Making childhood sexual abuse visible in public services

– learning from Leeds

(the Visible project)

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EXECUTIVE SUMMARY

The Visible project is a Leeds-based initiative which aims to support improvements in service responses to adults with a history of child sexual abuse, by acting as a catalyst to change in statutory bodies and third sector organisations across the city. It is hosted by the Leeds Women's Counselling and Therapy Service. Funding granted by the Lloyds Bank Foundation for two years from May 2017-April 2019 included an amount for an independent evaluation so that other areas might learn from its experience. This paper presents the key learnings from that evaluation.

The widespread prevalence of child sexual abuse and its impacts on adult mental health are well-established by research. Recently increased recognition means the project sits amidst many parallel developments - it is timely and has been widely welcomed. Growing interest also in broader frames such as ACEs (adverse childhood experiences) and trauma informed care for contextualising mental health problems have informed the project's work.

The project employed a Project Manager for three days a week and contracted an independent organisation specialising in supporting service user involvement, Leeds Involving People (LIP). Three networks – Strategic (for decision-makers in key organisations), Organisational (for managers in a wider range of organisations), Frontline (for practitioners) – and a service user involvement group were initially set up. The **organisational network** met only once, after which the needs of organisations were addressed by developing a policy statement that all could sign up to, with resources to support each in working out their own approach to it available on a website. **Training events for frontline practitioners** were held four times in the first year and were very positively evaluated, including by experienced people who valued the space to share experiences and reflect on their work. Thereafter it was thought a better use of resources to develop online training sessions which could be shared within organisations and/or teams. Practitioners also need ongoing reflective spaces to sustain both good practice and their own well-being in this complex and sensitive work, which requires professional judgement and carries a risk of vicarious trauma.

Flexibility from the funders enabled the project to adapt to changing priorities in a fast moving environment and focus where most effect would be gained. The **sensitivity of the subject** and its relevance to many of those involved or who encounter it makes this work 'really tricky' - constant attention is needed to building and maintaining healthy relationships and supporting self-care.

There has been a strong commitment to **service user involvement** throughout the project - space has been made for the voices of those with lived experience of child sexual abuse and of services in all contexts. New insights on what needs to change have been offered this way, and it has a particular impact on professionals to hear direct from those with lived experience. Support for those service users involved is vital. The contract with LIP gave a committed and skilled worker the sufficient time (initially 10 hours a week, increased to 13) to offer opportunities to input in whatever way works for each person along with effective support to ensure they are not left more vulnerable by doing so, and to maintain channels of communication with the wider project. This has enabled most service users involved to have a largely positive experience as well as to influence the project and wider developments. A group meeting was held monthly and became a significant source of support for those who attended, though many of those involved were engaged in other ways. Recruiting service users diverse across gender and ethnicity has been challenging (most are white women). Some progress has been made however, and outreach work was also undertaken to raise awareness with and elicit views from other groups (e.g. the Bangladeshi community, refugees and asylum-seekers, people who self-harm). The relationship between the group and the wider project (including its representation on the Steering group) developed over time, and required attention to

the project's 'duty of care', to the mechanisms of influence and to making meetings safe for service users' participation. The support worker role is a challenging one – group dynamics can be complex and highly charged, and different and changing needs and expectations have to be managed. Where to draw the line around the project's duty of care is often unclear. A support worker in this kind of role needs sufficient support and supervision herself.

The Strategic steering group also met throughout and continues. Membership of this group was the key mechanism of influence in the Visible project acting as a catalyst to system change across Leeds. Members were carefully chosen – people committed to change, decision-makers with influence and/or in the right roles, e.g. safeguarding. Statutory stakeholders represented were Leeds City Council, Leeds York Partnership Foundation Trust, NHS Leeds Clinical Commissioning Group, and Leeds Teaching Hospital Trust, IAPT and the Police. Four voluntary organisations, working with sex workers, people with drug and alcohol problems, people in mental health crisis and service users more broadly were also represented, along with Forum Central who are the collective voice for the health and social care third sector in Leeds. A high level of commitment was sustained throughout.

Meetings were held at two monthly intervals, over lunchtime with a break for food, respite from the intensity of the issues and networking. Members were at different starting points in relation to the issues, but they shared high aspirations for change across the city and commitment has been maintained by ensuring they were learning something from attending meetings that they were able to apply in their own organisations to further that goal. Their learning has been from those with lived experience of child sexual abuse whose views were represented by the LIP support worker and who increasingly contributed directly themselves to meetings, from recent documents and other resources circulated before the meeting and summarised at the meeting by the Project Manager, from specialist input to meetings (regarding e.g. trauma-informed working, the needs of deaf service users) and from each other. In the second year, developing a short one-page policy statement which a range of different organisations could sign up to to demonstrate a commitment to responding appropriately to adults with experience of child sexual abuse became a key focus of the Steering group's work and there was further learning in the negotiations required to agree this. Members were able to pass on their learning in their organisations in a range of ways.

Over the two years, progress was reported towards the Visible project's aims in all the local organisations represented, both statutory and voluntary. Changes included rethinking assessments, new trainings and/or resources for training, revising commissioning protocols, adding in awareness of vicarious trauma to staff well-being policies, ensuring links to specialist online resources (see below) were made known, adding links to relevant resources to organisational and departmental websites, making other resources available (e.g. in a public health resources centre) and making the Visible project itself visible in city wide policy. The pace of change is inevitably slow though often faster in small voluntary organisations.

The policy statement is now available on the Visible website, along with supporting documents. Its development offered an opportunity for collaboration across and discussion within organisations, and for input from service users, and its agreement within 10 months was a significant achievement. It remains to be seen what it will mean in practice - some form of monitoring is needed to ensure real change.

Online resources - self-help pages were developed with input from the Reference group and added to MindWell (a Leeds online mental health website) and MindMate (for young people). A Visible website was developed with many links to local, regional, UK and international resources. These have been well received, and ongoing publicity will be needed to ensure they are used.

Recommendations

For those wishing to follow the example of Leeds, there is a section on the Visible website with the steps followed in Leeds and some basic tips, 'Setting up Visible in your area', at the link below:

https://visibleproject.org.uk/1628-2/

Further recommendations from the evaluation include the need:

- to ensure the work is informed by all relevant knowledge and parallel developments,
- to maintain a culture of ongoing reflection and learning,
- to nurture networks to learn together and support their members' commitment to change,
- to give time to building the relationships which are at the heart of the capacity for change,
- for awareness of diversity and its implications,
- for sufficient support for service users involved and for their supporter(s),
- to maintain the flexibility and adaptability to respond to a fast changing environment,
- to develop systems of accountability for commitments made to policy change and ensure publicity is ongoing for online resources,
- to educate existing services and to develop further services.

