should be just as much of a priority as CSE. The inspection recommended that a national strategy is needed to ensure that victims and survivors of all forms of CRaSA can receive long-term holistic therapeutic support. However, RCCs do not report much progress in this area, as reflected on by one Centre in the North East:

"I think there's been a real agenda around Child Sexual Exploitation, which of course is valuable and important, but Child Sexual Abuse is different... far more prolific and there's been nowhere near the amount of funding put into it. And so you have [generic CYP organisation] with all their CSE workers but then when you're having sexual violence not in the context of exploitation, where's the support?"

As set out further below, where therapeutic services are available for CYP who have experienced CRaSA, these are usually statutory and/or generic support services, which our research shows are usually unsuitable for victims and survivors of CRaSA, who require specialist support to address the specific trauma they have experienced.

Child and Adolescent Mental Health Services (CAMHS)

CAMHS (Child and Adolescent Mental Health Services) are NHS services that assess and treat CYP with mental health difficulties. CAMHS teams can include nurses, therapists, psychologists, psychiatrists, social workers and support workers. Whilst services are commissioned differently in different areas of England and Wales, there are four 'tiers' of CAMHS services nationally (Hertfordshire Partnership University NHS Foundation Trust, 2023; NHS England, 2014):

- Tier 1 services provide early intervention and prevention services. These services are usually offered by practitioners who do not specialise in mental health, such as teachers, health visitors, and GPs.
- Tier 2 provides brief, goal-focused early help interventions and targeted services to those who have mild to moderate mental health difficulties which impact their day to day lives. For example, those with anxiety, anger management issues and simple phobias. Tier 2 services are usually provided by mental health practitioners.
- Tier 3 provides services for those with moderate to severe mental health difficulties, including eating disorders, post-traumatic stress disorders, suicidal ideation, self-harm and psychosis.

- Tier 4 services are specialised day and inpatient units, where CYP with the 'most severe' mental health problems can be assessed and treated.

CAMHS appear to be the most commonly commissioned services available for CYP who have experienced CRaSA. However, these are not specialist CRaSA services, since they are designed to provide mental health support for all CYP rather than focusing on specific conditions or needs. Indeed, research published in 2012 noted that CAMHS did not record data on sexual abuse and so it was impossible to determine how many CYP accessing CAMHS had experienced CRaSA (Allnock et al., 2012, p327). Further, NHS England's (2014) Model Specification for Tier 2 and 3 services makes no mention of CRaSA, except to direct commissioners to 'ensure that any additional vulnerability or inequality suffered by children and young people (e.g., learning disability, victim of child sexual exploitation) is properly considered when identifying appropriate interventions' (p15).

Whilst the provision of CAMHS appears to be relied upon by most commissioners as satisfying their duty to provide therapeutic support to young victims and survivors of CRaSA, a range of practical and clinical suitability challenges have been widely reported for many years.

Practical challenges include:

- Long waiting lists (even longer if an individual has additional access requirements, such as the need for an interpreter (Women's Health & Equality Consortium et al., 2016))
- Low capacity
- Variable provision across different localities

These challenges mean that for those CYP for whom CAMHS services are or may be appropriate, waitlists are unmanageable, and delays in accessing services risk compounding emotional and psychological stress and distress.

Furthermore, existing CAMHS services are not appropriate for all CYP, and aren't community-based. Other factors pertaining to the suitability of CAMHS-commissioned services for CYP who have experienced CRaSA include:

- Strict access criteria (e.g., in some areas referrals are only offered to CYP who have a diagnosed severe mental health condition or are actively suicidal)
- Access depends on referral into the service, rather than any outreach into the community to those who may need it
- Brief interventions (in most areas only six sessions of therapy are offered to CYP)

- A tendency to pathologise victims and survivors of CRaSA due to the use of a clinical service model (explored further in section 2D of this report)
- A lack of capacity to offer support to the wider support networks of CYP
- Services rarely have links with culturally sensitive and responsive agencies within the community

As a result of these practical and clinical suitability challenges, multiple sources have argued that it is inappropriate to refer young victims and survivors of CRaSA to CAMHS for therapeutic support (Kaur and Christie, 2018; IICSA, 2022). This view is echoed by many CAMHS practitioners who have acknowledged that their services are simply unable to offer support to CYP who have experienced CRaSA, since the specialist support required is not in their capacity or remit. Similarly, many Rape Crisis Centres (RCCs) report that CAMHS practitioners either will not work with CYP who have experienced CRaSA, or else prefer to refer these CYP to specialist RCCs, acknowledging that they are best placed to work with the trauma experienced by these CYP.

RCCs are well placed to provide trauma-informed and community-based care for CYP who have experienced CRaSA, but need funded pathways to be able to do this consistently and without significant and harmful delays for the children who need them.

Several Centres we spoke to reflected on the interface between CAMHS services and their own CYP support services:

“... people refer to CAMHS, CAMHS get a hint of sexual violence in any of its formats and send them straight to us having pocketed the referral fee and don't pass anything along... it's mirrored in the IAPT team... As soon as there's sexual violence, pass them on... I would feel far better about them if they actually gave us some funding and made it an official referral pathway”. (Rape Crisis Centre in West England)

“In terms of the way services are commissioned for children and young people in our area it's very much focused around... services like CAMHS, which you know we have really struggled with and who will often refer on to us or if we have tried to approach them to make a referral it's things like, you know, there's a nine month wait or this child is... 'too complex' or, you know, that sort of really harmful language pathologising survivors' responses to the experiences they are subjected to. So not the most wholesome service I don't think”. (Rape Crisis Centre staff in East England)

“And CAMHS, they just refer on to us which is the reality of what happens. CAMHS just refer on to

us... that's how it works... when we've spoken to like health commissioners it's always been like that CAMHS is the answer for children. But when you speak to CAMHS practitioners they don't feel that they have the skills or expertise around sexual violence, so they just refer to us”. (Rape Crisis Centre staff in North East England)

CAMHS are statutory services which, like many others, are under a huge amount of pressure and have limited resourcing. Some Rape Crisis practitioners we interviewed shared an understanding of the pressures caused by the bureaucratic processes that CAMHS workers have to adhere to:

“They are victims of the process, so there's some great therapists and practitioners that work for CAMHS that are working against an unhelpful process... procedurally they are tied up in paperwork and driven so hard for outcome measures and clinical measures that are all quantitative and not qualitative. It's a systematic approach, actually the system doesn't work for children and young people... They're overworked, they're burnt out, they don't get the same support... I strongly respect any practitioner that works for CAMHS because they've got to be resilient... they have got really long waiting lists, they're really oversubscribed, but that's not their fault, it's the government's fault.” (Rape Crisis Centre in South East England)

However, even if CAMHS were properly funded and fully resourced, we argue that these services - which centre a clinical model, rather than a specialist understanding of the specific trauma caused by CRaSA - are inappropriate for young victims and survivors of CRaSA, as explored more fully later in this report.

Generic Children and Young People's Support Services

Aside from CAMHS, commissioners in some areas fund generic third sector CYP services to provide support to CYP victims and survivors of CRaSA.

Generic CYP organisations can and do successfully support CYP on a range of issues, such as bullying, bereavement, drugs and alcohol use and dependence, and sometimes the experience of sexual violence and abuse (SVA), or perpetration. Whilst some generic services will take a broadly trauma-informed and child-centred approach, they will not be equipped to deal with the specificity of CRaSA and its impacts, so can therefore be unhelpful to young victims and survivors of CRaSA, as explored in more depth below. Some of the programmes established by large national organisations for children will not be created with local community-based expertise and knowledge that supports effective sexual violence and abuse service provision.

Part 2: How Rape Crisis Centres support children and young people affected by CRaSA



This service has been incredible. A real safe space where I've been fully understood and allowed to talk, cry and see certain things from a different perspective, rationalise irrational thoughts, make friends who are also going through the same thing, and be taught various ways to cope with things.

(Feedback from a client of a Rape Crisis Centre in the North of England)

There are currently 36 Rape Crisis Centres (RCCs) providing specialist support to CYP who have experienced CRaSA, across England and Wales – 95% of the Rape Crisis England and Wales (RCEW) membership. RCCs have been providing this support for decades and there is a wealth of evidence to suggest that they are the best placed services to do so. Research by IICSA into support services for CYP who have experienced CRaSA found that 'across all support services, the most highly rated by survey respondents were counselling provided by a charity/voluntary organisation specialising in child sexual abuse and sexual abuse, rather than 'generalised' counsellors or statutory services (IICSA, 2020, p4).

The feedback from many victims and survivors is that they prefer to access independent and specialist sexual violence and abuse (SVA) services, such as RCCs, for support around CRaSA and the research and data supports this (Adisa et al., 2023; Gekoski

et al., 2020). According to recent research, there are more than 55,000 children and adults affected by CRaSA on services' waiting lists across England and Wales (Parkinson and Steele 2024). However, despite the volume of referrals coming into RCCs directly from criminal justice, health and other statutory agencies, RCCs still receive little or no funding or recognition from the commissioners who have responsibility for ensuring this cohort of victims and survivors have access to therapeutic support:

"We've got referrals from sexual health, from CAMHS, GPs, children's services we work very closely with, and there are more interested – social services, children's services... it's...just relentless, you know? And no, we have no funding. No, we operate on a shoestring". (Rape Crisis Centre in West England)

This section of our report sets out why RCCs are best placed to support CYP who have experienced CRaSA, and identifies the mutual benefits of formal, funded referral pathways for commissioners as much as for the specialist services and CYP they serve. This is particularly important considering Recommendation 16 in IICSA's final report (above) and the Victims and Prisoners Act, which, when fully enacted, will require commissioners of CRaSA support services to work together to meet the needs of CYP.

From our interviews with Rape Crisis practitioners, and feedback from victims and survivors, we have identified five key elements of the work of RCCs which make them best placed to offer specialist support to victims and survivors of CRaSA:

A. Rape Crisis services are flexible and agile



We are formed and shaped by what survivors tell us they need in that time, in that moment. And we are incredibly responsive, we're small and agile and we're just fierce.

(Rape Crisis Centre in East of England)

RCCs are third sector organisations which have been established and shaped by and for the communities they serve. They listen to the needs of their clients and develop services to meet those needs. This flexibility has many benefits to CYP who have experienced CRaSA, and is evident in the way that RCCs:

i. Create services to address gaps in local support offers

As set out in the previous section, there is a postcode lottery when it comes to accessing specialist support for young victims and survivors of CRaSA. Various commissioners have responsibilities for providing support to these victims and survivors, however these responsibilities are unclear and often overlap. This often leads to gaps in suitable provision. Specialist support services offered by Rape Crisis centres (RCCs) are developed to provide a service where commissioned services cannot, or where these statutory/generic services are unsuitable for young victims and survivors of CRaSA.

