

Exploring the need for a widely adopted  
and accessible public health framework  
to address child sexual abuse in the UK

Pat Branigan  
Churchill Fellow 2020



The logo for the NSPCC (National Society for the Prevention of Child Abuse and Neglect), featuring the letters "NSPCC" in a green, sans-serif font, centered within a light gray square.

*“Imagine a childhood disease that affects one in five girls and one in seven boys before they reach the age of eighteen; a disease that can cause erratic behaviour and even severe conduct disorder among those exposed; a disease that can have profound implications for an individual’s future health by increasing the risk of substance abuse, sexually transmitted diseases and suicidal behaviour; a disease that replicates itself by causing some of its victims to expose future generations to its debilitating effects.*

*Imagine what we, as a society would do if such a disease existed. We would spare no expense. We would invest heavily in basic and applied research. We would devise systems to identify those affected and provide services to treat them. We would develop and broadly implement prevention campaigns to protect our children. Wouldn’t we?*

*Such a disease does exist – it is called child sexual abuse.”*

**James A Mercy, Center for Disease Control and Prevention, Atlanta, US**

Pat Branigan is an Assistant Director at the NSPCC. He has had a diverse career – he’s a medical anthropologist with a background in public health. When based at the London School of Hygiene & Tropical Medicine his specialism was research into sensitive health topics and he led the development of national HIV and sexual health campaigns, harm reduction work in HM prisons and national and international illicit drugs research including the development of ‘Talk to Frank’ with the Home Office. In 2016 he co-authored the national operational Harmful sexual behaviour framework (revised in 2019) and has since published a range of training packages for primary and secondary schools as well as the health workforce in how to manage incidents of harmful sexual behaviour. Pat is now responsible for leading on key elements of the NSPCC’s Together for Childhood 10-year place-based initiative to prevent child sexual abuse.

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## Acknowledgements

Prof Jennie G. Noll  
The Ken Young Family Professor for  
Healthy Children  
Department of Human Development  
and Family Studies  
Director, Child Maltreatment  
Solutions Network  
PI, NICHD P50 Capstone Center for  
Healthy Children  
The Pennsylvania State University

Prof Elizabeth J. Letourneau  
Interim Chair and Professor,  
Department of Mental Health  
Director, Moore Center for the  
Prevention of Child Sexual Abuse  
Johns Hopkins Bloomberg School of  
Public Health

Prof Michael Seto  
Director at the Royal Ottawa  
Health Care Group, Ottawa

Kimberley Ducato  
Director of Operations and  
Administration  
Center for Safe and Healthy Children  
The Pennsylvania State University

Dr Amanda E. Ruzicka, MA  
Senior Research Associate,  
Mental Health Faculty  
Deputy Director, Moore Center for  
the Prevention of Child Sexual Abuse  
Bloomberg School of Public Health  
Johns Hopkins University

Jon Brown  
Director of Strategic  
Partnerships, Barnardo's

Dr Brian Allen, PsyD  
Director of Mental Health Services  
Center for the Protection of Children  
Penn State Children's Hospital  
Associate Professor of Paediatrics,  
and Psychiatry and Behavioural  
Health  
The Pennsylvania State College of  
Medicine Hershey, PA

Dr Luciana C. Assini-Meytin, PhD  
Assistant Scientist, Department of  
Mental Health  
Deputy Director, Moore Center  
for the Prevention of Child Sexual  
Abuse  
Johns Hopkins Bloomberg School of  
Public Health

Prof Simon Hackett  
Professor of Child Abuse and  
Neglect, and Deputy Provost,  
Durham University

Sanjiv Bhattacharya  
British investigative journalist, based  
in Los Angeles, California

Dr Rebecca L. Fix  
Assistant Scientist, Department of  
Mental Health  
Deputy Director, Moore Center  
for the Prevention of Child Sexual  
Abuse  
Bloomberg School of Public Health  
Johns Hopkins University

Prof Chad E. Shenk  
Associate Professor of Human  
Development and Family  
Studies, Department of  
Paediatrics, and Psychiatry and  
Behavioural Health, The  
Pennsylvania State University

## Abbreviations/glossary

**ATSA** – Association for the Treatment and Prevention of Sexual Abuse. An international, multi-disciplinary organisation dedicated to making society safer by preventing sexual abuse

**CDC** – Centre for Disease Control (Atlanta, USA)

**CEOP** – Child Exploitation Online Protection (a law enforcement agency), led by the National Crime Agency (NCA), throughout the UK and overseas. It identifies risks and threats to children from online activity and aims to bring offenders to account

**CSA** – child 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.’* (Working Together to Safeguard Children, 2018)

**CSE** – child sexual exploitation. *‘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)

**HSB** – harmful sexual behaviour. *‘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 and/or be abusive towards another child, young person or adult.’* (Derived from Hackett, 2014)

**IICSA** – Independent Inquiry into Sexual Abuse. The Independent Inquiry into Child Sexual Abuse published 19 reports on 15 investigations covering a wide range of institutions. The Inquiry published its final Report in October 2022. The Report makes a number of powerful recommendations, based on separate investigations and a unique body of research. It also includes the voices of victims and survivors of child sexual abuse

**Intrafamilial child sexual abuse** – *‘Intra-familial child sexual abuse refers to child sexual abuse (CSA) that occurs within a family environment. Perpetrators may or may not be related to the child. The key consideration is whether the abuser feels like family from the child’s point of view.’* (Centre of Expertise on Child Sexual Abuse, 2018)

**NCA** – National Crime Agency

**NOTA** – National Organisation for the Treatment of Abuse. It changed its name and registration in 2019 to reflect its focus upon prevention; previously it was the National Organisation for the Treatment of Abusers

**NSPCC** – National Society for the Prevention of Cruelty to Children

## Executive summary

In the UK 7.5% of adults are estimated to have experienced sexual abuse before they were 16 – this represents approximately 3.5% of men and 11.5% of women – according to the latest prevalence survey by the Office for National Statistics (2020). Sexual abuse can have a devastating impact on children, often leading to long-term effects on their wellbeing, mental and physical health, relationships, and education.

The World Health Organization (WHO) recognised child sexual abuse (CSA) as a preventable public health issue that substantively contributes to the global disease burden over a decade ago. Those who work in the field of stopping child sexual abuse are familiar with thinking about this crime as a public health issue and many academic papers have been referring to child sexual abuse as a public health problem for at least 20 years. So why isn't more being done in the UK to prevent child sexual abuse before it happens?

If child sexual abuse is understood and approached as a public health problem – in that it affects all communities, its impacts can be multiple, long lasting, and costly, and it can be prevented from occurring in the first place – this can provide a helpful framework through which prevention activity can be planned and delivered. There is no reason why we cannot stop child sexual abuse before it occurs by employing a public health approach.