MAKING CHILDHOOD SEXUAL ABUSE VISIBLE IN ADULT SERVICES – LEARNING FROM LEEDS

(THE VISIBLE PROJECT)

In 2015 Leeds Women's Counselling and Therapy Service held a workshop for people across the city interested in the impacts of child sexual abuse on adult mental health and in what Leeds could do to improve its response. The day brought together professionals, people with lived experience of sexual abuse and those who are both, to discuss the issues, share experiences and start a process of change for which the Visible Project later became the frame. Seed funding of £24,000 from Leeds NHS Clinical Commissioning Group (CCG) in 2016 enabled initial activity to start and supported the seeking of further funding. A grant of £99,000 was awarded by the Lloyds Bank Foundation under their *Transform: Domestic and Sexual Abuse* programme for two years from May 2017-April 2019. The name of Visible was adopted after the LBF funding began. The Visible Project's aim is to support improvements in services' responses to adults who have experienced child sexual abuse, and to support statutory bodies and third sector organisations in developing relevant policies and best practices.

The LBF grant included funding for an evaluation so that other areas might learn from the experience of Leeds. The evaluation was designed so that the project would also learn from its findings as it developed, with surveys and interviews conducted at three points, beginning, middle and end of the two years, and feedback on all meetings and events gathered throughout. It was primarily qualitative though some quantitative measures were included. Further details of the methodology are given at the end. This paper summarises the key learnings from this evaluation for those who wish to pursue similar aims in other areas.

At the end of the two-year development period covered by the LBF grant and this evaluation, the Visible project was officially launched in June 2019, alongside an article by Yvonne Roberts in The Observer on its work published 9.6.19, and a public commitment by Leeds City Council to responding appropriately to adults with experience of childhood sexual abuse. It continues with some further funding from LBF and Leeds NHS CCG to cover the next nine months. An application is in to the National Lottery Community Fund for more to develop further service user involvement activity, peer support and work with grassroots organisations. Further sources of funding are being explored to support strategic lobbying work and responding to queries from other areas.

Background

The widespread prevalence of child sexual abuse (CSA) and its impacts on adult mental health are well-established by research (see e.g. NSPCC, 2018 and note 1 at the end of this document). Historically there has been much resistance to the recognition of child sexual abuse (see e.g. Olafson et al, 1993) and a medical model of mental illness has prevailed but there is growing recognition of the need to pay attention to the role life experiences play in mental health problems (since e.g. Department of Health, 2002). National initiatives in England, Wales and Scotland are addressing the needs of adults with histories of child sexual abuse (CSA) amongst other forms of violence and abuse and/or more broadly of trauma (NHS England, 2018; NHS Education for Scotland, 2017; Welsh Government, 2017). Other parallel developments include the Independent Inquiry into Child Sexual Abuse established in 2014 which is investigating past and ongoing organisational failures to protect children and Operation Hydrant which is coordinating police investigations into non-recent cases across the UK. The Centre of Expertise on Child Sexual Abuse was established in 2017 and is actively producing useful research. Public awareness has also increased since the Savile case erupted in 2012, and media interest continues high both in child sexual abuse (e.g. in the Catholic church, in

sport) and other forms of abuse and violence (e.g. the Me Too movement, domestic violence). The Visible project's goal of raising awareness of child sexual abuse (making it visible) and acting as a catalyst to system change across Leeds (where a link to the Jimmy Savile case gives added motivation to change and a commitment has been made to developing a compassionate city for all its citizens) is therefore very timely and has been widely welcomed.

Child sexual abuse has been a focus for activism and research since the 1980s (and before) and for several other inquiries preceding the Savile case. The current definition is given in the government guidance, *Working Together to Safeguard Children* (HM Government, 2018) – see note 2 – and is broader than formerly. Definitions change as new forms of harm are recognised and should always be treated as provisional. In addition, it is not always clear to people in what ways child sexual abuse causes harm and it is important to understand its particular dynamics in order to avoid as far as possible repeating them in service responses and hence re-traumatising people (Hooper & Koprowska, 2000). Aswell as the physical injuries involved for some, child sexual abuse commonly leaves a psychic legacy reflecting dynamics of intrusion, betrayal of trust (both by the perpetrator and often by others to whom the child turns for help), powerlessness/captivity (children are often unable to escape contact with the perpetrator), traumatic sexualisation, stigma and isolation, secrecy/silencing (children may be threatened with further harm to themselves or others they love if they tell anyone) and terror (Herman, 1994; Browne & Finkelhor, 2000). The emotions evoked may overwhelm a child's capacity and lasting impacts can affect all aspects of a person's life via their effect on relationships (in personal life, education, work, friendships, and the wider community), mediated partly by physiological responses to trauma (van der Kolk, 2015).

Child sexual abuse is also one amongst other adverse childhood experiences and its impacts may be affected not only by the form, nature and duration of the abuse and the child's relationship with the perpetrator but by its context in the person's broader life experience, in particular the presence or absence of non-abusive relationships and other experiences that contribute to resilience in childhood and adult life. There is growing interest in broader frames for contextualising adult mental health problems – in ACEs (adverse childhood experiences), MACEs (multiple adverse childhood experiences) and TIC (trauma informed care), all of which are informing the Visible project's work. Resilience and healing are also realities and it should not be assumed that all those with a history of child sexual abuse necessarily need help at all times.

The project

The Visible project is hosted by the Leeds Women's Counselling and Therapy Service, which offers a central and easily accessible base in Leeds, and a supportive and informed environment for the work. As an established organisation concerned with women and girls' mental health it has a strong motivation to address the issue of child sexual abuse given its high prevalence amongst women and girls. Boys and men are also sexually abused however, if less often, and a separation has had to be maintained between the project and its host organisation in order not to obscure that.

A project manager has been employed for three days a week throughout the two years. The initial structure of the project involved three networks – Strategic (for decision-makers in key organisations), Organisational (for managers in a wider range of organisations) and Frontline (for practitioners) – and a service user involvement group, each discussed further below. In the first year much of the project manager's time was spent organising events – a launch and three training events for frontline practitioners, a launch event for organisations, and Strategic steering group meetings, at first three-monthly and then two-monthly. The Organisational network was quickly discontinued and after the first year further training was also dropped, and in the second year her

work focussed mainly on coordinating the Strategic steering group, overseeing the development of a policy statement, developing a website and liaising with the service user group. The project has worked in a fast-moving environment in terms of policy developments nationally, and has also needed to adapt to the priorities of individuals, groups and local organisations as they were identified. Continual listening and openness to learning has been required and flexibility from the funders has allowed for intended outcomes to change several times to be responsive to a complex and constantly changing environment.