Stepping in and providing services where these aren't already available

An RCC in the North East of England explained how their CRaSA services were established to meet the needs of CYP who were struggling to access therapeutic support from the generic CYP organisation which is funded in their area to provide this. Due to complex referral pathways and lengthy waiting times, children and young people faced barriers to accessing the generic service:

"[Our] ISVAs were coming... with issues that there wasn't sufficient therapeutic support for the children and young people that they were supporting... We do have other providers locally, but the pathways are quite limited... for example, [generic CYP support organisation] have a therapeutic service for children and young people, but the only routes into that service are through a GP referral or through a social worker.

And what we found was that for quite a lot of the young people we were supporting, there wasn't an active social worker... so that pathway wasn't open to them. And in terms of GP routes, it would very much would depend on your GP surgery, their level of knowledge, their experience and understanding. And... what we were also finding from families talking to us was... that process has quite a lot of barriers in it as well, so for those that do go down a GP route it has to go to a panel, the panel has to make a decision as to whether funding will be allocated to the young person and all the while the young person is sitting on a waiting list. If it's rejected, it'll go to appeal and if it's accepted, then they'll go on to a waiting list and then obviously the wait time... there was quite a decent waiting list at one time, so young people were sitting... having made a disclosure, with no support, and struggling with that and families were struggling with that. So we ended up developing our offer to make sure that we could try and address some of those gaps".

Delivering services to those who need them, rather than those who are 'eligible' for them

Another barrier facing CYP victims and survivors of CRaSA who try to access support is the strict eligibility criteria enforced by some services. This is a widely reported problem by CYP who have tried to access support through CAMHS and been turned away. Research conducted by the British Association of Counselling and Psychotherapy (BACP) (2020) found that in 2019, 26% of CYP nationally referred to CAMHS were rejected as they did not meet the eligibility threshold. In some areas the rejection rate was up to 66%.

The youth mental health charity stem4 (2022) recently conducted a survey with 1,001 GPs across the UK to ask about their experience of referring CYP to CAMHS. They found that:

- Half of GPs said that at least 60% of the referrals they make to CAMHS for CYP suffering with anxiety, depression and self-harm are routinely rejected because these symptoms are not considered severe enough, even though GPs only refer the most at-risk cases. For example, a CAMHS service in eastern England declined to accept a referral for a 12-year-old boy found with a ligature in his room because the lack of any marks on his neck meant its referral criteria had not been met.
- 95% of GPs surveyed said that CAMHS services are either in crisis or very inadequate.

One CAMHS staff member interviewed as part of an NHS England review in 2014 stated that: "Unfortunately it's no longer enough to have experienced a trauma like sexual abuse. We can only see children with a severe mental health condition requiring therapy" (Goddard et al., 2015, p83). CYP speaking to

IICSA reported that they were considering self-harm in the hope that they might meet the threshold to be treated by CAMHS (IICSA Engagement Team, 2019, p19).

One Centre reflected on the strict access criteria of services such as CAMHS, and how the threshold for access changes according to the capacity of the service, which is in stark contrast to the person-centred approach that is taken by RCCs:

“...many statutory services... will often change their criteria to fit their existing resource which I have real fundamental problems with. So we might get in contact with them and they’ve completely changed... [and they say] ‘oh yeah we don’t do that anymore, we haven’t got capacity. So now we’ll only take referrals for children who have had one unsuccessful attempt at suicide’ or, you know, ‘who are at this point of feeling at the end of their tether’. So for me a lot of it is about waiting until children are at breaking point, before going ‘right now we’re moving in’... [We] try to explain to [CAMHS] that at the point where a child or a young person might express the need for help, they’re already not in a great place. Because it’s taken so long to get to that point... we often feel quite frustrated by the way that they... work”. (Rape Crisis Centre in East England)

Offering support at the point of need, rather than the point of crisis

It is concerning that statutory services are only able to accept referrals for CYP when they hit crisis point, rather than stepping in earlier, i.e. from the critical moment of disclosure, to avoid the young person reaching a point of crisis. The impact on a young person’s life (and those around them) in the interim period could be catastrophic and have far-reaching consequences for the future. Even more concerning is that where CAMHS referrals are accepted, CYP are then faced with lengthy waiting times, with no support in the interim. In some areas it takes two years from a GP referral for CYP to start receiving help from CAMHS (stem4, 2022) – a delay which disproportionately affects CYP, given their ages and stages of psychosocial, physical and emotional development, and dependency on carers.

RCCs are aware of the possible impact on CYP of not receiving specialist support at the point of need, as they also support a huge number of adults who have experienced CRaSA in the past. In the year 2022-23, of all victims and survivors who accessed Rape Crisis services, one in five service users were adults who had been subjected to CRaSA when they were children. Many RCCs have therefore proactively created services for CYP who are struggling to access the support they need through statutory pathways. Whilst RCCs also have to manage

long waiting lists due to funding shortfalls, they are often able to eliminate the strict access/eligibility criteria enforced by CAMHS and other services, and provide support to CYP who would otherwise not be able to access it. This includes some form of support whilst CYP are on the waiting list for specialist therapeutic support. With further funding, RCCs could offer specialist support to even more CYP who need it.

ii. Innovating and developing services to meet the need

The support services offered by Rape Crisis Centres (RCCs) are survivor-focused; they are developed in response to what service-users need, rather than victims and survivors being expected to fit themselves around what is available.

For many Centres, the development of CYP services is not a static piece of work, but an iterative process; Centres continuously seek the feedback of CYP and professionals and keep abreast of changes to commissioned support pathways in their areas to determine whether they can improve their service offer for current and future clients. As explained by one Centre in London:

“It’s that whole concept of... nothing about us without us... we need to hold the young women and girls at the Centre... because otherwise, it’s just gonna be a really big disconnect from, from what they actually are needing... you can see that... pathways are very much developed by the funders, rather than what women and girls said they need”.

As a result of listening to what young victims and survivors said they needed, many Centres now not only support young people themselves, but also their caregivers/family members. One Centre in the East of England reflected on the value of being able to create such a service:

“We developed... our [counselling] offer to parents and non-abusing caregivers... following feedback from the young people... because what they were saying to us was, you know... this disclosure happens, lots of agencies get involved, police get involved, ‘Mum and Dad get really upset and it’s all my fault’. And so Mum and Dad don’t know what to do... don’t know kind of what’s going on for that child or how best to support that child... so it’s looking at, you know... what are the barriers around that?”

But it also looks at whether there’s something going on for that parent or that caregiver in terms of their own experience, because there’s often trauma and triggers there... [Now] the children will say ‘oh I don’t have to worry about my parent or my caregiver... they’re getting support’, and that has

made a massive difference in the outcomes for the children and young people. So having those two things as an offer, like we are really seeing the value of it... We do all of this work with that child, but if the home environment is not changing, if the parents aren't looking at the impact that it's had on them... [and] we're sending that child back to that... [then] the work that we're doing is being unraveled, because it's just a circle that continues. So there's nothing more powerful than this work [with caregivers] to support our work that we do with the young people... it does change a lot for that child to be able to put that backpack down that they hold for the parent and be able to then just look at their own stuff".

Feedback from the parents of victims and survivors who had been accessing a specialist parents' peer support group in the North East of England shared how it had equipped them to understand their child, and reduce isolation:

"I don't feel so alone, I've been given some excellent advice and methods for supporting my child, that I would never have thought about. I am able to see where patterns of behaviour have started." – Parent of child survivor of CRaSA

"The classes have gone a long way to help me understand my anxieties as a parent. I feel able to reflect more on [our] family situation by recognising the stories of others and shared communications." – Parent of child survivor of CRaSA

Other Centres have developed alternative services in direct response to what CYP have told them they would benefit from. For example, one Centre in London has established an 'expert by experience programme', which allows young women who have experienced CRaSA to support and empower each other, as well as receive training around leadership. They are further planning to launch a young women's Sunday Camp. Centre staff explained how this initiative came about:

"That really came up from a concern that we had about some of the most... vulnerable young women that were known to our service over the summer holidays, were really just left with not a lot of support there, you know, [the] kind of safety net of being in school and [being seen] by professionals every day is suddenly not there for a really long period of time. So this intervention is really with an aim of providing them with a safe space at the start of the summer, where we can provide an intervention around feminist consciousness raising and activism and also just having a bit of fun in the summer as well... There's no specific funding for this type of work... but it's just, it's a need. And if we're not doing it, then it's just not going to happen".

RCCs have the expertise, through their direct work with adult and child victims and survivors, to recognise the need for such additional support, and develop services in response.

iii. Work flexibly with CYP in response to their needs

As well as creating new services in response to CYP's needs, RCC staff are able to work flexibly within those services, in a way that is not mirrored in statutory or generic CYP services.

One Centre spoke about the difference between their counselling and play therapy services. Whilst traditionally, counselling is offered to older CYP and play therapy reserved for younger children, Centre staff highlighted that they will work flexibly and according to the needs of the child or young person, regardless of age:

"...working with young women is not quite as straightforward as it is with adults so... there is a bit of an overlap, you know, for example, we do find sometimes for some young women if there is a barrier in communication or if perhaps there is a slight preference more towards creative expression when you're working with teenagers, that we can and we do encourage that sort of creative way of working or, you know, [we] find... other ways that are not always necessarily directly talk therapies". (Rape Crisis Centre in London)

This flexibility is often missing from the support offered by statutory and/or generic services. In research commissioned by the Children's Commissioner for England, young people reflected on the rigidity of the support that was offered to them by CAMHS. In comparison to their experiences with third sector specialist support, young people described CAMHS as less accessible, less welcoming, inflexible and unable/unwilling to offer more than a limited number of sessions and opportunities to build rapport with practitioners (Warrington et al., 2017).