The very implications of a public health approach mean an effective preventative response will require effort from all areas of society – at individual, relational, family, community, societal and system levels. This is important and translates to mean that every child, parent/carers, teacher, social worker, healthcare professional who works with children, family member, and friend should understand what child sexual abuse is and know how they can play a part in preventing it.

Due to the nature and scope of the child sexual abuse challenge we will need to draw upon learning from other public health, crime prevention and community engagement models that have been developed outside of sexual abuse and violence. This model can usefully be based on a socio-ecological thinking and should encompass work with individuals, families, children in schools, communities, settings and systems prior to abuse, as well as after it has taken place. It should seek to prevent adult-on-child and child-on-child sexual abuse and violence.

In the last decade data has indicated that the US has undergone a fall in the prevalence of child sexual abuse with suggestions that this could be due to primary prevention efforts, which began at scale in the 1980s, contributing to raising public awareness about the signs of sexual abuse and how to respond. Research from the US also indicates that a public health approach that broadens the scope of child sexual abuse primary prevention efforts will also increase the odds of impacting on the burden of wider child abuse rates. Given the wide professional consensus in the US and Canada that child sexual abuse is a preventable, treatable, public health issue, it is instructive to understand how such an approach is being put into practice and apply any learning that would help properly embed a UK public health response to addressing this issue. In particular, to what extent does conceptualising and approaching sexual abuse as a public health problem help to organise our thinking in relation to prevention? How does it need to be further refined and developed?

## Findings

Evidence from the US points firmly towards the adoption of four key components of public health thinking, namely: identifying the scale and scope of the child sexual abuse problem in the UK; identifying the risk and protective factors; development and evaluation of effective preventative interventions; and dissemination and implementation of these. Work in both the UK and the US demonstrates the need for employing prevention frameworks based firmly on evidence-informed theories of child sexual abuse (such as contextual safeguarding, socio-ecological models, situational prevention and offender behaviours) and using the public health three-tiered approach of primary, secondary and tertiary activities to describe a system-wide response.

Findings from this report also point to the need for further thinking in certain areas of these frameworks, for example preventative work with those who have a sexual interest in children but have not yet acted on these thoughts, as well as those who have sexually offended against children previously. Another key area is the preventative response to children and young people who display harmful sexual behaviour (HSB) and how we respond and treat this in a way that understands and actually addresses root causes of the behaviour. The idea of a 'whole family approach' makes sense in terms of the wider aetiology of harmful sexual behaviour and links particularly well to also addressing other types of child abuse within the family unit. One size will not fit all: young people with harmful sexual behaviour are not mini adult sex offenders and we need to remember that sexual abuse and violence is not gender neutral, that societal shifts and changes can take a generation or more and, finally, we should recognise the progress we have made and are making.

The Covid-19 pandemic has exposed the fact that, although intrafamilial sexual abuse forms the majority of the child sexual abuse in both the UK and the US, there is a real paucity of evidence for targeted preventative work addressing this type of sexual abuse, although some development work has been carried out in both countries. More community-specific prevention thinking is needed and there is space for learning about some of the inventive and simple ways (the additive approach) to target certain parts of society, such as parents, which has proven effectiveness in raising awareness and increasing confidence to respond to child sexual abuse.

Finally, findings tell us that we need to be clearer around how communities and the public in general are currently framing and understanding child sexual abuse because this can help focus and refine prevention messaging and the type of discourse and conversations that are likely to gain best traction. There is a need to communicate to the wider public that child sexual abuse can be prevented and to involve the media in promotion of positive examples of this in action, as well as lobbying for government support for wider evaluation, adaptation and dissemination of effective prevention efforts.

## Recommendations

The idea of applying public health approaches to areas such as road safety, knife crime and violence is not new, but still the term 'child sexual abuse' is being used to mean different things and no nationally agreed definition of a 'public health approach to child sexual abuse' currently exists. Prevention frameworks have been developed and adopted in the UK and US, but gaps remain in primary child sexual abuse prevention activities in both countries. This report explores current gaps and advocates the wider focus of community preventative activities to achieve a broader balance in addressing all types of child sexual abuse.

It makes two main recommendations. Firstly, the **development of a widely adopted and accessible public health framework and model to address child sexual abuse** – informed and updated by learning from primary prevention initiatives across the UK, US and internationally. The target audience for the framework would be local authorities, safeguarding partnerships and government departments in the UK and would help inform local and national child sexual abuse policy and practice ensuring a preventative focus on the future funding of activities and priorities.

Secondly, whilst not all professionals or sectors of society are yet able to fully conceptualise the idea of public health methodology, there is much more unity and support for the principles of the prevention of harm and abuse underpinning a public health approach. Wider engagement and collaboration will come from **the framing of CSA as a preventable public health problem** and strengthening societal resolve that child sexual abuse can be prevented. It is recommended that learning from the Johns Hopkins collaboration with the Frameworks Institute in Chicago is used as a blueprint to fund a similar but culturally relevant approach for the UK.

# Introduction

## Context to the project

Child sexual abuse is a significant public health problem internationally. In the UK 7.5% of adults are estimated to have experienced sexual abuse before they were the age of 16 (Tackling Child Sexual Abuse Strategy, Home Office, 2021). This translates to an estimated 3.1 million people having experienced child sexual abuse in England and Wales – 700,000 men and 2.4 million women. The most recent data (February 2023) from the Centre of expertise on child sexual abuse<sup>1</sup> states that in 2021/2022, local authority children's services in England recorded concerns about child sexual abuse in 33,990 assessments of children, a 15% increase on 2020/2021; and police forces in England and Wales recorded 103,055 child sexual abuse offences, the highest ever level and a rise of 15% on the previous year. Looking more widely at a number of different retrospective surveys that ask children and adults about their experiences of child sexual abuse, the Centre of expertise on child sexual abuse suggests the prevalence could be even higher, estimating that, at a minimum, 15% of girls and 5% of boys experience some form of child sexual abuse.

*“The devastation and harm caused by sexual abuse cannot be overstated – the impact of child sexual abuse, often lifelong, is such that everyone should do all they can to protect children.” (IICSA, 2022)*

In the absence of support and ongoing protective factors, those who have been the victims of child sexual abuse can experience short-term and long-term impacts on their health and wellbeing. Survivors of sexual abuse are more likely to experience mental health issues (including depression, anxiety and post-traumatic stress disorder), have difficulty in forming healthy interpersonal relationships, experience disrupted psychosocial development (e.g. engaging in compulsive or inappropriate sexual behaviours, or experiencing intrusive and disturbing sexual thoughts), and experience feelings of guilt, shame and self-blame. One particularly insidious aspect of early sexual victimisation is its potential for intergenerational transmission. This is where the abuse has lasting effects on parenting into adulthood (i.e. through its effects on mental health, and substance misuse), and so children of child sexual abuse survivors are also themselves at increased risk of becoming victimised.