A team approach has been central and the composition of the project team in terms of experience, skills, networks and reputation has been important. The core team were the Director (CEO of LWCTS), the project manager, the support worker for service users (based at Leeds Involving People) and the Chair of the Strategic Steering Group (the Commissioning Manager for Adult Social Care at LCC), with an evaluator affiliated to York University. It has been helpful that both the Chair of the Steering group and the Director of the project are widely known and influential in the city. There have been some boundary issues about responsibilities within the team and clarification might have been helpful earlier on, as might more time spent learning from the literature for those with less experience in the field of child sexual abuse. This is enormously sensitive territory – many of those involved in the project in all ways have lived experience of abuse themselves and the emotional impacts of the subject may also affect everyone involved. Recognition that there are personal journeys involved for many in working on this issue is crucial and some difficult dynamics and resistance to change are to be expected. People may or may not speak about their own histories (and this should always be a matter of choice for the individual concerned). The 'really trickiness' of the work was an early learning of the project, requiring constant attention to building and maintaining healthy relationships, the ability to accept difficulties without taking them personally and the creation of as much space as possible for flexibility so that people could withdraw from or reduce their involvement when they needed to for their own self-care.

Service user involvement

There was a strong commitment from the beginning to the involvement of adults with experience of child sexual abuse themselves, to inform all aspects of the project's work. Some became involved at the initial workshop before funding was applied for. Once the grant was awarded, Leeds Involving People (LIP) were contracted to work with them and develop a wider group of people with lived experience to consult, and to support those thus engaged to influence the project. Leeds Involving People are an independent organisation specialising in enabling and empowering service users who want to influence health, social care and other services to do so by sharing their experience and expressing their views. They recognise that people need support to do this, especially when they are already vulnerable, and that to offer this entails building and maintaining relationships with them. LIP were contracted initially to give 10 hours a week to the Visible project, increased as the demands on the role grew to 12 and then 13 hours a week. Over the two years of the evaluation the membership of the group has fluctuated as people came and went, for a range of reasons, but for most of the time there have been 12 or 13 people on the database (14 at maximum) and 8-10 actively involved. 29 have been involved in all. Two-thirds of the group at the time of initial survey had been involved in similar groups before – i.e. it was quite an experienced group in terms of service user involvement, and diverse in many ways though not initially in gender or ethnicity, it was mostly white women. The group was given the somewhat cumbersome name of Child Sexual Abuse Leadership Reference Group, commonly shortened to the Reference group. There were of course many others involved in the project who had lived experience of childhood sexual abuse, including most of those in core team.

A key focus of the Reference group's work has been a monthly group meeting. These have been held every month except August, when in the first year a social event took place instead and in the second there was a break as many people were unable to attend anyway. Attendance has ranged from 4 to 9 with an average of 5 to 6 in the first year and 4 to 5 in the second year. While the numbers attending may seem low, members do not attend meetings for a range of reasons, including their own changing health and other commitments, or because of knowing members from other settings which make it inappropriate to do so. From the researcher's observations it was a good number for maintaining a safe and supportive atmosphere for those who attended. Motivations for participation vary and are often mixed – with a few joining primarily for their own benefit/recovery by sharing experiences and reducing isolation and more doing so to improve services for others and have their voices heard and respected in that process. Those who don't attend group meetings have been engaged in other ways – the worker tried to contact everyone on the list by phone or email each week, to keep in touch and gain people's input, though not everyone responded each time. By and large this approach, supplemented with one to one meetings, has worked well - the majority of members of the group who have completed questionnaires for the evaluation have reported their experience as mainly positive at each point (5 out of 9 in the first survey, all 3 respondents in the second, 8 out of 9 in the final survey). The overall sense in the final survey was of a safe space, where people felt their experiences could be shared and were heard, where they felt supported and for participating in which they have come to feel less alone personally and able to make something positive of their experience by knowing they are contributing to helping others.

To a large extent this positive experience was attributable to the support worker. It took some time to find the right worker for the group – by the middle of the project, there had been five since the group began, three within the Visible project, the previous ones having left fairly quickly. It is a challenging and demanding role. The dynamics of the group can be complex and difficult to manage – members who attend value feeling less alone with their histories of trauma and being able to contribute to change on behalf of others but differences and the conflict they generate are highly charged with issues of power and powerlessness, difficult memories and emotions are sometimes triggered, and trust is hard to build and maintain. As trust grew with the worker who stayed, expectations also changed and though the group began with a focus on the work on behalf of others, as members began to share more of their own experience, at times it was necessarily a support group for members. For the worker, this made it 'like quicksand', with the need to adjust to constantly shifting needs and goals, and individuals positioned differently from each other and changing over time. Managing expectations was a continual challenge. The demands on the worker were intensified by the lack of other services available – a lot of her time was spent supporting individuals, signposting/referring them on to other services and attempting to find them the help they needed elsewhere. They were also a product of the trust she built with members, they opened up to her and it took time to respond with appropriate care. In the first year 2-4 hours per week were spent on one to one contact and/or meetings – by the end of the second year it took more than half of a 13 hour working week

It was clearly important to the group that the worker who stayed (who received wholly and enthusiastically positive feedback) shared some of their experiences. That she identified as a survivor of abuse herself helped to replace an 'us and them' situation with a 'we' relationship, reducing the risk of the group feeling 'othered' and hence reinforcing the stigma they are already familiar with. There is more to how she related to the group than sharing the experience of sexual abuse however – her approach was characterised more by shared humanity ('we're all human'/'we all have baggage') informed by an insider understanding of the dynamics of abuse, and a strong

commitment to the goals of the project combined with an ability not to take difficult dynamics personally, to recognise that they were the effect of people's histories. She was both reflective about her own practice and realistic about the process ('erratic is the best you can expect'), and able to offer the flexibility and reliability required to maintain engagement. Though there were clearly benefits to the group of the worker sharing a history of trauma, it also increases the risks of the work impacting on her well-being, as difficult memories and feelings are sometimes triggered for her. The trust she built and the demands that placed on her made her vulnerable to overwhelm and/or burnout, as well as vicarious trauma (as anyone in this role would be) - support for someone in this kind of role is vital.

It has remained unclear throughout where the line should be drawn around the project's 'duty of care'. How far should the support worker go in meeting participants needs for support? At times she has been in daily contact with a member in crisis, and several have had regular one to one meetings with her (from twice a week to monthly). Views have differed about the extent of the worker's responsibility but service changes in Leeds and the impacts of austerity have intensified the vulnerability of some members and hence the demands on the worker of offering a supportive relationship. In effect she is often filling a gap by acting as Care Coordinator and more to some members of the group.

The relationship between the group and the wider project has developed over time. It is to be expected that a group of adults with histories of child sexual abuse will have particular sensitivities about power and powerlessness, being heard with respect and valued for their experience or being used as a means to an end, and about inclusion and exclusion. These issues deserve to be taken very seriously to ensure that as far as possible involvement in such a project contributes to participants' well-being rather than causing further harm, i.e. that service user involvement is both effective and ethical, but trust inevitably takes time to build. Feedback from the group early on indicated that some members felt the Reference group was 'off to the side', their involvement not appropriately valued or appreciated, and that decision-making, power and ownership were not sufficiently shared such that abusive dynamics were sometimes unwittingly replicated. In response to this it was made clearer that the project had a duty of care to those involved as service users (though as described above, the boundaries of it remain unclear) and the mechanisms of influence were explicitly strengthened. Visits to Reference group meetings were made by the Chair of the Steering group, the Director and the Project Manager, monthly meetings took place between the Project Manager and the LIP support worker, and there were increased opportunities for members of the Reference group to attend Steering group meetings. This seemed largely to solve the problem – in the midway and final survey most respondents were satisfied that the group were influencing the wider project - although two long-standing members of the group left when conflicts of interest arose which could not be resolved.