We have heard testimony from numerous victims and survivors about the limited number of sessions offered by some statutory providers, including most secondary mental health services. Often these services will offer only six sessions of counselling. Survivor-activist Viv Gordon, founder and artistic director of the Viv Gordon Company, wrote a poem about how this made her feel:

Six Verses by Viv Gordon

I get six sessions
To answer a lifetime
Spent floating outside myself trying to come in

I have six reasons
To stay in this body
But I cannot remember them, not even one

It takes six minutes
To tick all her boxes
How food is a nonsense and still I can't sleep

I have six hours with
The woman, her training
Her offerings of labels and drugs I don't want

It takes six seconds
To absorb her word "stuck"
And to watch myself drowning engulfed in its wake

I have six words to
Spit back at the woman
"Evidence" and "outcomes" and "fuck you, you arsehole"

I have six months which
I don't think I'll last through
I'm staring at nothing and brick walls and nooses

I have six women
Who hold my heart gently
Who tell me I matter until I believe them

I have six songs now
I sing to the women
They all start with hope and they all end with change

By Child Sexual Abuse survivor-activist and artist Viv Gordon, co-founder and artistic director of Viv Gordon Company CIC. "Six Verses" was originally published in 'We Are the Change-Makers: Poems Supporting Drop The Disorder!' published by PCCS Books. Learn more about Viv Gordon's work: [Viv Gordon Co - about \(vivgordoncompany.co.uk\)](http://vivgordoncompany.co.uk)

One Centre we interviewed reflected on the offer of six sessions of therapeutic support for CRaSA victims and survivors, and how they developed their CYP service to be flexible enough to accept referrals from CYP who are unhappy with the limited offer from generic/statutory services:

"...if a child decides that they've, you know, they've gone through the paediatric SARC and they've only had three sessions and they don't like it and 12 months later they come back to us... then the thing is we take them, we don't just turn around and go

no. And I think one of the conversations that we've had with an incredibly frustrating Commissioner is... 'but you'll know six sessions of CBT [Cognitive Behavioural Therapy] sorted me out...' There's no understanding of the complexities... It's... subject specialism, community connection and understanding, reflexive and responsive services". (Rape Crisis Centre in West England)

Offering a very limited and fixed number of sessions can arguably do more harm than good for SVA/CRaSA victims and survivors. It can often lead to

children and young people - and later adults - being stuck in a revolving door of help-seeking, which doesn't support their wellbeing and creates a false economy for commissioners. This approach also places pressure on victims and survivors, as set out by two women interviewed as part of research we conducted with partners in 2016:

"Quite often you'll have a block of counselling sessions and you'll get to a point where you feel all right about yourself or situation and that's fine, but actually if you've got tons more stuff that you know is aggravating you, you need to work through it, you have to go through the referral process all over again. At times the waiting list can be up to 12 months long." (Women's Health & Equality Consortium et al., 2016)

"You approach your counselling with the mindset [of] 'I have got six sessions and I have to cover everything' and it puts a lot of stress on you, it's not a natural way to work through things and it can be counterproductive. And it can leave you hanging which is potentially really dangerous. The practitioner, for example, the therapist say they are trained to leave you in a safe place as you come to the end of your time but even so who are they to say when you are better?" (Women's Health & Equality Consortium et al., 2016)

By its very nature, an act of sexual violence or abuse is an attack on an individual's choice and autonomy, so asking a victim/survivor then to fit themselves around rigid and predetermined service offers in their recovery can be challenging and, in some cases, harmful (or at least undermining) of recovery efforts, which look different for everybody.

A former CAMHS practitioner also reflected on the inflexible and uniform approach of statutory mental health services in an article for the BACP:

"CAMHS today is a travesty of its former self... Everybody does the same thing in the same way in the same amount of time, and all clients follow the same route along their designated pathway. Once a client is accepted, they're offered a self-help app and effectively told to go away, try to sort the problem out for themselves, come back in a few weeks and tell us how they're getting on. Then they might get offered groupwork, which can be great for some people but not all. If, after all that, they do get individual therapy, it's three to six sessions of one-to-one with an emphasis on self-help and behavioural techniques. That's the same, no matter whether they're anxious, depressed or suicidal. Before, we used to give a lot of time to working systemically in the context of the family history and developmental issues. Now there's no family therapy and no time to ask about the family history; the focus is on the here and now and fixing

the 'problem'. Effectively, it's setting up a revolving door. The waiting lists are down and the discharge rates are up, but young people get re-referred multiple times. They are no better off than when they started because they haven't received the therapeutic treatment and support they need". (Former CAMHS practitioner) (BACP, 2020)

Offering CYP a 'one size fits all' approach to support fails to provide the responsiveness or child-centred approach that they need, nor does it support them to develop trust and confidence in the service, which is essential when being asked to open up about intimate experiences such as CRaSA. RCCs have specialist knowledge and understanding of the trauma that can be caused by an experience of CRaSA and develop their service offer accordingly, with tenacity and creativity. RCCs aim to facilitate an environment in which victims and survivors feel comfortable to discuss their feelings and allow enough time for CYP to build trust with their therapist and work through their feelings.

The number of sessions of therapy offered to victims and survivors needs to be flexible, especially for CYP who cannot easily fit their trauma into a neat number of sessions and have developmentally less capacity for containing and metabolising the challenges that a rigid number of sessions presents. RCCs have always tried to be guided by the need of the individual victim/survivor. Sometimes they need just a handful of sessions, sometimes more than 20. Where RCCs are commissioned to provide therapeutic support, they often face pressure from commissioners who want more victims and survivors to receive support, but without offering the necessary increase in funding; this, in effect, can force specialist services to reduce the number of sessions they can offer. Commissioners must work with Rape Crisis services in order to ensure that they are able to sustain what they know to be the most effective ways of supporting victims and survivors.

iv. Adapt service offers to maximise initial and continuing engagement

Young people interviewed about their experience with CAMHS within other research have also reflected on the difficulty they experienced in travelling to the appointment locations (particularly if they live in rural areas with poor transport links) and the 'rigidity and formality of the CAMHS appointment slot' (Warrington et al., 2017, p105).

Anecdotal evidence obtained by RCEW suggests that CYP are denied support through CAMHS if they miss two appointments, regardless of the reason behind the absences. This approach shows little understanding of the barriers that may be preventing CYP from engaging with the service.

There may be physical barriers, such as travel challenges, or social barriers, such as discomfort with the type of support being offered, or a lack of trust in the practitioner. RCCs work flexibly, adapting their service offer to maximise initial and continuing engagement, and working with CYP to overcome any barriers that may be in their way.

A number of RCCs we interviewed highlighted the need to mitigate travel obstacles in their areas to facilitate the engagement of CYP. We heard about the frequent failure of statutory and generic CYP providers to do this, either due to inflexible service offers or, in the case of national CYP organisations delivering locally, poor knowledge of the local areas they are trying to work in:

“[Generic CYP support organisations] jump into contracts locally where they then suddenly find out that they can’t meet the geographical responses. So we, we’ve taken one contract off [generic CYP provider] and we’ve also lost out to one... they’re not [in the] community... but because they have got the big organisations that can do the tender writing, they win the contracts... We are in a big geographical rural [area], [with] horrendously poor transportation links, [so] a lot of our children’s services are delivered within schools. So you know... I might have a counsellor who is seeing a child for an hour, but they’ve got an... hour’s travel either way. [It] makes it less cost effective, but otherwise, that child’s going to miss an entire day at school... It costs us to go out to schools, but it is an active choice of does that child miss a half or a full day? Does the parent miss a day’s work so that the kid gets an hour of support? Or do we... take the service to where it’s needed... we are responsive, and we can change and if it’s not working, we can swap things out quickly”. (Rape Crisis Centre in the West of England)

“We had a case that... was in [place name]... this lad had started off with bra pinging and then digital penetration and his behaviours escalated and escalated until he raped a child, then another child, and we had every single member of our advocacy team involved supporting different children and their parents and everything else, and we coordinated it and they decided to hold the hearing in [another place name]. So we had our entire staff team literally moving up to [place name]... which is not a small distance, because it was the right thing to do for those children. And I defy any CAMHS service to say that they would ever come out of their offices, let alone ship their entire team up to [place name] to look after kids. And that’s the difference I would say”. (Rape Crisis Centre in West of England)

As well as working to overcome travel issues for CYP and their families, other Centres reflected on

the need to provide their services in easily accessible locations, such as schools, to ensure that other barriers to engagement are removed for CYP, including those around confidentiality and feelings of safety:

“...in terms of engaging in counselling, what we’ve found is... schools will offer us a space to see that young person in, and that’s really helped with ensuring the young can attend, because if they don’t want to tell a parent or somebody to bring them here [to the Rape Crisis Centre], it means they can be seen on site”. (Rape Crisis Centre in East England)

“In particular with younger children... parents [are] more at ease knowing that we could maybe go into the schools to see them. They felt that the children were safer, they didn’t feel like children were going to be taken away, you know, removed from their care, because we were going into the school... it makes things feel more secure in terms of doing that work with you”. (Rape Crisis Centre in East England)

Other Centres we interviewed spoke about the need to work differently with different CYP to ensure they are able to approach the service from the outset. One Centre spoke about the ways in which they have developed their presence in the community to make it easier for initial engagement with the service by CYP:

“In the early days... when you’re [doing] a stall or doing PR or whatever, we’re the loneliest stall in the village. Nobody wants to come to us, no one wants to be identified standing under a Rape Crisis banner. So, over the years, to increase our profile with young people and the general community, we’ve delivered a whole range of activities to encourage them to, you know, engage with us and we’ve had to do that a lot with young people. So, we will go to the local colleges, and... sixth form, the schools when they’ve open days. So, we’ve had to kind of think about how [we] present, so we come up with marketing, whether its baseball caps or caps for their drink... or nail paint was one of them that changes colour when you dip it in your drink, stuff like that... So, we know that young people really do like to take things away, so the more in the goody bag the better”. (Rape Crisis Centre in East England)

Most RCCs also run their own specialist local sexual violence and abuse support helplines which can be accessed anonymously. For victims and survivors who face barriers to seeking support, using a helpline is a common and valued way of making first contact with a service to ‘test’ its suitability. This is particularly true for victims and survivors from Black and minoritised backgrounds who may

be mistrustful of services due to previous experiences of racism or cultural insensitivity, or who may face ostracisation from their communities for speaking out about the SVA they have experienced. Helplines can be used to seek advice and support anonymously, and/or to build trust with RCCs over time before making a referral to more formal support offered by a Centre. This is not an option with statutory services, where a referral from a GP or other 'official' body is required, which will then be documented in a CYP's medical or school records. Professionals speaking to the Centre of Expertise on Child Sexual Abuse spoke of the consequences of disclosing CRaSA in Haredi Jewish and some Irish communities, illustrating the importance of CYP being able to access specialist support confidentially (Ali et al., 2021, p27):

"Mesirah [is] the prohibition of reporting things [about other Jews] to secular authorities... Somebody who does that is called a Moser. And there's a very strong taboo."