In the UK the 2022 conclusions of the Independent Inquiry into Child Sexual Abuse (IICSA) highlighted just how widely society is affected by child sexual abuse. The inquiry noted how non-offending caregivers, parents, siblings, close relatives and friends often experience significant emotional and psychological impact after learning that a child may have been sexually abused, including self-blame and post-traumatic stress. The impact of allegations and convictions for child abuse in schools, clubs or other trusted institutions can have an enormous impact on community relationships and erode feelings of trust, safety and local identity.

The public health case to prevent child sexual abuse is also a UK economic concern; NSPCC research estimated that the cost of child sexual abuse to the UK in 2012 was between £1.6 billion and £3.2 billion (Saied-Tessier, 2014). If we consider an inflation related uplift<sup>2</sup>, for 2023 this figure can now be estimated to fall between £2.1 billion to £4.2 billion at current prices. This figure in

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<sup>1</sup> A multi-disciplinary team, funded by the Home Office, hosted by Barnardo's and working closely with key partners from academic institutions, local authorities, health, education, police and the voluntary sector (<https://www.csacentre.org.uk/>)

<sup>2</sup> <https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator>

addition to personal costs, is also composed of shared financial costs for communities and the nation in terms of healthcare costs, productivity costs, child welfare costs, costs to the justice system and education.

A political shift in focus from treating often entrenched problems to intervening early in the life of a problem came in 2008 with a cross-party paper on early intervention. The paper provided the groundwork for two independent government reviews of early intervention by Graham Allen MP, published in 2011. Over a decade later, despite the amount of good work done and being developed across the UK by local authorities, private, voluntary and independent organisations, more coordinated action is needed to create a common framework of policies and high-quality evidence-based preventative programmes to bring about social change and eradicate child sexual abuse in the UK.

## Background to the Churchill Fellowship report work in the US

The Churchill Fellowship enabled me to travel to North America in late 2022 to meet and speak with experts in the field of child sexual abuse prevention and treatment. Highlights included attending and speaking at the ATSA 2022 conference in Los Angeles and a week in residence with the Department of Human Development and Family Studies at the Pennsylvania State University, where I delivered seminars and took part in group discussions with Penn State College fellows.

Over the last 20 years the UK has seen a string of high-profile cases which has brought the widespread nature of sexual harassment and sexual abuse firmly into the public consciousness. More recently in the UK, public awareness of child sexual exploitation (one type of child sexual abuse) has also grown following exposure of large-scale sexual abuse rings in towns such as Rotherham, Rochdale and Oxford. More recently, following the launch in June 2020 of ‘Everyone’s Invited’, an anonymous space for survivors to share their stories of sexual abuse in schools, the Department of Education set up the ‘Report Abuse in Education’<sup>3</sup> helpline hosted by the NSPCC. In April 2021, Everyone’s Invited triggered an Ofsted review in schools that reviewed safeguarding policies and practices relating to all types of sexual abuse.

Whilst child sexual abuse has increasingly been seen as a public health problem by people who work in the field over the last two decades, relatively little progress has been made at a country level to deal with the issue by the full adoption of a public health approach. The Child Abuse Prevention and Treatment Act was passed in the US in 1974 and ushered in a focus on a public health approach to violence including successful strategies to combat child physical abuse, bullying and other forms of maltreatment. What was largely absent from these strategies was any direct focus on child sexual abuse. So, whilst the US is one of the few countries to have implemented a wide raft of primary prevention child sexual abuse programmes since the 1980s, there are still ongoing calls for a more formal inclusion of child sexual abuse in existing strategies to address maltreatment of children and young people.

Similarly to the UK, child sexual abuse is a serious public health issue in North America (Mercy, 1999), affecting approximately 10–17% of girls and 4–5% of boys in the United States. However, between 1990 and 2017, rates of CSA declined 62% (Finkelhor et al, 2020). The reasons for this decline are not yet well understood, but it is likely that primary prevention efforts, beginning in number in the 1980s, contributed to the reduction in prevalence by raising public awareness about

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<sup>3</sup> <https://www.nspcc.org.uk/about-us/news-opinion/2021/sexual-abuse-victims-schools-helpline/>

the signs of abuse and how to respond. Importantly, this decline has been seen to plateau over the past decade, and prevalence estimates from 2018 indicate that rates of CSA in the US may actually be on the rise. So, whilst gains have been made there appears a compelling case, given the individual and societal costs of child sexual abuse and increasing prevalence rates, for effective child sexual abuse primary prevention strategies to be further understood and rolled out across the US.

## Aims and objectives of the report

The aim of the report is to explore how conceptualising and approaching sexual abuse as a public health problem can help to organise thinking in relation to child sexual abuse prevention in the UK. It hopes to highlight the need in the UK for a widely adopted and accessible public health framework to address child sexual abuse. The findings draw on experiences and ideas from the US and Canada to build on current prevention frameworks and activities in use in the UK. The report explores gaps in prevention initiatives and thinking and recommends a way forward to develop a shared framework informed by the latest thinking from North America. It also highlights the need for communication research around the framing of child sexual abuse as preventable to counter the fatalistic view among the UK public that it cannot be stopped or eradicated, and to ultimately influence government thinking and future deployment of resources into solutions outside of purely criminal justice responses.

## Findings

The following three sections summarise the main themes of discussion that emerged from the interviews, meetings, seminars and conference sessions with experts in the field of child sexual abuse prevention and treatment across the US and Canada.

### Findings 1: Child sexual abuse should be conceptualised and approached as a public health problem

Among the experts, academics and researchers I met and interviewed in North America there was strong consensus that adopting a public health approach to child sexual abuse prevention has enormous potential as a framework to organise, structure and develop our thinking.

#### **A public health approach to prevention of child sexual abuse**

At its very simplest, a definition of a 'public health approach' would be preventing disease, prolonging life and promoting health through the efforts of society, rather than through clinical health interventions such as medicine and surgery. The broader concept of public health is underpinned by a distinct set of agreed principles:

- There is a focus on whole population, not just on high-risk individuals.
- The emphasis is on prevention, on 'upstream' interventions that are aimed at the causes of the problem, not at its treatment.
- A whole system-wide approach is needed, including action by all parties and stakeholders (such as primary care, education and a wide range of government departments).
- There is an emphasis on collective responsibility for health and a significant role for the state (not just individual responsibility).
- There is an emphasis on working in partnership with the population being served. Public health is undertaken with and for communities.
- There is a focus on tackling underlying inequalities as a major cause of health inequalities.
- Interventions are data driven. Understanding the characteristics and needs of the population are key, and actions should be evidence based.
- Decisions are taken that require long-term commitment.

Experts I spoke to also pointed out that by conceptualising child sexual abuse as a public health problem a number of important objectives in the eradication of child sexual abuse were brought to the fore, such as:

- situating child sexual abuse within the personal/familial context (as opposed to the stranger/predator stereotypes)
- recognising child sexual abuse as a correlate or consequence of other social issues, such as inequality, neglect and education
- shifting activity, research and policy (and society's) attention to prevention rather than reaction.