The representation of the group's views at the Steering group has also evolved over time. The support worker attends and feeds in the group's views and activities on their behalf, and members of the group are invited to attend but most choose not to. Understandably most found it daunting to go into a group of professionals who are strangers to them, to whom their history is instantly exposed by their status as representatives of the group and uncertain of what will be asked of them and what they will have to say. By the end of the second year participation was working well however – with two members who wanted to going regularly and contributing their input directly across the agenda, the Chair making efforts to make meetings safe for them to participate in (e.g. ensuring language used was accessible, avoiding jargon and acronyms) and much appreciation from the Steering Group for their input.

The Reference group was initially all white women, and it remained mostly so throughout though they differed across education, literacy and professional status. Efforts were made to engage men and BAME groups to ensure a wider representation of views and experiences with some success. In the second year two men were engaged and one remains involved. The quite challenging task of introducing men to a group of women with histories of child sexual abuse (who may have fears specific to men) was accomplished successfully, with benefits to all involved. Dependent on timing and support for all members, a co-gender group can offer potential for reparative experiences with the other sex in a safe environment and for challenging gender stereotypes (e.g. the construction of women as victims and men as perpetrators which may reflect a past reality but distort a present one, see Hooper & Warwick, 2006).

Three BAME women were also contacted. One was both a service user and mental health worker who was unable to attend the group owing to work commitments but gave her input individually. The second came forward after meeting the support worker through another project – a year after first being told about the Visible project - and the third was introduced by the second. Neither gave any input – the first because she had not used services herself and therefore felt unable to give feedback, the second because she made contact on behalf of her daughter and family circumstances then interfered with finding the right time for a conversation with her about the Visible project. The building of relationships and trust necessary to engage new members around this issue is slow work which cannot be hurried. It may also be that cultural differences mitigate against widening participation to certain groups in this kind of service user involvement. As well as a lack of recognition of child sexual abuse in some communities, and barriers to service use such as the impacts of shame and stigma, and perceived or experienced discrimination, Reavey et al (2006) argue that the Western understanding of selfhood which underpins attention to the individual's need for help is not necessarily shared by South Asian women. In relation to BAME communities, the addition of interventions at the cultural level (e.g. via the mosque) should be considered as priorities alongside engaging individuals.

Outreach work to raise awareness with other groups was also undertaken, and focus groups conducted in visits to the Asha project (working with the Bangladeshi community), Meeting Point (with refugees and asylum seekers) and Battle Scars (with people who self-harm). This helped to inform the project with a wider range of experiences and needs.

The activities of the Reference group have been wide-ranging, including

- preparing input on their experience of services for Adult social care commissioning, a primary care mental health services consultation, an IAPT consultation, a meeting with the Victims Commissioner Baroness Newlove, a Visible seminar for local commissioners
- developing training scenarios, and reviewing the draft training modules developed by the Visible project (see Frontline practitioners below)
- reviewing and giving feedback on the Highland policy and drafts of the Visible policy statement (see policy statement below)
- contributing to the development of the MindWell site (see online resources below)
- formulating aspirational 'I statements' relevant to experience of child sexual abuse based on Together We Can statements coproduced with mental health service users to be used to evaluate services across Leeds
- generating thoughts on the costs of inadequate care, after which a member gave a presentation to the LYPFT Board on this informed by her own experience
- brainstorming ideas for a public education campaign
- reviewing and generating comments for the website

It was also agreed early on that there would be a social event every three months for members of the group to thank them for their involvement – these have offered new and positive experiences and helped to build supportive relationships within the group.

The group have been keen to participate in training, to influence professionals directly by sharing their experiences in that way. Trainings are increasingly coproduced with service users and there are opportunities but it also requires care to ensure that people are sufficiently prepared and supported for the situation they are in which will inevitably be unpredictable in some ways (in terms e.g. of what participants say). In a somewhat similar situation, members of the Reference group were invited to speak to an extended meeting of the Steering group with larger than usual attendance but did not in the end feel comfortable doing so to this bigger group. Other ways could be found to draw on service users' experiences to inform and educate service providers about good practice and the needs of specific groups such as refugees and asylum-seekers, e.g. through a 'Learning from Service Users' section on the website.

Overall, service user involvement has been very important to the Visible project – those with experience of child sexual abuse and of services can offer new insights on what needs to change, and it has a particular impact on professionals to hear directly from those with lived experience. The project has made space for their voices in all contexts and although the numbers involved or attending events are often small, even one person's voice can make a difference. It is also important to bear in mind the uniqueness and diversity of experience, and to draw on evidence from research as well to contextualise the input of what is inevitably not a representative group. Attention to support for those involved is vital and involvement has been a largely positive experience for members because, after some early failures, the support worker had the skills, commitment, flexibility and humanity to make it work. The monthly group structure has worked well in the second year thanks to her support, and in the process it has become a significant, at times vital, source of support for some members too. This raises issues about the boundaries of the worker's role and about managing an ending or reduced availability as funding changes. Offering support and opportunities to give input in whatever way works for each person, and maintaining channels of communication with the wider project too, i.e. creating a real experience of inclusion, takes considerable time. It may be that if sufficient time is not available, other areas may wish to consider alternative models e.g. a three monthly meeting to avoid raising expectations which cannot be met.

Strategic Steering Group

A Strategic Steering Group was formed at the beginning of the Visible project with representatives from the statutory and voluntary sector across Leeds. Membership of this group was the key mechanism of influence in pursuing the aim of acting as a catalyst to system change, and both the organisations involved and their representatives were carefully chosen - people committed to change, decision-makers with influence and/or in the right roles e.g. safeguarding. The number of departments/organisations represented has grown somewhat over the life of the project but has been deliberately limited to allow space for all to contribute in meetings. Statutory stakeholders represented include Leeds City Council (Adult Social Care, Mental Health and Public Health), Leeds and York Partnership Foundation Trust (LYPFT) (Psychiatry, Personality Disorders and Mental Health Integrated Teams), NHS Leeds CCG (Maternity Commissioning and Contracts/Procurement), Police (Safeguarding Office of West Yorkshire Police and Crime Commission), Leeds Teaching Hospital Trust (Safeguarding Office) and IAPT. Four key voluntary organisations (Leeds Survivor Led Crisis Service, Basis which works with sex workers, Forward Leeds which works with people with drug and alcohol addiction problems, and Leeds Involving People who support the Survivor Reference Group) were also represented as well as Forum Central who are the collective voice for the health and social care

third sector in Leeds. Representatives were able to appoint deputies to attend when they could not, and a high level of commitment has been sustained, with an average of 11 members (excluding the Director and Project Manager) attending meetings across the two years.