"I have heard stories of people in Ireland – rural communities, you know – people who have disclosed and then they were excluded from the family, including mother rejecting the child or the young adult... Those stories are not uncommon."

As well as initial engagement, RCCs take a bespoke and tenacious approach to continued engagement. One Centre interviewed spoke about the need to look more closely at why a young client is not engaging with support, rather than withdrawing the offer of support after two instances of non-engagement, as is the practice in many statutory/generic services. This demonstrates the person-centred approach which is at the heart of Rape Crisis services (explored further later in this report):

"[We consider] for example... engagement, what does a lack of engagement look like for a young woman... maybe a reluctance to speak things out, is that because of her age or is that because she communicates in a different way... also that increased level of self-awareness that is associated with the different developmental stages and that the counsellor needs to be aware of and work with, if they are to provide the same outcomes for that young woman. So I think it's sort of around how we tailor the approach, you know to make it suitable for a woman of that age and to look at the different factors that are playing out in her life. The different levels of agency that she has at that age, in order to benefit from therapy... These are areas that we are always sort of developing and maybe partly because we are a slightly smaller service that we are able to dedicate that attention individually and to really look at what's going on". (Rape Crisis Centre in London)

By working flexibly to meet the needs of CYP, even before they have entered a Rape Crisis service, RCCs are able to ensure young people and their family feel safe in accessing support. This benefits everyone involved, not least a young victim or survivor who is able to properly engage with specialist support following an experience of CRaSA, feeling valued, listened to and believed, rather than just another number in an inflexible system.

B. Rape Crisis Centres provide holistic, wraparound support

RCCs recognise the importance of a holistic support offer for CYP who have experienced CRaSA and have developed their services to provide as much wraparound support as possible.

IICSA, in their final report, stated that:

'Support needs vary greatly and can change over time, triggered at different points in a victim's lifetime, sometimes in unpredictable ways. Recovery is often a non-linear process and victims and survivors might need practical support about how to report abuse and obtain medical assistance, advocacy support as well as therapeutic support such as counselling and psychotherapy' (2022, p 262).

Further, the Government set outs that commissioners should 'ensure the provision of support services for rape victims is approached in a transformative, holistic way that puts victims' needs first' (HM Government, 2021c, p30).

Holistic, wraparound support recognises that the impacts of CRaSA can permeate several different areas of an individual's life, and that in order to recover, victims and survivors often need support with more than one issue at a time.

RCCs therefore ensure that, where possible, a number of services are available to CYP, for example:

- Therapeutic support for CYP (counselling, play therapy, group work)
- Therapeutic support for non-abusing family members (counselling, peer support)
- Practical support and advocacy (providing food parcels, accompanying to health appointments, liaising with schools and colleges)
- Emotional support
- Support through the criminal justice system (CH/ISVA support)
- Opportunities to get involved in activism (see section A above)

One Centre outlined some of the services they offer to CYP and their families which ensure that support is provided in various aspects of victims' and survivors' lives. Many of the services available are not typically offered by statutory/generic support organisations:

"...we support not just the parents, but other family members can come in as well... siblings... so it's very much a holistic approach that we have supporting that child... we have support with education and things as well, so obviously, when a child has gone through this, it feels as though their whole world is falling apart and they may not feel that they can engage in school so much. So at the moment I have one [client] who's actually out of school because school is just too much for them so our [practical and emotional support] team is supporting me with that and looking at changing the education or removing [them] to a more supportive education". (Rape Crisis Centre in North East England)

Other Centres also discussed the importance of a whole-family response and the services they have created to provide holistic support to all family members affected by CRaSA, informed by the specialist knowledge of how CRaSA can affect people differently:

"One of the things our kind of work has shown us is that you can't support the victim in isolation, it has to be a family response and I think that's... the most significant change we've made... So, an example... one of the things we've really developed is supporting dads. So, we provide a male counsellor for the dads, it's quite specific work, we've had really good feedback from it, where dads are... you know, the first thing they want to do [when they hear about their child being sexually abused] is go and get a gun or they don't know how to handle it, they don't know how to be. So, we've developed that piece of work and I would suspect that other Rape Crisis Centres have done that and again it's a bit of a light under our bushel, it's not something that people would go 'ooh Rape Crisis offer support work to dads'. You know, it's not seen, it's invisible". (Rape Crisis Centre in East England)

"The child comes with a distressed parent. We've got a wraparound service, we've got the offer of keeping that parent in that service. We've also got the joined-up work with the criminal justice system. You've just come out of that, let's make it a smooth pathway in. Yes, we understand how that has impacted on you and often that's the trauma we're dealing with first - the impact of the criminal justice system - before we even go in there. The understanding of the needs of that client is so much greater within a specialist service because

it is not just about the incident, it's about the ripple effects on the family, it's about understanding that whole process. It's about understanding that somebody in school doesn't understand that this is still going on for me, even though it's NFA'd. It's about everything around that whole criminal justice process". (Rape Crisis Centre in West England)

The Home Office's CSA Commissioning Framework (2019, p29) states that 'CSA has a serious impact not just on the individual child or adult but on all the relationships in the family. For services to be effective it is likely that intervention with other family members, such as the non-abusing parent or carer and siblings, will be needed'. However, there is little available support for family members of CRaSA victims and survivors in many areas, and the RCCs that deliver these services are rarely funded by any of the commissioners mentioned above, who hold responsibility for providing CRaSA support. It is clear then that RCCs go above and beyond to ensure that victims and survivors have a holistic support offer.

As well as providing services for family members, RCCs try to support victims and survivors with other aspects of life that statutory/generic services would typically not be able to assist with due to their more rigid service models and focus on clinical outcomes:

"One of the families that [Rape Crisis worker] was supporting, the dad had interim care of the 6-year-old. And they'd been put in an HMO [house of multiple occupation]... it's a common thing. So, you've got... vulnerable people being placed with all kind of characters and where he'd received interim care... the child was sleeping in the same bed, double bed, and the whole reason she was coming to us was around... another family member... had abused her. But she's sleeping in a bed with an adult male... we had no concerns about Dad at all but you know all of that trauma for her and for Dad as well who was really like, 'what do I do? How do I manage this, what happen?' you know... so, we were able to get them... some single beds... At least we could do that, we couldn't do anything about the housing situation, but we could make that situation better for both of them [and] that would hopefully help them go forward... and ensuring she had the right school uniform and the right clothes... because she had been moved schools so many times, the dad, you know, there's no allowance for the amount of uniforms that that child had, so we ensured she has a win... I mean, one of our things is making sure our kids have got winter coats, that's one of our things. So, they're the things we fundraise for, any donations that come into [Rape Crisis Centre] we buy that. That's what it buys... And making Christmas happen

for them because that doesn't stop for some of these vulnerable families and the children don't understand and they've already gone through a lot anyway. You know, so we try... we work with them as a family as well as with the trauma of what they've gone through". (Rape Crisis Centre in East England)

Many Centres told us that they hold fundraising events and seek to bring in unrestricted grant funding to pay for such necessities, as it can make such a difference to the lives of CYP who are recovering from the trauma they have experienced. One Centre told us how difficult it is to communicate the importance of this work:

"And it's holding on to that in all the policy, fundraising, commissioning nightmare, it's like what is our bottom line. I mean, I know what mine is... It's about getting that message out, isn't it, that it's not just about a child or a young person or a parent coming along to have some work done with them, it's about the, you know, the whole thinking around what does that look

like to meet the needs of that family, really. And it's not just about an hour, coming into a service, doing a therapy session or counselling and then leaving them going home. So, it's about getting the message out, really, that it's much more than that... it's not just about the offer, it doesn't begin and end there. It's not the whole journey". (Rape Crisis Centre in East England)

This creative and holistic support is provided by staff members who have the necessary expertise and empathy to understand the needs of CYP who have experienced a specific kind of trauma through CRaSA. RCCs have honed this expert knowledge over decades of supporting clients who have experienced SVA. The impact of this additional support on the ability of CYP and their families to cope and recover from CRaSA cannot be understated. Whilst there may be other services who may provide support with clothing etc., it is incredibly unlikely that this will be provided in-house by the same professionals providing specialist therapeutic support for CYP victims and survivors of CRaSA, as it can be in RCCs.

C. Rape Crisis Centres have specialist expertise and experience

[It's] so important for us... defining what we mean by specialist... because we know the Home Office and the Ministry of Justice are a bit confused and they're giving contracts to [generic private providers] to run ISVA services, you know, so it is a really critical point I think that both within our Centres but within our network that we're able to articulate that. And there is something around the longevity of our services, the grassroots nature of our organisations, the led by-and-for survivors context of our staff, our volunteers, our trustee boards, the lived experience within the organisations and the women who deliver services as well as... and I know all these things get... banded about but that notion of... coproduction... collective growth... we are not afraid of sitting with someone who is in acute pain, we will lean into that not away from it. And I think what we see either in non-specialist services or... statutory services is that the inclination is to lean away from it. I think as a network we have remained people-focused not process-focused and that's what gives us the edge. I genuinely think it does.

(Rape Crisis Centre in East England)

RCCs are defined as specialist because sexual violence and abuse (SVA) is their primary focus. They are different to 'general' or 'generic' multi-modal services that may provide support for a range of people, not just victims and survivors of CRaSA. RCCs are independently governed by their own boards of trustees and secure funding from a range of sources so that they are not owned or managed by the state. The Rape Crisis National

Service Standards (RCNSS) ensure that all Centres work to an established good practice model and set of values, and services are delivered by highly trained staff with decades of collective expertise, many of whom have lived experience of SVA and other forms of VAWG. This section explores in more depth these elements of RCCs which combine to make them specialists in the field of CRaSA.

i. RCC staff have expertise in the field of sexual violence and abuse

IICSA's work with victims and survivors of CRaSA found that voluntary sector specialist services were the most highly rated form of support across all services accessed by victims and survivors. The victims and survivors that IICSA interviewed stressed 'the importance of such specialist support being from counsellors/ therapists with training in, and particular knowledge of, trauma generally, and child sexual abuse specifically' (IICSA, 2020, p267).

Participants commented on their inability to engage with counsellors provided by health services because they did not understand their experiences. One individual relayed an occasion where a counsellor stated that she did not believe that she had been sexual abused as a child (IICSA, 2020, p55). CYP - and indeed adults - who have experienced SVA/CRaSA frequently internalise various societal myths and stereotypes which question the validity of their experience and frame them as responsible for their own victimisation. Validation of victim and survivor experience is essential when providing support - this is integral to all RCC models of working.