## What could a public health approach look like?

Part of the appeal of a public health approach is that it does not present as being unduly punitive as it reframes the issue of child sexual abuse, so the focus is on promoting wellbeing and tackling underlying causes, rather than on legal and penal responses to the crime. A public health approach to child sexual abuse will therefore need to understand the underlying principles of why it happens in the first place, as this will direct the kinds of interventions employed in response.

At its very core, public health is about populations. It is not about curing individuals, but it is about improving the average population health and therefore the emphasis in traditional public health is to get the maximum benefit for the largest number of people. Whilst individuals benefit, the approach does not start with the individual, but instead with a whole system-wide approach. This is needed to achieve the population focus and should encompass work with individuals, families, children in schools and communities prior to as well as after abuse has taken place. As such, a truly public health approach comes from a rather different world view than the individual responsibility model that tends to dominate thinking in the current criminal justice interventions and responses to sexual abuse in the US and the UK.

## Public health approach to violence prevention

One such public health model that is currently popular in the US and also recently adopted by the UK police Violence Reduction Units (Christmas and Srivastava, 2019) is the public health approach to violence prevention, which provides a framework for the development of evidence-based strategies based on the same core principles of the World Health Organization (WHO) public health thinking.

The model is composed of four main components: 1) identifying the problem; 2) identifying risk and protective factors; 3) developing and evaluating interventions; 4) dissemination and implementation.

### **1) Identifying the problem**

Ideally, population-based data is examined to identify and define what the problem is. Importantly, the data can also be used to better understand the context in which the abuse occurs – such as the setting, the relationship of the perpetrator to the victim and the severity and type of abuse (i.e. contact or non-contact, online or intrafamilial or peer-to-peer). Sources of data could include police, health, social care, third sector, community engagement, schools and local authorities.

In the US, as in the UK, the majority of child sexual abuse data comes from three main sources: information reported to child service agencies (in the UK Local Children Safeguarding Boards (LSCB), child social care agencies and Looked After Children (LAC) data etc), offences reported to the police (in the UK Crime survey for England and Wales and police statistics) and victim surveys (in the UK bespoke surveillance surveys and Office for National Statistics).

The problem currently is that child sexual abuse data reported to the authorities in the UK (and in the US to the National Child Abuse and Neglect Data System and the Uniform Crime Reporting System) only provide information on cases *actually known* to child protection agencies and the police. As we have discussed, these cases are only a small percentage of all child sexual abuse. In the UK, findings from research studies (including victim surveys) usually reveal much higher numbers of

children who have been abused than statistics from services that work with children show. This again gives an indication of how much child abuse does not come to the attention of the authorities<sup>4</sup>.

## **2) Identification of risk and protective factors**

The identification of risk and protective factors for child sexual abuse may help inform potential areas in which to intervene to reduce the likelihood of abuse. From discussions in the US and the UK, the research so far has mostly been based on sexual offenders known to authorities or currently in prison. However, there is a need to know more about those adults with sexual interest about children who have not yet acted on these urges and those who have not yet been caught – as thinking and research in the US indicates that it is not necessarily helpful to generalise about all sex offenders from only those known to authorities or who have been caught.

Sadly, sexual abuse perpetrated by children and young people (also known as harmful sexual behaviour – HSB) is not a rare phenomenon. Official statistics suggest that at least a quarter of all sex offenders in the US are juveniles<sup>5</sup> (Allen et al, 2018) and between 20% and 33% of all reported child sexual abuse in the UK involves other children and adolescents as the alleged perpetrators (Hackett et al, 2019). There is a big caveat again, as official figures are likely to be an underestimate of the true scale of the problem and not enough is yet known about the risks and protective factors involved when children and young people display HSB.

## **3) Develop and evaluate interventions**

This component is informed by the preceding two elements. We will discuss the research and intervention mapping work of Letourneau and Seto funded by the Oak Foundation in the next section. However, feedback from colleagues in the US corroborated strongly with UK experiences in that whilst there is widespread recognition of the need for a more comprehensive prevention approach, it is still felt to be early days in the development and evaluation of prevention of perpetration (before the first offence).

## **4) Dissemination and implementation**

After research has demonstrated effects, the dissemination of and adaptation to other contexts can be considered. Colleagues in the US were strongly of the opinion that programme feasibility and implementation according to fidelity were crucially important to the ultimate success of this component. This was not surprising given the level of investments and funding into US academic research programmes – where the randomised control trial (RCT) is still seen as the only real gold standard of measurement in terms of effectiveness.

## **Describing what prevention looks like**

Prevention is about changing behaviour and is particularly important in the context of the child sexual abuse problem in both the US and the UK in terms of the scale and the huge personal, social and economic costs associated with it. Preventing the abuse in the first place is far more desirable than trying to reverse the insidious impacts of child abuse, and it is far more proactive to address and improve family interactions before they get locked into potentially negative and harmful

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<sup>4</sup> More people will disclose abuse during research interviews because they are able to do so anonymously and confidentially, without worrying about an investigation from the authorities or the effect on their family, but this is still felt to be an underestimate of the true picture.

<sup>5</sup> US language – in the UK we would use ‘children and young people who sexually harm’.

behaviours. Public health approaches start from the principle that prevention is better than cure. A three-tier approach and the language used in both the US and the UK recognise that there are opportunities for prevention even after a problem has emerged:

- Primary prevention is preventing the problem occurring in the first place. This work is at the core of public health initiatives and tends to address the entire population of interest.
- Secondary prevention is intervening early when the problem starts to emerge and resolving it, often using targeted interventions to try to stop people drifting into higher risk categories.
- Tertiary prevention is making sure an ongoing problem is managed to avoid further incidents and reduce overall harmful consequences. Some interviewees felt that, strictly speaking, this is where a drift out of the territory of traditional public health can be seen, as this involves intervening after the problem has clearly manifested itself, and by this stage there is inevitably more focus on individuals than groups.

### **Current and emerging prevention frameworks in the UK and the US**

Understanding child sexual abuse as a public health problem allows us to use existing frameworks and theoretical models to design effective interventions and activities to prevent it. Historically, programmes in the US or the UK aimed at preventing child sexual abuse were not necessarily based on any particular theory and consequently were often set up on outdated, inaccurate views about the characteristics of abusers (for example, a stranger danger) and placed the majority of the burden of child sexual abuse prevention on children and young people to protect themselves, rather than across all members of society. Many experts I spoke with agreed that primary prevention efforts have predominantly been focused on teaching personal safety skills to school-aged children with the purpose of strengthening children's knowledge and skills to prevent victimisation<sup>6</sup>. It is important to re-emphasise that it is not the responsibility of the child to stop sexual abuse and that abuse does not occur because of a child's vulnerability, but rather an offender's inclination and ability to take advantage of this vulnerability.