Levels of awareness and experience of the issues varied widely within the group at the beginning, with local pockets of expertise both within the voluntary and statutory sector represented along with those relatively new to the issues such as the police. Members shared high aspirations for change across the city however, and a strong commitment to hearing the voices of those with lived experience in the process, and motivation has been maintained by their commitment to improvement in service responses and because members were learning something from attending meetings that they were able to apply in their own organisations, i.e. the group helped them to achieve that shared goal. In exchange for their involvement, members were offered opportunities to learn and to network/make connections, a good lunch, and in the second year the prospect of 'tangible outputs' (a policy statement and website). Individual representatives have sometimes changed but all organisations have stayed involved, and members have gained some inspiration and greater understanding from each other (including of their different organisations' roles and perspectives) as well as from the input to meetings, and have been able to pass on their learning in their own organisations. At the end of each meeting members of the group were asked to complete feedback forms, offering them a space to reflect on the meeting and to report what they had found helpful and unhelpful, and any next steps they had identified for themselves. The most common themes in next steps were i) sharing and discussing information/their learning with others in their organisations, ii) further networking and iii) in the second year actions relating to the policy statement (which offered another focus for raising awareness and negotiations within their organisations).

Meetings have been held at two monthly intervals – the initial plan was to make them three monthly but more often was felt to be needed to maintain momentum. They are held over lunchtime (12-2), with a break for food which helps to pace them, offering respite from the intensity of working on this issue and a space for informal networking, and at a central location easy to access for all. At the beginning the group agreed its terms of reference and the focus of the project on system change (to act as a catalyst to service development across the city), and on health and well-being or public health not only mental health. During the first year or so, someone with specialist expertise offered input at each meeting (on trauma-informed working, the needs of deaf people with experience of sexual abuse, working with groups of survivors, working with sex workers, developments in routine enquiry) from which the group learnt together. Later, in the second year, the focus shifted towards agreeing a policy statement that all organisations in the city could be invited to sign up to, and participants continued to learn from discussions over that task and from their exchanges about developments in their own organisations and institutional contexts. Throughout the two years the project manager has given updates to the group on recent developments, local and national, at these meetings, and summarised key documents published, and in the second year the NHS Scotland's short video on Trauma Informed Practice was shown for discussion. (A full list of the resources shared with the group is given in Appendix 2.) The Visible website was also shared for the group's feedback before its public launch. Each meeting (except the extended meeting described below which had a different structure) has also included an update on the work of and input from the Reference group. All the elements of the meetings described above were reported as helpful in feedback forms, with very little reported as unhelpful.

The Project Manager has sent out emails two weeks before the meetings to all on the group list, with agenda, minutes of previous meetings and links to any recent policy documents and relevant

resources. Those not able to attend were still able to read the documents and to spread the word in their organisations by passing on the links. An extended meeting (10-3) was held early in the second year, which offered the opportunity to review participants' own organisations progress so far, sharing ideas and experience more fully than in a regular meeting, and to participate in reflections on the Visible project so far and planning for the next three years - this attracted higher attendance than average, both from within the group list and beyond it (further voluntary organisations were invited). A separate half day seminar for Commissioners was also held in the second year, which reached a wider group than those represented on the Steering Group, where research evidence and input from the Reference group were presented to inform and influence them, a resource pack given for them to take away, and space offered for learning, reflection and networking. At the end of this, all participants agreed that commissioning practice was likely to change.

Over the two years, progress towards the Visible project's aims was reported in all the local organisations represented on the Steering group, both statutory and voluntary, and also in commissioning practice in LCC, LYPFT and NHS Leeds CCG. The Visible project was not the sole influence on such changes of course but its timeliness (sitting amidst e.g. growing awareness of the role of trauma in mental health issues and increased reporting of historic cases of child sexual abuse to the police) enabled it to contribute to momentum and inform and influence developments. Changes included rethinking assessments to pay more attention to all aspects of trauma (including CSA within broader attention to ACEs or trauma), new trainings and/or resources for training on trauma-informed working, incorporating specific attention to child sexual abuse and monitoring of service provider responses in commissioning protocols, raising awareness of vicarious trauma in staff well-being policies, ensuring the link to the MindWell resource (see online resources below) is widely known (by advertising it to service users and/or embedding it in assessment and crisis planning tools), making other links circulated by the Visible project (including the Scottish video on trauma informed practice and the Visible website itself) available on departmental or organisational websites, and making other resources available (e.g. a Safe to Say DVD *Time to Respond* about child sexual abuse and postnatal depression was launched with representatives of maternity and mental health services and then placed in a public health resource centre for anyone to use). The Visible project and its aims were also incorporated into City wide policy from early on with a mention in the Mental Health Needs Assessment of 2017 and again in a report on the State of Women's Health Leeds 2019 in which all services were recommended to sign up to the Visible policy statement. Negotiations over signup further contributed to ongoing discussions and raising of awareness in all the organisations represented on the Steering group, and some collaborations between organisations were also generated through the networking opportunities the Steering group created.

The pace of change has inevitably varied. Increased understanding of the needs of people with experience of child sexual abuse and improved awareness of best practice amongst staff was reported in all the voluntary organisations represented on the Steering group. Small organisations can gain the commitment of all staff more easily and hence move faster. Large organisations necessarily change slowly and a representative of Leeds NHS CCG offered her learning as the need 'to protect time for this work - taking small steps is good and leads to bigger change'. Other activities of the project staff team have also influenced developments locally and more widely, e.g. the project lead delivered training to nurses on trauma informed practice, the project manager linked up people beginning to develop trauma informed strategies city wide in Leeds and Bradford and gave input based on local experience to the Home Office as they developed a framework to support all commissioners of support services for victims and survivors of CSA.

Organisational network

A meeting was held early in the first year for representatives of organisations in management roles (neither strategic nor frontline). A questionnaire circulated there found there was a wide range of awareness of best practice amongst them, and that on a number of key issues identified as good practice, practice was very variable in their organisations. Getting 'organisational signup' for change was identified as a key need, and this was pursued in the second year by the development of a policy statement for Leeds that all organisations are now encouraged to sign up to (see below), with a website to support implementation offering links to training resources, guidance on good practice, relevant services and networks. The Steering group took the lead on the policy statement and the project manager on the website, and no further meetings of the organisational network were arranged. A fundraising workshop was offered in the second year but cancelled due to insufficient takeup – it may be that organisations already had the experience in fundraising they felt they needed, or other demands on their time precluded interest.