Various studies have found that the beneficial effects of therapeutic support – such as victims and survivors feeling less isolated, possessing a greater sense of self-worth and being able to contextualise the abuse – were most likely to be achieved when therapists have knowledge of trauma generally, and CRaSA specifically, and survivors feel that they are heard and believed (Chouliara et al., 2011; Chouliara et al., 2012; Parry, S. and Simpson, J., 2016; Sneddon et al., 2016).

Victims and survivors speaking to IICSA reflected on how they did not feel able to disclose their experiences of CRaSA to generic services and could therefore not work through the feelings attached to their experience. When seeking support through an RCC, there is no need to disclose that they have experienced CRaSA. The very fact that they are accessing support through that service removes the need to share any details of the experience (unless of course that client wishes to disclose), and the focus can instead be on that person's current emotional reality, and their journey towards recovery and/or rebuilding their lives in the aftermath of abuse. The SVA itself can be an unspoken, accepted fact, between a client and their experienced therapist who is able to work with (hold in mind) what may remain unspoken.

One Centre in London reflected on this strength:

"We have young women who work with generic... counsellors... who say... the counsellor didn't have that understanding of... the specific nature of the

trauma when it happens in the form of sexual violence, what that does and how I experienced that... and there's something about... being an organisation with that knowledge that women and young women find quite comforting, that they're coming into us not having to explain, not having to say, you know, repeat or talk about the specific impacts, because there is the shared understanding that we understand... and I do think it is reassuring - this is what women do tell us that it is reassuring, to know that we can provide that specific support".

Another RCC in the North East of England reflected on the importance of therapists holding specialist expertise on SVA when supporting CYP who have experienced CRaSA, and how this cannot, and perhaps should not, be replicated in generic services:

"We are specialists in sexual violence and I would argue that organisations that are specialists in working with children do not have the specialism or the grounding in sexual violence that you need. Whereas the skills about working with children - it's a way of working isn't it, it's techniques, it's practice - whereas a rounded knowledge and experience in sexual violence is not something you can easily learn. And also it's the wider point as well is that about for individual workers to do sexual violence work you have to be, in my view, situated within an organisation that has a culture and knowledge and understanding of sexual violence, because it's really hard work to do. So I would argue that... we are incredibly well placed to do [this work] because we have all that supportive culture and understanding around sexual violence and then we can train our staff in how you work with children and young people. Whereas children's organisations, if you're doing sexual violence work, you're maybe going to have one worker who's doing sexual violence".

A victim/survivor who gave evidence to the All-Party Parliamentary Group on Domestic and Sexual Violence Inquiry (2015) also suggested that non-specialist services should not be attempting to work with the trauma caused by CRaSA. Approaching this work without the necessary understanding, despite any good intentions, can be harmful to victims and survivors who are putting their trust in a therapist at a time when they have been so betrayed by another person they likely trusted:

"Without the specialist knowledge, I would not have been able to obtain the education about what had happened to me... Attempting to provide therapy to someone without understanding what they are up against may be more harmful than beneficial."

Other professionals working with CYP more generally appear to also recognise the specialism in RCCs, as reflected on by several Centres we interviewed:

“We’ve had loads of calls from social workers wanting to hear about it [new family support project] because I think like they don’t know what to do with parents... and they don’t have the skills around sexual violence at all. I mean I know they do safeguarding but the actual grounding in sexual violence I think is really limited in social work teams”. (Rape Crisis Centre in the North East)

Many Centres spoke to us about how CAMHS often refer CYP to RCCs and then close their own case, refusing to support that young person. Whilst this is frustrating for the Centres who do not receive the funding or recognition that CAMHS do, and the CYP who are struggling to access appropriate support, many RCCs we spoke to saw this as a sign that CAMHS professionals agree that RCCs are best placed to work with CYP victims and survivors of CRaSA.

“Yes, some of them [CAMHS practitioners] do close [their cases] straight away... I think sometimes they close because actually what we need to understand is they’re not the right service for that child and young person, we are”. (Rape Crisis Centre in South East)

In our view, commissioning generic support services to work with victims and survivors of CRaSA is inadvisable. Many of those referred into generic services eventually require (and go on to access) specialist services – either by referral from the generic service, or through the victim or survivor finding that specialist service sometime after they have had a poor experience at the generic service. This calls into question current commissioning decisions, whereby money is directed to generic services who are not providing the support needed, whilst specialist services are desperately trying to find funding for the work that meets the needs of victims and survivors.

“Specialist services understand the impact of [sexual violence] and the importance of providing services to suit individual needs. A generic approach is more likely to provide a short-term fix that doesn’t help to improve the client’s health and well-being. This is evidenced by the number of referrals we receive from women who have already accessed generic services!” (Specialist sexual violence provider in written evidence to the All-Party Parliamentary Group on Domestic and Sexual Violence Inquiry, 2015)

ii. Experience

Typically, RCCs are more known for their work with adult victims and survivors of SVA, rather than their work with CYP. However, this experience in working with adults is not irrelevant to the delivery of effective support services for CYP. Indeed, we suggest that the experience Centres have in supporting adult victims and survivors is in fact integral to their work with CYP, particularly since one in four adult victims/survivors supported by RCCs have experienced CRaSA.

Two Centres we interviewed reflected on the value of Centre staff having knowledge of work with adult victims and survivors:

“We have got decades of experience of working with adult survivors and we know what happens with survivors when support is not put in place at a time that might have made sense to them and might have actually supported their ability to process”. (Rape Crisis Centre in East England, explaining what made them establish a CYP service in the first place)

“I think there is something about it being a service that covers the range of ages, because what also tends to happen is yes you are looking at women at different stages of their lives, but you can also see almost sort of the patterns sometimes and the links... because a lot of the adult women that we see come in because they’ve experienced sexual violence at a very young age, right?... and they’re presenting to us as an adult now, not with that childhood sexual abuse but with that, plus how that’s carried through in their lives. So, because of the... impact of that trauma at a very early age... and the way that that then connects to, you know, attachment, for example, and the way that women develop psychologically, how they make meaning really, how they make meaning of such an abusive experience in order to be able to survive... what that then does sometimes is it... creates pre-conditions for further exploitation at a later age, right? So then you start to see the patterns with women who have experienced sexual abuse as a child... and then as they grow been re-victimised. And... that then carries on and becomes complex trauma if they grow into... adulthood. So clearly the links are there and the fact that we have this oversight, the fact that we work not just with the age group and trauma in the wider sense, as I think [generic CYP service provider] sort of would do [is beneficial]... in terms of the sexual violence specifics and being able to understand how those early attachment stages then develop through a woman’s life and manifest into sometimes exploitative relationships and be able to make that connection... Yeah there’s something about that”. (Rape Crisis Centre in London)

As well as the decades of additional experience in supporting adults and teenagers, many RCCs do also have a wealth of experience in supporting younger children. Some Centres were involved in early groundbreaking work supporting child rape survivors and their families which shaped the way organisations work today. One Centre in the South East of England has recently sought accreditation with the National Open College Network as a training Centre for professionals seeking a Level 5 Award in Rape and Sexual Abuse Counselling with Children and Young People. At the time of writing, they are the only provider of this specialist child-focused qualification nationally.

iii. Technical Expertise

RCCs have a specific focus on SVA and therefore are aware of how involvement in the criminal justice system (CJS) can impact on a victim or survivor seeking support. Whilst most victims and survivors choose not to pursue a criminal justice outcome, those who do currently face a potentially lengthy wait. As set out in our recent research report *Breaking Point* (Rape Crisis England and Wales, 2023), there is currently a crisis in the CJS. Those who report CRaSA offences typically face a wait of nearly two years between reporting the abuse to the police and the case concluding in court – with child rape cases taking significantly longer (Karsna and Bromley, 2023, p7). As of December 2023, there were 10,141 sexual offence cases waiting to be heard in Crown Courts – a 196% increase on the same time in 2019, and a record high (Ministry of Justice, 2024). Disappointingly, the official statistics are not disaggregated based on the age of the complainant/the charge brought, so we are unable to determine how many young victims and survivors of CRaSA are waiting to have their case heard.

Lengthy waits for trials can impact on victims and survivors in numerous ways. RCCs report that they are being called upon to provide more intensive support for longer periods to victims and survivors who are awaiting a trial (Rape Crisis England & Wales, 2023, p47). RCCs recognise that the wait for trial can be incredibly difficult for victims and survivors and adapt their service offer based on each individual's needs. As explored above, statutory and/or generic services are ordinarily only able to offer a set number of therapy sessions and rarely deviate from this, regardless of a victim or survivor's situation. It is also not uncommon for statutory/generic services to refuse to support victims and survivors of SVA whilst they are pursuing a criminal justice outcome, for fear of breaching rules around pre-trial therapy and 'coaching' witnesses (Rape Crisis England & Wales, 2023, p40).

Revised CPS (2022) guidance on pre-trial therapy makes clear that victims and survivors await-

ing a sexual offence trial should not be denied the emotional support and therapy that they require. However, we know that this is not always the reality for victims and survivors. One young woman, who spoke to us as part of previous research, told us that she was denied NHS-funded therapeutic support services because they did not have the specialist training to deliver pre-trial therapy (Rape Crisis England & Wales, 2023, p41). We know that this is not an isolated case. Research conducted by IICSA into support for CRaSA victims and survivors found that 1 in 3 CYP who accessed support through non-specialist services reported leaving this support prematurely. Whilst there were a range of issues cited, one was 'reasons linked to the legal process' (IICSA, 2020, p23). Many non-specialist therapeutic services refuse access to victims and survivors of CRaSA who are involved in the CJS, as they lack confidence in providing pre-trial therapy. In contrast, all RCCs will offer victims and survivors pre-trial therapy and are skilled in providing this within the confines of the CJS.

iv. Local Expertise

As well as being experts on the subject of SVA with decades of experience in supporting victims and survivors, RCCs also hold specific expertise on – and are embedded within – their local areas. This is not to be underestimated when working with CYP and cannot be replicated by large national generic support organisations. Several Centres we spoke to reflected on the benefits of CYP being able to access specialist support that is provided by, for and within the community it serves, both in terms of the local knowledge and accessibility for CYP:

"Our staff, our volunteers, our clients live within the area. We have a very good understanding of the difficulties that people face... We have got lots of poverty, lots of incredibly poor transport links. But we actually understand the needs of the people in the area". (Rape Crisis Centre in West England)

"We've got people who live in the [X] area who will work in [X] and people who live in [Y] and who work in [Y]... so you do know, sort of locally, anecdotally what's going on with young people and in the community and what's the topic of conversation at the moment... And I think that has real value and it's not going to transfer to somebody coming in from a large national agency. And I think although, you know, we don't advertise where we are, yet young people talk and they all know where we are and it's not that uncommon to have somebody just turn up; we don't have a drop-in because we haven't got the space for that, but they will just turn up because they've been here, or their friend's been here". (Rape Crisis Centre in East England)

D. Rape Crisis services use a child-centred empowerment model



...I really feel it has turned my life around. I am much more in control of my emotions and also the choices I make. Even things like recognising I have the tools to move out of certain bad situations is something new to me. I have more confidence in myself; not just the way I look or the things I do, but deep within myself I feel confident. 100% my belief system is different and I know where I am going.