Integrating criminal justice theory with public health approaches may assist in developing practical steps forward. An effective public health model needs to consider the person-situation interaction of human behaviour so that we can understand more about how individual vulnerabilities or dispositions interact with situational factors to produce sexually abusive behaviour. These are relatively new concepts to the field of sexual violence and abuse, but the available literature highlights the utility of situational crime prevention techniques for preventing sexual violence and abuse.

Jon Brown (Brown et al, 2015) explains clearly how theory is important in designing effective prevention strategies through understanding how and why child sexual abuse happens in the first place, so that we can design programmes and policies to prevent it. The Smallbone, Marshall and Wortley (2008) integrated theory of child sexual abuse model was informed by the crime prevention model, which identified four prevention targets: developmental prevention, situational prevention, community prevention, and criminal justice interventions. These theories greatly help when

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<sup>6</sup> When sexual abuse prevention programmes started to become popular in the US in the 1980s, they often just focused on giving information to children.

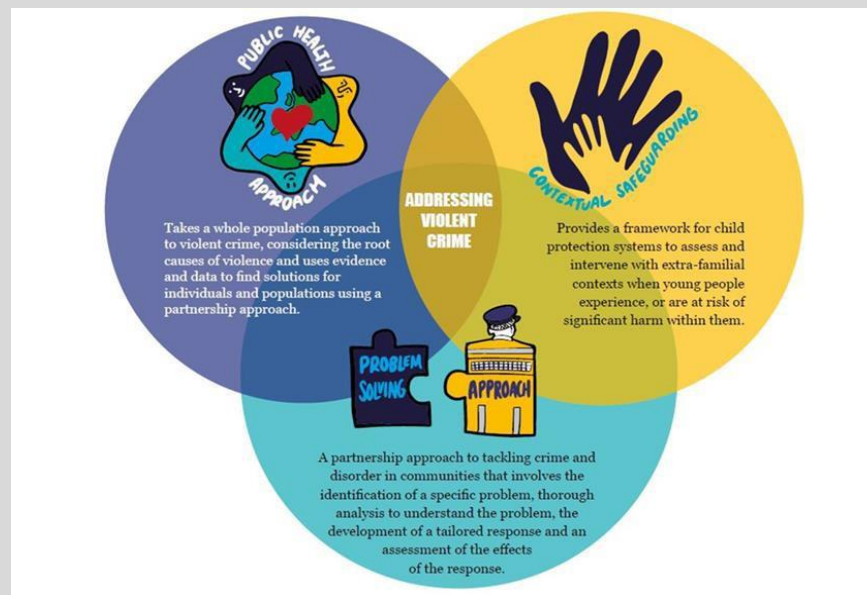
considering components 1 and 2 of the violence prevention public health approach model.

Other theories that have a lot of traction and can be applied to a public health approach are Ward and Siegert's (2002) Pathways Model which provides an explanation of why adults sexually abuse children.

### *Implications for the UK*

Recent conversations with police Superintendent Justin Srivastava (strategic lead for the National Police Wellbeing Service) and Catherine Randall (Head of Safeguarding, Department of Health) have been helpful in understanding how the police have adopted a public health approach to addressing violent crime. Public health approaches in policing (Policing Vision 2025) talks about proactive preventative activity, working with partners to problem-solve, vulnerability, cohesive communities, improving data sharing, evidence-based practice and whole system approaches, which clearly differs from traditional models of response policing where the focus is on individuals and enforcement. The way that the police have adapted the WHO violence prevention approach and models and overlaid them with the latest thinking from other disciplines is instructive in thinking about how thinking can be brought together. The police public health approach combines several models (public health, contextual safeguarding and problem-solving approach) to deliver a coordinated framework to addressing violent crime. This is potentially a useful starting point in terms of merging frameworks to create a practical and accessible model to address child sexual abuse.

**Figure 1. Police public health approach**



Source: Public health approaches to policing (Christmas and Srivastava, 2019)

## Findings 2: Where more focus is needed

### Sharpening the prevention focus on offenders and potential offenders

In the last decade some really innovative prevention approaches have emerged that have shifted the focus onto child sexual abuse perpetration. At the ATSA 2022 conference in Los Angeles a substantial proportion of the event was focused on these ideas, with much debate highlighting that prevention and treatment programmes targeting potential offenders can equip them with skills to avoid acting on harmful desires.

Professor Elizabeth Letourneau and her colleagues at Johns Hopkins Bloomberg School of Public Health talked more specifically about three types of audiences on which to focus prevention interventions to create a more upstream public health approach: targeted interventions focusing on individuals with a sexual interest in children; preventing the onset of child sexual abuse perpetration among adolescents; and prevention of child sexual abuse in child and youth-serving organisations. Building on this at the ATSA 2022 conference in Los Angeles, Michael Seto and Elizabeth Letourneau presented a piece of current work, which focuses on a framework for identifying and evaluating child abuse perpetration programmes from across the globe. An emerging framework is being used to try to populate where these initiatives sit by modality. This is part of a five-year global perpetration prevention programme funded by the Oak Foundation. Key aims are to bring science into the mix as part of identifying and evaluating preventative programmes for sexual offenders, then look at scale-up and advocacy and ultimately sustainability – as per a classic public health approach.

**Figure 2. Example of the framework being used to list and organise promising programmes in the US**

**Table 1.**  
*List of Intervention Programs Organized by Modality (see after for brief descriptions)*

Helpline	Self Help	Peer Support	Therapist Guided	Treatment	Institutional	Tech/Online
Stop It Now!	Get Help	Virtuous Pedophiles	Prevent It 2 (multiple languages)	<u>Kein Täter werden</u>	Responsible Behavior towards Younger Children	Google One-Box search interdiction
<u>Preventell</u>	Troubled Desire	B4U-Act	The Global Prevention Project	Stand Strong Walk Tall	Safe Dates	Facebook interdiction
Prevent SI	Help Wanted	Shadows Project		Det <u>Finnes Hjelp</u> (Help is Here)	Shifting Boundaries	Google Child Safety API (and similar classifiers)

Source: Letourneau and Seto, ATSA symposium presentation, Los Angeles, 2022

In the UK we have a project called Eradicating Child Sexual Abuse (ECSA), run by the Lucy Faithfull Foundation. This is working towards a comprehensive database of prevention approaches across the prevention continuum from the UK and around the world. It uses the framework below alongside a toolkit for professionals to help build preventative responses to child sexual abuse.

**Figure 3. Lucy Faithfull Foundation Eradicating Child Sexual Abuse (ECSA) framework**

Eradicating Child Sexual Abuse (ECSA) framework

	Primary prevention	Secondary prevention	Tertiary prevention
Offenders and potential offenders			
Children and young people (victims)			
Families and communities			
Situations			

Source: Lucy Faithfull Foundation

The sharing of promising and/or effective practice between the UK and the US is commendable, but the application of one nation's 'solution' in a different country, in the absence of an analysis of the context of the different types and circumstances of the sexual abuse, may not lead to the desired results.