Frontline practitioners

Development needs identified by participants at the launch of the Frontline network were as follows: increased awareness of needs and appropriate responses, training (including on opening up conversations, working with perpetrators who were also victims), information (including on available services, good practice, prevention) and partnership (especially with deaf organisations and specialist services). In the first year, three training events were offered, the first on vicarious trauma and self-care, and the second and third on 'Making it Safe to Say' (i.e. opening up and managing conversations with adults about experiences of child sexual abuse). The training events were attended by between 48 and 52 participants, coming fairly evenly from the statutory and third sectors. Representatives of 20 voluntary organisations attended one or more of these, with participants working with women, sex workers, victims/survivors of crime/sexual violence, those at risk of offending/offenders/ex-offenders, homeless people, people in crisis/with mental health issues, deaf people, survivors of torture, sex offenders, people with drug and alcohol problems, and more broadly with community well-being needs.

These events were all very positively evaluated with the sense from the feedback that they were addressing a much needed gap in bringing together practitioners from different organisations and offering them space to share and reflect on their experience, with input to extend their knowledge of the field, and skilled facilitation and support to build confidence in their practice. A question was asked on the feedback form about what could have been better to which the most common response overall was 'more time' (most left this blank). In the final workshop the most common response was more on the 'next step' – i.e. how to support people after they have disclosed child sexual abuse. Participants were also asked if they had identified any next steps for themselves by the end of the workshop, and many said sharing their learning with others, suggesting the impacts would ripple out.

Towards the end of the year a questionnaire was circulated to all those who had been involved in frontline events. The response rate was low (16%) but of those who replied the majority said their participation had made a difference to their practice since, and some also noted changes in their organisations' responses to adults with a history of CSA and in their support for staff. There were also many barriers to carrying forward the learning into practice mentioned, including capacity (time and/or resource constraints), lack of awareness or readiness to be trauma informed within their organisations, and remembering what they had learnt. Several had appreciated the opportunity to

continue discussions afterwards, either in supervision or with other members of their team who had also attended.

Many participants wanted further training, with priorities including how to support people through recovery, and diversity issues. However, a decision was made not to continue training events of this kind in the second year owing to the demands such events place on time and resources, and the recognition that those trained may leave their jobs so that unless training is embedded into organisational practice on a regular basis, gains are unlikely to be sustained. Overstretched organisations are also often reluctant to release workers for training. Instead two one-hour trainings were developed, with input from Sara Scott and the survivor reference group, that are now available online as PowerPoint presentations with facilitator notes, to be worked through within organisations and/or teams – one entitled 'Why ask about violence and abuse in the context of mental health?', the second on 'Responding well to adults disclosing non-recent child sexual abuse'.

While online resources enable more people to access training and its repetition as necessary, it is worth noting that many people came to training workshops rating their awareness of impacts and good practice as good already and nevertheless very much valued the opportunity to share experiences with others. This is complex and sensitive work, where practitioners are at risk of vicarious trauma and professional judgement is essential, and they should feel supported themselves to do it. As well as online training materials and links to other resources (see online resources below), consideration needs to be given to ensuring practitioners have ongoing reflective spaces, within their teams, through supervision and/or through peer group support across organisations.

Agreeing a policy statement

Developing, or influencing the development of, a citywide policy for Leeds was a key activity of the project from the start. Early on, examples of policies from other areas were circulated and discussed as possible models with particular interest shown in the Highland policy. Consultation with key informants on the development of that policy in Scotland revealed however that it had not been widely implemented and in retrospect was considered too prescriptive and too detailed to fit the widely varying organisations to which it was relevant. Something much simpler was recommended – a policy statement which a range of different organisations could sign up to to demonstrate a commitment to responding appropriately to adults with experience of child sexual abuse, leaving them free to work out for themselves how best they could do this. This approach was supported by senior management at LCC and a subgroup of the Steering group was formed to draft such a statement.

Initial discussions focused on who the policy statement would be for, how it might be used, what impact it could have and what its status would be (policy, guidance or 'best practice'). Drafts were presented to the Steering Group for discussion and taken back to members' own organisations for further discussion and the Reference group were consulted throughout for their input. There was considerable discussion of how to make the statement accessible to all in its language, with the emphasis on using plain language. It took ten months from the first meeting to agree a policy statement. The statement agreed recognises that both service users and employees of the organisation may still be suffering the impact of experiences of child sexual abuse. It is available on the Visible website, along with a briefing document and an Action Planning Resource which lists issues for organisations to consider as they work out how to make their commitment a reality in their particular context, to consider what they as an organisation can do to address the issue.

The process of developing the statement itself was valuable, offering an opportunity to network and collaborate on a shared commitment to change to a group of interested professionals and stakeholders across sectors (members of the Steering Group), and an opportunity to contribute and influence that commitment to the reference group. In the first few months, four statutory organisations (LCC, LYPFT, NHS Leeds CCG and LTHT) and five others (WCTS, LSLCS, Leeds Women's Aid, Leeds Forward, and the Just for Women Centre) signed up. Unsurprisingly the early adopters have been largely those organisations represented on the Steering group but commitment is beginning to spread more widely and other organisations are in a process of consultation. Questions remain about what this commitment will mean in practice, i.e. how organisations will implement it, and as yet no way of holding organisations accountable has been developed. A monitoring system will be needed to ensure signup means real change and more guidance to help organisations consider what is appropriate in different contexts may also be helpful (a separate paper on routine enquiry is in preparation).

The development of online resources

Early in the project, an online resource for adults with experience of child sexual abuse and those working with them was developed, with the input of the Survivor Reference Group. The pages were attached to a Leeds online mental health website called MindWell, and went live in July 2017 – see MindWell-leeds.org.uk/myself/feeling-unwell/someone-hurt-or-abused-me-as-a-child – and usage has been monitored. The pages were also linked to MindMate (for young people) in July 2018 and have been embedded in tools for assessment and crisis planning at LYPFT. Feedback received on the site has all been positive though there was some further work to do on the routing early on to ensure ease of access. Usage has fluctuated however – influenced partly by publicity given to the site in the media – and although use of the self-help pages has increased somewhat, it remains fairly low (especially the pages for professionals). Continual efforts are made to publicise the resource by distributing cards at all meetings, and the LTHT Safeguarding Team have cards to hand out when needed.

In the second year, much of the Project Manager's time was spent planning, designing and developing a website for the Visible project itself, with the help of communications support from the funders, a web designer and a copywriter. The website has sections 'About Visible', 'The facts' (covering the scale of child sexual abuse, consequences and impacts, and survivors' views'), 'Taking action', where the Policy Statement and supporting documents can be found and organisations can sign up, and with further subsections on Equipping Organisations (with local, regional, UK and international resources) and Equipping Staff (with training resources) and 'Useful Links' with a list of national organisations and useful research. The website is at https://visibleproject.org.uk

These resources are available to all regardless of location of course. For those developing web-based resources elsewhere however, issues that arose in the Visible project that may be pertinent were the need for sensitivity to the impact of the subject on all involved including the web designer and copywriter, and for careful thought about language (e.g. members of the Reference group expressed a preference for 'people who have experienced child sexual abuse' rather than 'survivors', since the former recognises that people are more than their experience of abuse and does not make of it an identity).