(Survivor, age 17, who accessed specialist SVA counselling through an RCC in East England)

I have felt that therapy has really helped me. It was a great experience and I finally have someone to speak about with me feelings. At first, I wasn't sure about it but now I feel open to talking about things. I have really liked it here and it had brought me to say things that I never thought I would say in front of someone before.

(Survivor, age 13, North East of England)

IICSA's research into support for CYP who have experienced CRaSA found that those who had positive experiences of support had therapists who ensured that they understood they were not to blame or in any way responsible for their experience of CRaSA (IICSA 2020, p50).

All RCCs are assessed against the Rape Crisis National Service Standards which require all of their services to 'promote empowerment and self-help to enable service users to take control of their lives and inform the delivery and development of services' (Rape Crisis England & Wales and Rape Crisis Scotland, no date, p6).

This empowerment model utilised by RCCs is grounded in a feminist approach to Violence against Women and Girls (VAWG), which recognises that it is both the cause and consequence of sex and gender inequality, and that impunity for perpetrators and patriarchal systems of male privilege and entitlement reinforce its perpetration and prevalence. The empowerment models place responsibility for violence and abuse with the perpetrator only, and seek to empower victims and survivors to reclaim the power and control that SVA takes from them.

An empowerment model also seeks to unpick the shame and stigma of SVA, as well as the societal myths and stereotypes that are internalised by victims and survivors. The model necessitates a political and societal analysis of SVA which holds perpetrators responsible for their behaviour, locates it within broader systems of patriarchal dominance

and misogyny, and recognises the disproportionate victimisation of women and girls by male perpetrators. This model also supports victims and survivors to regain confidence and understanding of who they are and what they want to achieve with their lives.

RCCs we interviewed were clear about the empowerment model underpinning all of their work with CYP, and the importance of it:

"I think the thing that makes the work that we do so different is that we 100% use political analysis of sexual violence alongside recovery for its individual impact. It's holding those two things at the same time that means our work is really unique in this area. So what we see for our area, for example, like the NHS talking therapies contract has you know gone over to some generic counselling service... Yeah they provide a service and I'm like... and where's your political analysis? Where's your understanding of the broader issues? Where do you see violence against women and girls sitting in the bigger picture around patriarchy and misogynistic cultures and structures and they're like 'ah'... You have to give survivors the words and the framework to understand what happened in order to validate [their feelings]... So everything we do has that kind of gendered analysis... the feminist perspective, notions of power sharing – personal and organisational – you know those principles redress the balances for so many survivors who obviously are feeling disempowered and disconnected from agency

and autonomy. And there's something about how we do that individually and how we do that collectively". (Rape Crisis Centre in East England)

The empowerment model is necessarily led by the victim or survivor, centring them as the expert in their own lives, rather than a helpless victim, and offering a choice of support that is right for that individual. When working with CYP the support offered is also child-centred, acknowledging that CYP possess even less power and control in their lives than adults. Several Centres we interviewed reflected on this:

"It's about working with that individual girl and understanding where she's at. And recognising how powerless children are intrinsically in society, then you add to that dynamic of sexual violence and abuse and it's just... so we try incredibly hard... you know that notion of the Rape Crisis empowerment model it's applied really passionately, particularly around girls in recognition that as children they already have so little control over decision making around their lives". (Rape Crisis Centre in East England)

"I think the fact that Rape Crisis services have been working with survivors of sexual violence for so long, that we do know what we are doing and do have all the robust training in place and having that kind of survivor-centred, holistic counselling and empowerment models means that we can work really well with young people who do not really have any power or control in a situation so I think in that sense it transfers really nicely across to young people. We would be non-directive and those sorts of things that are really important, particularly in the case of abuse of a child and an abuse of power like that". (Rape Crisis Centre in South East England)

One Centre spoke about the ways in which this child-centred empowerment model plays out practically in the work that they do:

"So I do have one [client] at the moment... and there was a family worker involved in the case... And the family worker... was quite judgmental... and a lot of what we were hearing from the professionals was that this was... attention-seeking behaviour from the child... and so they really weren't understanding the impact of that sexual violence on the child. And this was, this was... a family social worker, family support worker and CAMHS and everybody in the room was coming from that angle and I think [we] were the only one in the room advocating for the child... and bringing that child's voice in... we are kind of yeah well, very strong about making sure that it's the child that's being heard... the child is seen as more or less a case and a subject rather than a human being". (Rape Crisis Centre in North East England)

Trauma-informed support



...rather than ask, 'What is wrong with you?' and 'What shall we call it?', it is more sensible, and useful, to ask, 'What happened to you?' and 'What do you need?'

(Read, 2018)

Working to a child-centred empowerment model necessarily involves a specialist trauma-informed approach to supporting CRaSA victims and survivors. Not all professionals have knowledge and experience of working with the trauma caused by SVA/CRaSA and how this may be expressed and experienced, and statutory mental health professionals in particular often pathologise victim and survivor responses to this trauma, offering clinical diagnoses and/or medications for experiences which in fact require contextualisation.

Common diagnoses given to victims and survivors – such as depression, anxiety, and personality disorders – can be helpful to some and serve to explain their feelings of distress. In other cases, these diagnoses can help victims and survivors meet criteria for support or compensation. However, academics and experts have evidenced the dangers of over-reliance on 'medicalisation' within statutory mental health models of support, since there is a strong tendency to think about normal trauma responses as an illness or sickness with a diagnosis, which can obscure identifying and resolving the source of distress. Services that are equipped to only address the by-product of trauma, rather than the root of it, will be limited in their efficacy.

Taylor (2022) argues that pathologisation of victim-survivors of VAWG is the 'ultimate' form of victim blaming, as it transfers the impact of perpetrated violence as a problem with the survivor's mind and mental state. Adult victims/survivors of CRaSA spoke to researchers in earlier studies about their experiences of being pathologised:

"The doctor doesn't understand us and treats us like we are mad but all we need is support. You tell him one thing and he tells you something else. He doesn't ask why you have this problem, he just gives you medicine." (Women's Health and Equalities Consortium, 2014).

"I cannot access help with my experiences of organised abuse because there are not enough people trained in this that are able to offer free help... It has left me with no help and being stigmatised and not believed by medical staff and

other professionals. They seem to find it easier to locate the problem in the individual (by diagnosing you with some kind of disorder) rather than recognise that you are coping with the effects of trauma.” (Smith et al., 2015, p29)

Pathologisation may be more common for Black and minoritised CYP. A plethora of research discusses the stigma and taboo attached to mental health in South Asian communities, for example (Gutierrez and Chawla, 2017; Sawrikar and Katz, 2017). Statutory and generic services that are often too quick to diagnose a mental health condition may inadvertently be creating barriers to help-seeking for many CYP who have been brought up to internalise the stigma and shame attached to poor mental health.

In contrast to these services, RCCs operate with an understanding that a victim or survivor’s reactions are a normal response to a trauma. Such an approach ‘serves to normalise symptoms and behaviours that have traditionally been pathologised and viewed as examples of personal and social deviance’ (Bloom, 2000). Rather than working to identify clinical diagnoses and outcomes, RCCs support victims and survivors to achieve the positive outcomes that they identify as meaningful and useful, such as feeling more in control of their lives, experiencing better health and wellbeing, being more able to develop and maintain positive relationships with those who matter, demarcating and adhering to their own boundaries, and being better able to assert their rights.

We spoke to several RCCs who are concerned about the pathologisation of SVA victims and survivors, especially CYP, by statutory mental health services in particular. One Centre reflected on the ability of their experienced staff to recognise the physical impacts of trauma among CYP:

“So we have a really high volume of children that have digestive problems... and if you think about it yourself when you are anxious, of course you’re not going to digest the food, so then you’re going to get acid reflux and food things and sensory issues... not be able to eat certain stuff. So, that knowledge and experience is really helpful, sharing that with the young person, because then they don’t feel like, well, that’s okay; then you know it’s normal that that’s happening to me and we can work with it”. (Rape Crisis Centre in South East)

It is unlikely that a GP or other medical practitioner would consider the impact of trauma when presented with a young person experiencing digestive issues, as a clinical model does not lend itself to the consideration of the physical effects of a traumatic experience. Clinical models are also quick to diagnose mental health conditions where argu-

ably there is not always a need for this. One Centre reflected on the tendency of CAMHS services to make diagnoses and how they work to re-centre the CYP and their experience when working with them:

“... we must stop being afraid of children that have been diagnosed with medical conditions... sometimes it is trauma... they [CAMHS] do pathologise children with all sorts of things and actually they’ve been sexually abused, and that’s what we’re working with. And actually, you know, if a child has got a diagnosis of complex PTSD, that doesn’t mean that CAMHS [cases] have to stay open. And I think that there’s a lot of people being scared about that, but actually what we need to do is be looking at it in a different way and reframe it. CAMHS are closing [their case] because they’re not right for this child. You [the Rape Crisis service] are right for the child, you do the work. This is a person, a human being, we’re not worried what diagnosis they’ve got, okay? And we always ask, do you agree with them? You’ve been diagnosed with this, what do you think about that? Do you agree with it?” (Rape Crisis Centre in South East)

A clinical model which pathologises victims and survivors is at odds with the trauma-informed empowerment model utilised by RCCs, as set out by one RCC in the East of England:

“Well it’s so tricky...I think I recognise and appreciate that they [CAMHS] are, you know, a statutory service, they are inevitably therefore under-resourced... But I still struggle I think with some of the ethos or the ideology from which they work from with children and young people. I think it’s... it counters a lot of the work that we do... And I’m just not sure that it’s coming from a kind of survivor-focused empowerment model, I think it feels very medicalised, very pathologised. I think it’s very focused off a diagnosis which I often think is utterly irrelevant and inappropriate for survivors of sexual violence and abuse”.