#### *Implications for the UK*

The development of a public health approach to prevention on child sexual abuse would need to harness the findings of the excellent work happening in both of these international initiatives to help populate the framework under the public health model, rather than seek to replicate the detailed analysis work currently in progress. The public health framework would provide the confidence and knowledge to develop and deploy responses suited to a region's or nation's circumstance rather than to simply implement solutions created elsewhere.

### Children and young people who sexually harm (harmful sexual behaviour (HSB))

Estimates in both the US and the UK suggest that around a third of all child sexual abuse is carried out by children and young people against other children and young people, with schools being the second most common setting (after the home) for this type of abuse. In the UK, Everyone's Invited shone a light on the scale of child-on-child sexual abuse both within and outside education settings. The campaign, which began in 2021 as an online platform created by Soma Sara for survivors to share stories of rape culture, triggered an Ofsted review into safeguarding policies and practices relating to sexual abuse in educational establishments in England. Similar reviews also took place in Wales, Scotland and Northern Ireland. When the review was launched, there were over 50,000 submissions to the Everyone's Invited website.

Children and young people who display HSB continue to be an understudied population in the UK. Pre-adolescents (12 years and younger) who display HSB are even more often misunderstood. The role of HSB in the prevalence of UK child sexual abuse has received increased attention over the last decade and despite increasing evidence on the scale, nature and complexity of the problem, service

provision across the UK remains patchy and relatively uncoordinated, with some beacons of good practice. Levels of professional confidence and competence to address the challenge are, at best, varied. Many erroneous beliefs still surround this type of sexual abuse, with one common myth being that displays of HSB are indicative of a trajectory into adult sexual offending.

I spent a day in Harrisburg with Dr Brian Allen, the Director of Mental Health Services for the Center for the Protection of Children at Penn State Children's Hospital where the team are working with pre-adolescent children who display problematic sexual behaviour (PSB). There are some big differences, but also some startling similarities, in what we see and hear in the UK and the US. One of the main disparities is in the language we use to talk about children and young people who display sexually harmful behaviours: in the US terms like 'juvenile sex offender' are still in common parlance, whereas through our UK HSB framework we have been pushing the importance of person-first language to describe the behaviours of concern rather than labelling individuals.

The focus of Allen's research is in the area of problematic sexual behaviour in under 12s – this is also becoming a priority area of work, as in the UK. The Harrisburg team delivers trauma-focused Cognitive Behaviour Therapy (CBT) in conjunction with an innovative phase-based treatment model – which, not surprisingly, focuses about 70% of the work *on the parents of the child* displaying the harmful sexual behaviour (Allen, 2022).

### **Aetiology factors**

The most commonly discussed, and researched, aetiological factor in the development of HSB in the US, as in the UK, is a prior history of sexual abuse. However, a number of studies have found that the majority of children displaying HSB *do not* have a history of sexual abuse (Hackett, 2019).

There are **two other** main aetiological explanations. The first is the social learning and/or exposure to sex. Social learning about sex would include developmentally inappropriate exposure to sexual media, as well as inappropriate conversations with peers at school and parental/caregivers' behaviours and boundaries at home. The child learns rules and attitudes about sexualised behaviour as a result of these exposures (at home, online, school or peers etc) and then acts out accordingly. However, the behaviours then displayed are considered developmentally inappropriate or possibly harmful to self or other children in other settings.

The second often overlooked aetiological explanation is the exposure to other multiple forms of maltreatment and abuse (i.e. other developmental abuse histories besides sexual abuse). Multiple forms of abuse and maltreatment are linked to displays of HSB in the US as in the UK. Colleagues at the Pennsylvania State College of Medicine emphasised that HSB may reflect a pathological developmental trajectory in the early or ongoing adverse experiences (e.g. neglect, poverty) which potentially alter fundamental self-regulatory abilities (emotional regulation, impulse control) that give rise to the displays of HSB.

As in the UK, there are not many treatment options for children who display HSB. The attitude in the US was more straightforward when HSB is present in the context of having been sexually abused (sexual abuse-related post-traumatic stress); however, there are fewer evidence-based responses for displays of HSB related to the other two main aetiologies. Given that the research in the US and UK indicates that **the majority** of children displaying HSB **do not** have a sexual abuse history, the development of effective responses for this group of children and young people is a major gap.

The Penn State team have developed and pilot tested a phase-based treatment protocol for pre-adolescent children displaying HSB. The current offer is assessment driven, culturally adaptable, trauma sensitive, and capable of being implemented with **all aetiologies** of HSB. The pilot project is still small and ongoing but early findings suggest it appears effective at reducing displays of HSB as well as decreasing displays of family sexuality and improving emotional and behavioural relations. Caregivers of the children involved also gave positive feedback.

### *Implications for the UK*

The importance of understanding root causes in displays of problematic sexual abuse in under 12s is evident. In current NSPCC work with under 12s who display problematic sexual behaviour we talk about 'seen it, witnessed it or experienced it', which certainly resonated with the team in Harrisburg and tallies with the aetiology. However, it would appear a radical change of direction is needed in terms of the focus of the interventions and support we currently offer. Why do we expect to work closely and intensively with a child who displays problematic sexualised behaviour and then put them back into the very unchanged environment and context where the behaviour evolved, expecting that the problem is solved?

In the US the gold standard programme is the Oklahoma Cognitive Behavioural Therapy model, but the randomised control trial (RCT) is now over 20 years old. It is a group-based programme which brings added complications and limitations for delivery in the UK. Many service settings are not able to see sufficient numbers of children to make a group-based programme feasible. Also, due to the nature of the work, staffing capacity may simply not be available – i.e. separate and parallel sessions needed for child and caregiver groups. Colleagues at Penn State have been keen to explore whether an individual offer for this type of intervention can work – and the findings look good as the most effective techniques were:

- teaching caregivers behaviour management skills
- development of rules regarding sexual behaviour
- psychoeducation for caregivers
- teaching the child impulse control skills.

All the above are components of treatment offers which are currently delivered individually, and discussions with Penn State and Be Safe UK<sup>7</sup> suggest that the constituent components of the Oklahoma CBT model may also continue to be effective when delivered in individual format.

As such, exploration of a family referral model for addressing PSB in pre-adolescent children appears warranted in the UK and should be developed. This would also have the added benefits of linking to work around other types of abuse such as neglect and domestic abuse.

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<sup>7</sup> NHS specialist HSB team based in Bristol UK who have adopted the Oklahoma model.

## Intrafamilial sexual abuse

Most children who experience abuse are abused by someone they know. In the 2019 Crime Survey for England and Wales, 37.3% of those who had been sexually abused were abused by a friend or acquaintance, followed by family member or carer/guardian (36.1%) and stranger (30%)<sup>8</sup>. As a large amount of child sexual abuse is perpetrated by family members there is a need to better understand effective strategies to prevent the onset of child sexual abuse when the perpetrator is part of a family group.