Concluding comments

This paper has set out the key learnings from the Visible project's first two years for other areas who might wish to pursue similar aims. Visible is a small project with ambitious aims – its potential for

impact depends a great deal on its timeliness, that it sits amidst parallel developments with similar intent, and can inform, connect, add momentum to change and help to equip others going in the same direction. At national level, the IICSA's Truth Project and the Centre for Expertise on Child Sexual Abuse have offered valuable resources, and growing interest in ACEs, MACEs and trauma-informed care, both locally and across the country, has informed and continues to support its work. A new diagnosis of childhood trauma was officially added to the ICD-11 (international classification of diseases) in May 2019 which it is expected to take three years for all countries to integrate into their policies, adding a further layer of recognition. Media interest continues high, and towards the end of the two years development period focused on the project itself, which added motivation and momentum where change was already under way. Other areas wishing to do something similar should be able to make use of this context too, and other emerging movements such as that promoting compassionate mental health (see www.compassionatementalhealth.co.uk) to open doors.

Change takes time, the pace varying in different contexts - there are very different starting points in different communities, for example, as well as for individuals - and there is still sometimes resistance. Managing expectations has been a constant challenge, entailing careful listening to the needs, capacities and hopes of different individuals and organisations throughout, and the flexibility to adapt the project's focus as necessary to balance attention to them all within an ever-changing environment. Progress has been made, and it is clear that a small number of people in the right positions can make a significant difference quite quickly, with change under way in all the organisations represented on the Steering group. The recognition that good working relationships were important to facilitate the work has been important, and flexibility from the funders enabled extra help to be bought in when needed (for communications support to develop a website). The role of Leeds Involving People and of a committed and skilled worker with sufficient time to offer effective support has been central in enabling service user involvement which has been both effective and ethical, offering a largely positive experience to most of those involved as well as many insights and contributions to developments within and beyond the project. The online resources developed – MindWell and the Visible website – have been well received, though ongoing efforts will be needed to publicise them to ensure they are used. The agreement of a policy statement for the City represents a significant achievement of collaboration – the next step is to ensure that it becomes embedded in real cultural change in the organisations who sign up to it and that there is some means of monitoring its implementation in practice. The Strategic steering group is to continue meeting so will have space to address these issues.

There are also some very real challenges in working on this issue in the current environment. The focus on childhood sexual abuse rather than the broader frames of trauma or ACEs was driven by the funding programme – while it has some benefits in highlighting an issue which has often been lost sight of in the past, the single focus can also obscure some of the complexities of trauma which may have multiple roots and this should always be borne in mind. The sensitivity of the subject of child sexual abuse and its emotional impact affects everyone involved, with or without personal experience, entailing a need for care and sensitivity in meetings of every kind. There have been recurring concerns about opening up the issue with service users and raising expectations without sufficient help to offer – with perhaps only online self-help resources and a place on a waiting list for counselling or therapy available, at least in the short term. The impacts of austerity on service users' lives and on service provision (which may include limiting the capacity of organisations to absorb and embed new learning e.g. on trauma informed practice, as well as service provision) both constrain and may counterbalance the efforts of such a project to improve service responses and hence service users' well-being. If people are not to be left more vulnerable when they are encouraged to

speak about painful experiences, what is on offer, in terms both of service availability and quality, requires serious consideration. The necessary education of services clearly has a good way further to go in Leeds. During the time of the evaluation, local CMHT services were restructured in ways which increased some service users' distress, suggesting a lack of awareness of or lack of attention or priority to good practice in relation to managing change and handling endings with vulnerable people some of whom lack other support. There have also been concerns about when and how widely asking questions about childhood sexual abuse is consistent with promoting adult well-being. A separate paper with reflections on routine enquiry addresses this issue, but current thinking on trauma suggests there are some risks to extending this practice beyond mental health assessments, although a caring and compassionate response to those troubled or in distress is clearly desirable in all contexts.

Recommendations

The relevance of childhood sexual abuse to adult life is a complex issue and public services are complex environments. There are no simple solutions. Improvements in awareness, approaches and availability of help are all possible and urgently needed however. For those wishing to follow the example of Leeds in its aim of improving service responses, across both statutory and voluntary sectors, there is a section on the Visible website with the steps followed there and some basic tips, 'Setting up Visible in your area', at the link below:

https://visibleproject.org.uk/1628-2/

This covers establishing a group of adults with histories of childhood sexual abuse to consult and ensuring they are well supported, securing the support/initial leadership of (a) local influencer(s), fundraising for start-up money, holding a workshop to bring together interested parties, establishing a Strategic Steering Group including representatives of relevant statutory and voluntary organisations who can network and learn together and also promote change within their own organisations, looking out for opportunities to 'piggyback' awareness-raising of the impacts of childhood sexual abuse on adult life onto existing or emerging initiatives, projects and campaigns, engaging with large organisations in relation to the prevalence of childhood sexual abuse both amongst their workforce and their service users, and sharing knowledge and resources to inform and equip organisations and their staff whilst also bearing in mind the constraints within which they work.

Further recommendations from the independent evaluation are as follows:

Work on this issue should be informed by what is known about the prevalence of child sexual abuse (which means there are likely to be people with personal experience of it in all contexts), by an understanding of its impacts and its dynamics which create particular sensitivities (care is needed to avoid repetition and/or re-traumatisation as far as possible), and the potential for vicarious trauma amongst those who work with the issue and need for self-care. Understandings should be informed by wider frames for contextualising mental health problems such as adverse childhood experiences and trauma informed care – sexual abuse is often accompanied by other forms of abuse or neglect in childhood, and other adverse experiences both then and in later life may affect its impacts.

A culture of ongoing reflection and openness to learning should be developed and maintained – knowledge and thinking are evolving all the time and individual experiences are also unique, heterogeneous and influenced by specific life contexts. Practitioners need both training input and ongoing reflective spaces to manage the sensitivity and impacts of the work and the uncertainty associated with it, and to develop their practice.

Establishing networks is an essential starting point – they need then to be nurtured with attention to process, and opportunities for shared learning, including of the different perspectives and experiences within them, and for cocreation, so as to develop shared understandings and support the commitment of their members to promoting and enabling change in their own organisations and beyond.

Relationships are at the heart of building the capacity for change. Time needs to be given to building and maintaining trust in all working relationships – within a project team, within a Strategic Steering Group, between a project/Steering group and a service user group, within a service user group, between a support worker and a group/ individual service users, and between a project team and those in the wider service environment. The emotional impact of the subject of child sexual abuse can affect everyone – with or without personal experience – care and sufficient flexibility to allow for self-care are needed to maintain the commitment and well-being of those who work on this issue. Activities such as developing a local policy statement and online resources offer opportunities for participation, collaboration and discussion which are valuable in themselves for building relationships.