We argue that clinical models of support are largely inappropriate for CYP victims and survivors of CRaSA, and indeed adult victims and survivors. This is a point also acknowledged by IICSA (2020, p79): ‘at specialist services – such as Rape Crisis Centres – the focus is on healing from trauma, specifically sexual trauma. Whereas at generic adult mental health services, the focus may be more generally on symptom reduction and may not seek to address the underlying trauma. This was observed by some participants in this research who commented that there was an over-reliance on medication to treat symptoms of, for example, anxiety or depression, but that the cause of these were not adequately addressed’.

The All-Party Parliamentary Group on Sexual Violence (2018, p11) also criticised current approaches to commissioning, stating: 'The increased focus on a medicalised and clinical response... This push towards the medical model is despite evidence that victims and survivors benefit most from independent, community-based, long-term and non-medicalised services'.

Commissioners must ensure that the safest, most effective services are provided for victims and survivors of SVA, and that ineffective, or even harmful pathways are not established. One-size-fits-all approaches to commissioning that reflect and reinforce the clinical hierarchy for support must end and we call on commissioners to instead fund RCCs to provide specialist, child-centred services which seek to empower CYP in their recovery from CRaSA.



I have suffered sexual abuse and other abuse through childhood and adult life too. I was neglected as a child and ended up in the care system and was failed by so many adults that should have protected me. For years I have fought daily with what at the time was undiagnosed complex PTSD and what [Rape Crisis Centre] has given to me is a priceless treasure of acceptance. An ability to understand myself and how what has happened has affected me at a core level. I have gone from strength-to-strength, learning to understand my own core values and what I had locked inside. I faced demons that have haunted me and freed myself from the grip they held and now have a whip to keep them at bay. I stand taller, I think deeper and I breathe easier. I feel safer inside myself and found a peace that I have never had... What the NHS could offer was basic help that was not specialised enough to deal with what I have going on. I never felt safe to fully open up and trust them and was just medicated. I am grateful for that and understand the NHS limits, but what [Rape Crisis Centre] have given me flies above what the NHS could give.

(Adult survivor of CRaSA after receiving specialist sexual violence counselling and group support, East of England)

E. Rape Crisis Centres are for life

It is rare for a victim or survivor to be 'fixed' or 'healed' after receiving a fixed number of sessions of support. This is the case irrespective of whether that support is accessed through a specialist or generic service, because the fact is that rebuilding lives in the aftermath of SVA is a non-linear and often ongoing process. The language of 'recovery' is also problematic, since it infers that life can go back to how it was prior to SVA, which fails to capture the typically life-changing nature of SVA. Whilst many victims and survivors will feel able to exit therapy at a certain time, different things will come up in their lives which may mean that they may need to re-access support.

Since child victims and survivors of CRaSA have experienced trauma at an early age, it is not unusual for them to want to access support later in their

lives, whether that be later in their childhood, or in adulthood. A benefit to accessing support through an RCC is that a Centre will be there to support victims and survivors at every stage in life, with specialist staff on hand who understand how SVA, in particular CRaSA, impacts on people, and can surface at different times across the lifespan. Several Centres we interviewed spoke about CYP returning to their services years later and the benefits that can have for a young person's sense of safety:

"It's not that you've been in the service, you can't come back... Because we understand that at different stages, there's going to be different things that need to be adapted and supported for that young person to be able to go through that time period in their life. And I think that that's a really amazing thing that we can do for them... It just works doesn't it?... But articulating that... to the powers that be... it's so hard". (Rape Crisis Centre in North East)

“What we do find with children... is that they will... come back. And it's rarely ever a one-off because as they go through different life stages, you know, you've got your first boyfriend, you've got your first relationship or what whatever it is, we will often have them coming back and... that doesn't tend to be recognised anywhere”. (Rape Crisis Centre in West England)

Some young people may even be actively accessing support when they turn 18 and officially enter 'adulthood'. If this support is being accessed through a service such as CAMHS, the support will likely be ended and that young person will have to seek alternative support with an adult mental health service. One victim/survivor of CRaSA interviewed by IICSA (2020, p54) spoke about this abrupt ending of support and how they were not even told where to find an adult service that would be right for them:

“You know [after finishing with the Child and Adolescent Mental Health Service] I would've liked – even a referral or told about an adult service to go to. It was literally just, 'you're done now. You're going to have to find out if you need someone else', kind of thing”.

The transition from youth to adult services is known to be a difficult period for young people. The Government's CSA Commissioning Framework states: 'It is important for commissioners to note that the transition from youth to adult services can be an extremely vulnerable time, as the entitlement to, and availability of, a range of statutory support services, changes significantly in a short space of time. Commissioners should consider what is best for the individual when considering the transition' (Home Office, 2019, p20). Clearly the best thing for young victims and survivors would be to remove the need for a transition altogether and for RCCs to be resourced appropriately to offer this as an option, with the added benefit of being staffed by professionals who are knowledgeable about how CRaSA impacts people at different ages and stages in life.

Conclusion

Arguably one of the most significant reports on the subject of CRaSA ever to have been published in the UK, the final ICCSA report – published almost two years ago – recommended that:

“...the UK government and the Welsh Government introduce a **national guarantee** that child victims of sexual abuse will be offered **specialist** and accredited therapeutic support. There should be **sufficient supply** of these services so that children in all parts of England and Wales can access support in a **timely** way. These services should be **fully funded**... There must be no **eligibility criteria** for children to access these specialist therapeutic services other than having been a victim of child sexual abuse”. (Emphasis added)

It is a damning indictment of the last ten years of commissioning and policy work, that children who have experienced CRaSA still do not have access to universally available, specialist, and survivor-centred support in England and Wales.

In the (then) Government's May 2023 response to the above recommendation, a commitment was made to ‘elicit views on the future of therapeutic support, through extensive engagement and consultation’ (HM Government, 2023). This is yet to happen.

Commitments were also made to place a new duty on PCCs, local authorities, and ICBs to collaborate when commissioning; commission the Centre of Expertise on Child Sexual Abuse to map existing specialist CRaSA support to support commission-

ers; and work with NHS England to introduce new access and waiting time standards for mental health services. However, none of these commitments will increase the provision of specialist CRaSA support.

Whilst the last Government ‘worked’ on these goals, they stated that holistic support was available for CYP who have experienced CRaSA, and their families, through such programmes as ‘Supporting Families’, which is delivered by the Department for Levelling Up, Housing and Communities. But this is not anything like a specialist CRaSA support service, which is what IICSA's recommendation called for. Indeed, CRaSA is not even mentioned in the ‘Supporting Families’ objectives guidance, which states that the programme is aimed primarily at supporting ‘vulnerable’ families to prevent escalation into statutory services and the removal of children into care (Department for Education and Department for Levelling Up, Housing and Communities, 2022).

As we have set out in this report, the other main sources of support for CYP victims and survivors of CRaSA – CAMHS and generic CYP services – are not well suited to many victims and survivors, who have experienced a specific kind of trauma which can permeate all aspects of their lives, well into adulthood. We submit that CYP victims and survivors benefit most from the support of specialist SVA services, and the feedback from victims and survivors supports this. RCCs are already offering this support in many areas and would relish the opportunity to expand existing services and create new offers of support, if they had the necessary funding.



When I first came to see you I felt alone, I had closed down completely. Now I have a group of people who I know will listen and understand. Thank you for giving me the courage to reach out.

(Survivor aged 15, who accessed specialist SVA counselling with an RCC in the East of England)

There can be little doubt that the comprehensive commissioning and resourcing of specialist support for survivors of CRaSA is urgently required. There is ample evidence demonstrating the importance of specialist support services, including the findings of the National Institute for Health Research's recent study into the contribution of the voluntary sector to mental health crisis care. The findings identify that the voluntary sector is crucial in any mental health response, plugging gaps in provision of statutory care, and providing a 'longer-term holistic...compassionate and human' alternative to the poor quality sometimes found in non-voluntary crisis care services (Newbigging et al., 2020).

RCCs are flexible, agile, and offer holistic, survivor-centred support. They do not unnecessarily restrict eligibility for CYP who wish to access their services. The staff employed by RCCs are experts in their field and work to a child-centred empowerment model, which has numerous benefits for victims and survivors – not least the avoidance of pathologising CYP. Finally, RCCs are there wherever and whenever they are needed, across the lifespan, supporting CYP and adults, and removing the need for transition between CYP and adult services. RCCs can see how CRaSA impacts on individuals at different stages of their lives, and can be there to support them throughout.

We make recommendations below regarding the upskilling of statutory and generic services that support CYP, in recognition that there is not currently an RCC in every area of England and Wales. However, where possible we make the case in this report for the relevant commissioners to come together and fund accredited RCCs to support CYP who have experienced CRaSA, as we do not believe statutory/generic services are best placed to support victims and survivors of CRaSA.

Specialist SVA voluntary sector services are perennially at risk within the funding landscape. They are often undercut by general support services who can compete on cost but not on meeting survivors' needs. However, we argue that commissioning generic services creates a false economy. Although the short-term costs may be lower than some specialist services, service users will often need to go on to access specialist services for longer-term and more specialist support, which understands their needs, as set out by one specialist SVA service provider who provided evidence to the All-Party Parliamentary Group on Domestic and Sexual Violence Inquiry (2015), below:

"The women we work with need support and what commissioners need to understand is that we need these specialist services. To provide a gender-specific, mental health service costs more, but in the long-term they're going to save because if you provide a generalist service, it doesn't meet the needs of women and you could have women in the long-term who resort to substance misuse and whose mental health gets worse." (2015, p29)

We make recommendations for change, below.