Several times during the course of my Churchill Fellowship I have spoken with Prof Michael Seto, Director at the Royal Ottawa Health Care Group in Canada, about sexual offending modus operandi. He is an international expert in sex offender behaviour and the developer of the 'motivation-facilitation' sex offending model (Seto, 2019), which is a key development of the more traditional and widely adopted 'Finkelhor's four precondition model' for sexual offending (Howells, 1995).

Characteristics of cases of child sexual abuse reported to authorities differ from those not reported. For example, reported cases in the US tend to involve physical threats or are life-threatening, and are more likely to be committed by a stranger than a family member. This might result in a general failing to properly characterise intrafamilial sexual offending and sexual offences without serious physical injury or threats.

Seto is clear about the need for more research and effort on what can stop the onset of child sexual abuse in families, prompted most recently by emergent findings during lockdowns that there were reported increases in intrafamilial sexual abuse. One particular area he is currently focusing on is the potential increased sexual abuse risks in blended families or stepfamilies.

### *Implications for the UK*

There is clear need to better understand effective strategies to prevent child sexual abuse when the perpetrator may be a family member (parent, carer or sibling). There is a need to review work in the UK and US which has been focused on working with blended families or stepfamilies and to interrogate and improve national datasets to better understand the scale and scope of intrafamilial abuse.

The National Clinical Assessment and Treatment (NCATS) service in Camden, London is rearticulating its HSB offer into a specialist sibling abuse service. This would be an excellent opportunity to look at some of the implications for prevention of sibling sexual abuse.

In taking forward a public health approach to prevention there is strong agreement that more work needs to be done to educate and partner with policymakers and to connect personally with individuals and communities, so that people can understand that sexual abuse and violence is not 'out there' but within our families and communities, and we therefore all have a role in its prevention. This is a key part of recommendation 2 of this report.

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<sup>8</sup> Note: The three figures add up to more than 100% (but this could be because some individuals are reporting more than one category).

## Communities and systems

Prevention from a public health perspective is rooted in social and educational policies that support the healthy emotional and sexual development of all members of our society, and children in particular. Conceptualising health this way goes beyond 'sexual education', and includes moral development, empathy, good citizenship, etc. It is important to note that none of this is necessarily specific to child sexual abuse, but child sexual abuse does not occur in a vacuum. In fostering and enhancing skills and strengths within our communities and population we build a stronger social foundation that is less vulnerable to all sorts of social and personal dysfunction.

Adopting a public health approach opens up so many more options for preventing sexual violence and abuse, through working across multiple levels of prevention and community engagement, focusing on disparate population impacts (e.g. gender and other socio-demographics), and by promoting evidence-grounded and culturally informed interventions. It also shapes our thinking about how we can best respond to the specific risks and needs of offenders, victims and communities rather than a 'one programme fits all' approach so that programme implementation has a 'real' impact.

Engaging with hard-to-reach communities is a major obstacle. Conversations with the fellows at Penn State in the Department of Human Development and Family Studies outlined ways to engage with communities through getting community 'leaders' or 'stakeholders' involved, as they are listened to and respected by the community. Communities are willing to take the word, advice and direction of these community people as they are already invested as 'one of them', understand the context of their lives and have lived experience within the community.

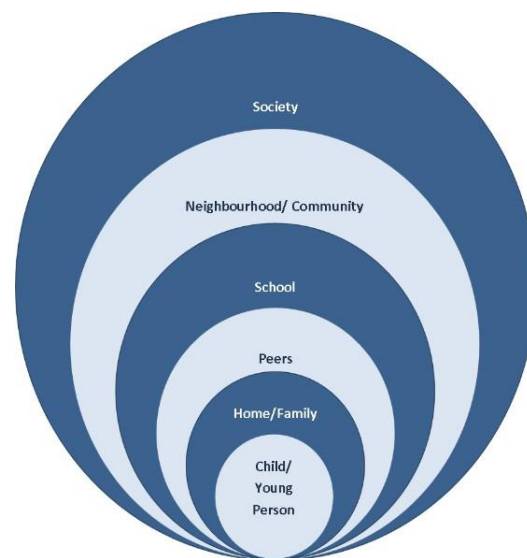
### **Socio-ecological thinking**

To influence the health of the whole population, as is necessary with public health problems, interventions are needed that can reach every area of society. Joan Tabachnick (co-chair of ATSA's Prevention Committee) talks about the need for true social change in order to address child sexual abuse prevention, and this would require interventions at every level of an emergent public health framework for the UK.

Professor Jennie Noll, Director of the Child Maltreatment Solutions Network at Penn State University, champions the need to broaden the scope of child sexual abuse primary prevention efforts in order to increase the odds of impacting overall on the rates of all child maltreatment and abuse. As such, a comprehensive child abuse prevention strategy adopting a similar public health approach would include efforts at individual, relational, community and societal levels.

Another really helpful framework often used when discussing child sexual abuse as a public health problem is the social-ecological model (Krug et al, 2002). This has been further adapted by the ground-breaking work of Professor Carlene Firmin and the Contextual Safeguarding Network in the UK to look at child sexual exploitation and extra familial harm.