An awareness of diversity should inform all aspects of the work. Childhood sexual abuse occurs across genders, class and communities, although there are significantly higher prevalence rates amongst women than men. To ensure developments are informed by the full range of service user experience requires establishing and supporting a group of service users, taking time to build trust with those underrepresented in it to widen participation, attention to managing change and diversity within the group, outreach work with groups unlikely to participate (e.g. refugees and asylum-seekers), and consultation of relevant research. Cultural level interventions should also be considered e.g. at a mosque, to contribute to developing individuals' ability to speak of their experiences where it may be constrained.

Where service user involvement is extensive, the support required to make it ethical as well, i.e. to ensure that as far as possible those involved are not left more vulnerable by their participation, may be considerable - where to draw the line around the support offered is a question that requires ongoing attention. The role of a support worker is a demanding one and support and supervision for the supporter(s) is vital. Care needs also to be taken with language and process in meetings attended by service users to maximise the potential for them to have a positive experience of inclusion and minimise the risk of re-traumatisation.

Public services and policy interest in child sexual abuse are fast changing environments. Attention to different and shifting local needs and agendas, and flexibility and adaptability are needed to focus efforts and mobilise resources for maximum impact. While change in large organisations with large workforces is inevitably slow, a small group of committed people can make some difference quite quickly even in these contexts by naming the issue, sharing resources and promoting discussion. Small actions that reach across organisations, e.g. a separate event for commissioners, or for representatives of maternity services, offering information, resources and space to reflect on its implications, are also a quick way to sow the seeds of change.

Systems of accountability need to be developed to ensure 'organisational sign-up' to a policy leads to real change. Publicity needs to be ongoing (by e.g. embedding links in assessment systems) to ensure online resources are used.

Attention to the education of existing services in good practice and the development of further services are essential to promote service users' well-being.

Notes

1. Prevalence rates vary widely, affected by methods of research, definitions of abuse and questions asked, but a recent overview of the best evidence currently available concluded that some 15% of girls/young women and 5% of boys/young men experience some form of sexual abuse before the age of 16, including abuse by adults and peers (Kelly & Karsna, 2017/18). Much higher prevalence rates are commonly found in populations such as psychiatric patients, young and adult offenders (especially girls/women), homeless young people, sex workers and those with drug and alcohol problems.
2. The current definitions of child sexual abuse and child sexual exploitation are as follows:
   'Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.'
   'Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.' (HM Government, 2018, p103)

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Kelly L & Karsna K (2017/18), *Measuring the scale and changing nature of child sexual abuse and child sexual exploitation: Scoping report*, Centre of Expertise on Child Sexual Abuse/London Metropolitan University

NHS England (2018), Strategic Direction for Sexual Assault and Abuse Services – Lifelong care for victims and survivors: 2018-2023

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Van der Kolk B (2015), *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma,* Penguin

Welsh Government (2017), *Delivery of 'Ask and Act': the role of the frontline practitioner*

Appendices

1. Evaluation methodology

The evaluation methodology comprised the following:

- at the beginning of the project questionnaires were circulated to members of the Strategic Steering Group (completed by 14), the Organisational Network (by 18), the Frontline Network (by 30) and the Child Sexual Abuse Leadership Reference group (by 9)
- at the midway point further questionnaires were circulated to members of the Strategic Steering Group (completed by 10), the Frontline Network (by 23) and the Reference group (by 3). Eight telephone interviews were also conducted, with the three paid staff (the two based at Leeds WCTS and the LIP worker), the chair of the Strategic Group and four other members of that group who volunteered
- towards the end of the project, a final questionnaire was sent to the Strategic Steering Group (completed by 8) and to the Reference group (by 9). Further telephone interviews were conducted with the three paid staff, the chair of the Steering group and a representative from LYPFT.

Attendance registers, summaries of feedback from all meetings/events, and minutes of all Steering group meetings, quarterly reports from LIP and google analytics for the MindWell site were also reviewed. The researcher's observations from attending six Steering group meetings, three frontline events and two meetings of the Reference group further informed the analysis.

2 : Resources to which links were circulated to members of the Strategic Steering Group May 2017-March 2019

Publications:

Agenda Women's Mental Health Taskforce Report (2018)

Agenda and AVA (Against Violence and Abuse), Breaking down the Barriers (2019)

British Psychological Society, The Power Threat Meaning Framework (January 2018)

Centre of Expertise on Child Sexual Abuse (K Kaur and C Christie), Local commissioning of services addressing child sexual abuse and exploitation in England: a rapid review incorporating findings from five locations (2018)

Centre of Expertise on Child Sexual Abuse (D McNeish and S Scott), Key messages from research on child sexual abuse: on intra-familial CSA (June 2018)

Ending Violence against Women and Girls Strategy: 2016 to 2020

Independent Inquiry into Child Sexual Abuse Interim Report (2018) (and link to Victim and Survivor Voices from the Truth Project video)

Lancet article about childhood trauma

http://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30104-4/fulltext

Mental Health Australia on a Trauma Informed Approach – https://mhaustralia.org/general/trauma-informed-practice

Mental Health Coordinating Council (Wales) – Trauma-Informed Care and Practice Organisational Toolkit (TICPOT)

NHS Education for Scotland, Transforming Psychological Trauma: a Knowledge and Skills Framework for the Scottish Workforce (2018)

NHS Education for Scotland – The Scottish Psychological Trauma and Adversity Training Plan 2018

NHS England report: Strategic Direction for Sexual Assault and Abuse Services – Lifelong care for victims and survivors: 2018-2023

NSPCC Report, Child Abuse and Neglect in the UK today, Sept 2018

One Small Thing Initiative – Becoming Trauma Informed Tool Kit for Women's Community Service (2017/18)

Trauma Informed Practice for the Workforce animation (8 mins)

Victims Strategy 2018

Welsh Government, Ask and Act Training Resource

Websites:

Centre of Expertise on Child Sexual Abuse: https://www.csacentre.org.uk

Independent Inquiry into Child Sexual Abuse: https://www.iicsa.org.uk

Responding effectively to violence and abuse (REVA project): www.natcen.ac.uk/our-research/research/responding-effectively-to-long-term-consequences-of-violence-and-abuse

3. Further useful books

Extensive further links to online resources are now available on the Visible website. Some books on childhood sexual abuse and adult mental health which could be useful to develop workplace library resources are listed below:

Ainscough C & Toon K (2000), *Breaking free: help for survivors of child sexual abuse*, Sheldon Press

Bifulco A & Moran P (1998), *Wednesday's child: research into women's experience of neglect and abuse in childhood and adult depression*, Routledge

Cameron C (2000), *Resolving childhood trauma. A long-term study of abuse survivors*, Sage

Durham A (2003), *Young men surviving child sexual abuse: research stories and lessons for therapeutic practice*, Wiley

Herman J (1994), *Trauma and Recovery*, Pandora

Joseph S & Linley PA (2008), *Trauma, Recovery and Growth*, Wiley

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