Recommendations

To Government (all relevant Departments):

1. **Introduce a national guarantee that child victims and survivors of Child Rape and Sexual Abuse (CRaSA) will be able to access fully funded specialist therapeutic support.** As per IICSA's (2022) recommendation, there should be sufficient supply of specialist therapeutic support services so that children in all parts of England and Wales can access support in a timely way. These services should be fully funded by Government and there must be no eligibility criteria for children to access these specialist therapeutic services other than having experienced CRaSA. There should be no cap on the duration that support is available for. The benefits of providing specialist sexual violence and abuse support for victims and survivors of CRaSA, rather than statutory/generic support are set out in the body of this report.
2. **Publish an enforceable National Statement of Expectations which clarifies and simplifies the responsibilities of all commissioners with regards to the commissioning of specialist therapeutic support for young victims and survivors of CRaSA.** As set out in the body of this report, the commissioning responsibilities and remits of various local and national commissioners, namely NHS England, Integrated Care Boards, Local Authorities, Police and Crime Commissioners and the Ministry of Justice, often overlap and are unclear when it comes to therapeutic support services for young victims and survivors of CRaSA (see Home Office, 2019, p35). This translates into a postcode lottery of specialist support being available, particularly in terms of the standard and specialism of those services across England and Wales. The Government should review the current responsibilities of each commissioner and ensure that they are clear and that where necessary, commissioners have the tools required to work together to exercise their responsibilities in ensuring a specialist support offer for children and young people impacted by CRaSA. The Government should publish a National Statement of Expectations which clearly details those responsibilities and details how commissioners can be held accountable.
3. **Appoint a Sexual Violence and Abuse Commissioner to oversee the commissioning of specialist therapeutic support for young victims and survivors of CRaSA.** As per recommendation 2, the current commissioning landscape for CRaSA support services is confusing and ineffective. Unfortunately not all commissioners understand or fulfill their responsibilities. We recommend the appointment of a Sexual Violence and Abuse Commissioner with oversight of the commissioning landscape, to ensure that all children and young people who have experienced CRaSA can access specialist support in a timely fashion. This will be aided by the creation of an enforceable National Statement of Expectations, as per recommendation 2. The Commissioner should also have oversight of the commissioning landscape for adult victims and survivors of CRaSA.

To the Home Office:

4. **Review and amend the existing 'Tackling Child Sexual Abuse Strategy' (2021) to ensure that there are clear links to the wider cross-Governmental VAWG Strategy and that all forms of CRaSA are considered.** As set out in the body of this report, we are concerned at the decoupling of CRaSA from the broader VAWG agenda. CRaSA is a devastatingly common experience for young girls, yet this does not seem to be reflected in the 2021 'Tackling Child Sexual Abuse Strategy', which also largely focuses on Child Sexual Exploitation, to the detriment of all other forms of CRaSA, such as familial sexual abuse. We recommend that the Home Office review their strategy in light of these observations and make efforts to align work on CRaSA with VAWG more broadly. Rape Crisis England & Wales would be pleased to assist in this exercise.

To the Ministry of Justice:

5. **Urgently commit to extending and recommissioning the Rape and Sexual Abuse Support Fund (RASASF) past March 2025.** At the time of publication, funding awarded to Rape Crisis Centres (RCCs) under the MoJ Rape and Sexual Abuse Support Fund (RASASF) ends in March 2025, and the new Government have made no commitment to extend or recommission this Fund, which provides vital core funding for many RCCs to provide specialist therapeutic support to both children and adult survivors of CRaSA. RCCs continue to face precarious short-term funding cycles despite the huge demand for their services. We need the Ministry of Justice to urgently confirm the extension of current funding arrangements post March-2025 and the recommissioning of this Fund in the future. When recommissioning, the MoJ should ensure that there is adequate funding to meet the demand on specialist SVA services and that multi-year funding grants are awarded (as previously committed to), to ensure the sustainability of the sector.

To NHS England:

6. Ensure that all professionals working with children and young people – particularly those working in Child and Adolescent Mental Health Services (CAMHS) – receive comprehensive and frequent training on how to identify and respond to the impact and signs of sexual violence and abuse.

Whilst we believe that young victims and survivors of CRaSA should be offered specialist support through services such as Rape Crisis Centres, we acknowledge that at present there is a lack of such services in some areas, and that some children and young people will inevitably come into contact with, or be offered support through, statutory services such as CAMHS. In those instances, it is essential that the professionals they encounter are able to properly identify the signs of CRaSA, and effectively respond to their trauma.

We recommend that NHS England commission training for all CAMHS professionals from specialist services, such as Rape Crisis Centres, to ensure that all children and young people are met with an empathetic and professional response, not only in the therapeutic support sessions they are offered, but by these statutory services as a whole – for example, in their access criteria and penalties for ‘non-engagement’.

7. Immediately and proactively engage with responsibilities for commissioning support services for children and young people who have experienced CRaSA. As set out in the Home Office’s (2010) Commissioning Framework, there are two commissioners with responsibility for commissioning sexual violence and abuse support services in the health sector – NHS England and Integrated Care Boards (ICBs). Whilst NHS England fund Sexual Assault Referral Centres (SARCs), their responsibilities for commissioning ‘long term mental health services’ for CRaSA survivors is inconsistent. Meanwhile, engagement from ICBs in commissioning CRaSA support is minimal, if at all existent, in most areas of England. We call on NHS England and ICBs to immediately engage with the specialist sexual violence and abuse sector, and other commissioners, to realise their responsibilities in this area, and work together to improve the support available to children and young people affected by CRaSA.

8. Immediately publish the contact details of all relevant health commissioners across England and Wales.

As set out in recommendation 7, there has been minimal, if any, engagement from health commissioners when it comes to funding specialist sexual violence and abuse support. Indeed, staff from Rape Crisis Centres (as well as others in the VAWG sector) and other commissioners report that they are unable to even get in contact with the relevant health commissioners in their area, since they cannot access the correct contact details. We therefore recommend that NHS England and ICBs publish the contact details of all relevant professionals so that external stakeholders are able to contact them. This will help to ensure proper transparency and due process with regards to health bodies’ commissioning responsibilities.

9. Ensure that there are adequate, fully funded, pathways from generic/statutory mental health services into specialist sexual violence and abuse services, for children and young people who have experienced CRaSA.

As set out in this report, we believe that specialist sexual violence and abuse services, such as Rape Crisis centres, are best placed to support children and young people who have experienced CRaSA, and their families. Whilst we acknowledge that there is a need for statutory/generic support for children and young people in some areas, this is not the most appropriate option of support for large numbers of children. We recommend that NHS England work to ensure that there are seamless and fully funded pathways into specialist services, to ensure that all young victims and survivors of CRaSA can access specialist support to recover from the specific trauma caused by CRaSA. In this report, Rape Crisis centres and CAMHS professionals alike detail how specialist services, such as Rape Crisis centres, are best placed to support these victims and survivors, and how statutory services such as CAMHS already refer many CRaSA victims and survivors into specialist services, without any funding attached to the referrals, or any official referral pathway. NHS England should review the situation and formalise these pathways, with accompanying funding for specialist third sector services, who are currently struggling to keep up with demand on current budgets. We also ask that pathways into specialist services are built into any Young Futures hubs in the future, as proposed by the new Government in the 2024 King’s Speech debate (Hansard HC Deb., 19 July 2024, col.180).

To the Department of Health:

10. Commission an independent review of CAMHS treatment of victims and survivors of CRaSA and publish the findings in a public report. Update these findings each year, in an annual publication.

A review will assist the public's understanding of how CRaSA victims and survivors are supported by CAMHS. A review should include data on referrals for children and young people who have experienced CRaSA; demographics; co-existing risk/vulnerability factors; the support offered; cases where support is denied and why; waiting list volume and average waits; referral sources; onward referrals to other services, including specialist sexual violence and abuse services; feedback from service-users and their families; and feedback from CAMHS staff about their confidence and ability to support CRaSA victims and survivors.

To all commissioners of CRaSA support services (NHS England, ICBs, PCCs, Local Authorities and the Ministry of Justice):

11. End over-reliance on clinical models of support for victims and survivors of CRaSA.

a) Commissioners should challenge the hierarchy of provision which favours clinical models of support, and recognise the specialist sexual violence therapeutic work carried out by Rape Crisis centres, which is rooted in acknowledging trauma. Historically there has been a clear preference among commissioners to prioritise and fund sexual violence and abuse services which are linked to criminal justice processes, clearly demonstrated by the high level of funding provided to SARCs. Whilst SARCs play an important role for some victims and survivors, they typically provide a short-term forensic intervention for a minority of survivors, in comparison to specialist and longer-term sexual violence and abuse counselling services such as those provided by Rape Crisis centres. Yet the latter receive a fraction of the funding.

The deference to medicalised models of response and intervention among many commissioners has created a significant barrier for specialist sexual violence and abuse organisations seeking funding. This is because organisations such as Rape Crisis centres take an approach which recognises the specificity of trauma caused by sexual violence and abuse, and includes the social context for (and root causes of) sexual violence and abuse, rather than dealing exclusively with effect, or 'symptoms' of it – a process which is often experienced as pathologising and re-traumatising for survivors. Commissioners should move away from clinical models of support for victims and survivors of sexual violence and abuse and recognise the immense benefits of the trauma-informed approaches of specialist services.

b) Commissioners should immediately cease the imposition on specialist services of outcomes frameworks that are not suitable for those who have trauma as a result of sexual violence and abuse.

Specialist services are better placed to ascertain what outcomes are meaningful for victims and survivors. Commissioners should work with service providers to agree on meaningful baseline and follow-up measurements to understand survivor-focused outcomes within services, where required.

To the Department for Education:

12. Prioritise the prevention of sexual violence and abuse in schools and other education settings.

To prevent and respond to sexual violence and abuse, the Government should commit to strategic investment in all schools and higher education settings. Specialist Rape Crisis services should receive funding to conduct training and consultancy and other support for staff and students to contribute to the prevention of sexual violence and abuse, and ensure high quality and relevant RSHE/RSE delivery. Prevention is the only way to reduce the need for specialist sexual violence and abuse support services, for both children and adults.

13. Ensure that there is an established and fully funded pathway into specialist support services for victims and survivors of CRaSA who access mental health support in schools.

This recommendation is particularly pertinent given the recent Government commitment to provide access to specialist mental health professionals in every school (Hansard HC Deb., 19 July 2024, col 137). The source of mental health issues for many young women and girls is an experience of CRaSA and this must be acknowledged through the establishment of the establishment of pathways into specialist support.

Acknowledgements

Our sincere thanks to the incredible staff in the ten Rape Crisis Centres who contributed their time, insights, and expertise to this research.

We are hugely grateful to the victims and survivors who shared their feedback with the Rape Crisis Centres that supported them, and allowed us to include their words in our report.

Our special thanks to Viv Gordon, for giving us her permission to share her very powerful poem within the report.

We are truly indebted to Sheila Coates MBE, for her unwavering commitment to the Rape Crisis movement, and for her relentless focus on bringing about change for child rape and sexual abuse survivors.

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Rape Crisis England & Wales
October 2024

Rape Crisis England & Wales (RCEW) is a
Charitable Incorporated Organisation (CIO),
charity number: 1155140