**Figure 4. Contextual safeguarding model**

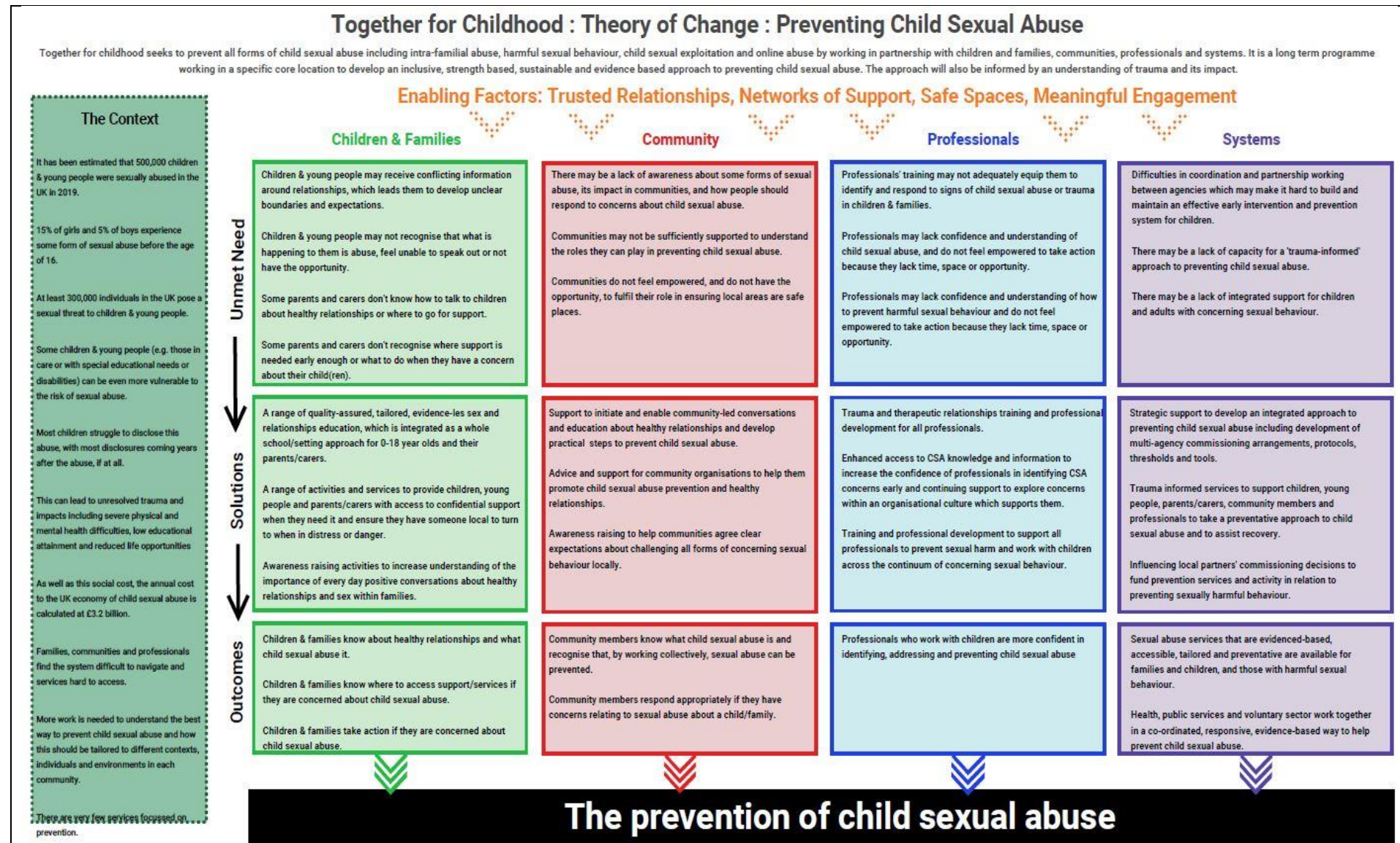


(adapted from Firmin, 2015, University of Bedfordshire)

### **Place-based community prevention approaches**

We have a real opportunity to understand and explore what it really looks like to prevent child sexual abuse in a community through the place-based initiatives that are currently running in several locations in the UK and US. 'Together for Childhood' is an ambitious 10-year place-based partnership approach developed by the NSPCC in the two UK cities of Plymouth and Stoke-on-Trent. It aims to radically improve the way we prevent child sexual abuse. Through collaborative working the two sites are developing and testing preventative approaches, focusing action at a local scale, and drawing on examples of best practice from around the world. Together for Childhood uses a theory of change already employing a public health philosophy to identify gaps, commission activities and interventions as part of a pipeline of preventative development work. Figure 5 shows the theory of change for the programme of work for Stoke and Plymouth.

Figure 5. Theory of change for Together for Childhood



The Together for Childhood partnerships place a growing emphasis on empowering and educating communities to tackle child sexual abuse through bystander interventions and campaigns to deter people from online child sexual abuse across Plymouth and Stoke-on-Trent. The main target audience for the latest mass media campaign was pre-arrest offenders, also with messaging for their families and friends, and the wider public.

### *Implications for the UK*

By using socio-ecological models in our thinking, it is clear that responsibility to prevent child sexual abuse cannot fall on only one group, especially children, and it is unlikely that one strategy focused on one segment of the population will really affect abuse rates.

Evaluation of place-based approaches is notoriously difficult and so linking up these place-based initiatives, such as the NSPCC Together for Childhood with new projects commissioned by Penn State University, working with communities in Florida, or the North Carolina Collective Impact project funded by the CDC, would be a useful project to share international learning and research techniques.

### **Additive interventions in systems**

Both the teams I visited at Johns Hopkins University and Penn State University were involved in the design and evaluation of child abuse prevention programmes delivered through the US school system. It was noted that school-based prevention programmes can improve knowledge and skills of young people in ways that help them better recognise, prevent and report inappropriate sexual behaviour and contact. Johns Hopkins had developed a programme called Responsible Behaviour with Younger Children (RBYC) which was the first known attempt to test a classroom-based universal (i.e. primary prevention for 11- to 13-year-olds) curriculum aimed at prevention of the onset of HSB.

At Penn State, Prof Jennie Noll suggests that parents can also have a notable influence on youth behaviour and are close to and aware of their children's environments. An involved, trusting relationship between parent and child which facilitates open discussion and disclosure can reduce the potential for and severity of victimisation. Parents are uniquely equipped to foster self-efficacy, thus rendering their children more difficult targets for victimisation. For example, child sexual abuse prevention requires parents to monitor the access that others have to their children both online and in person, given that most perpetrators are known by the victim and/or trusted by the family. Parents must also be knowledgeable about child development, and age-appropriate behaviours, as changes to a child's developmental trajectory (e.g. appropriate and inappropriate sexual developmental milestones) may suggest the child is being exploited sexually or being influenced by other negative contextual factors (access to pornography etc). Professor Noll and team developed a parent-focused child sexual abuse prevention strategy (Smart Parents) in Pennsylvanian schools that, when included in a comprehensive prevention strategy, increased the potential to decrease rates of child sexual abuse.

The really innovative element of the Penn State work was the additive approach to getting the schools to adopt the programme. A child sexual abuse-specific parent education module called

Smart Parents – Safe and Healthy Kids (SPSHK), was developed to use the evidence-based content of parent training programmes by adding three key child sexual abuse prevention components: healthy child sexual development, parent-child communication about sex and sexual behaviours, and CSA-specific safety strategies such as vetting a babysitter and monitoring one-on-one time with adults. In this way key elements of prevention for parents were delivered through existing statutory systems already in place in schools, so that reach was maximised, and parents didn't opt out of receiving the information.

### *Implications for the UK*

We need to be community specific in our prevention thinking; one size will not fit all – young people with harmful sexual behaviour are not mini adult sex offenders and we need to remember that sexual abuse and violence are not gender neutral; societal shifts and changes can take a generation or more; and we should recognise the progress we have made and are making. We also need to evaluate our prevention efforts carefully and specifically in order to identify what works for whom, how and in what circumstances. This is not straightforward or quick when working with communities and populations, but more evidence is needed about what works and how to implement prevention programmes using existing systems and settings (such as the Penn State additive approaches to embedding prevention messages in systems).

There is a need for a call-out for more thinking about community-level factors across the UK and internationally. Both the Lucy Faithfull and the Smallbone, Marshall and Wortley (2008) prevention models include 'specific situations' and 'broader community systems' as core areas of prevention focus which will continue to require much more attention in our field – with ongoing thoughtful consideration of potential contributions to prevention of child sexual abuse from other fields.

We need to be clear how communities are currently framing and understanding child sexual abuse because this can help focus and refine prevention messaging and the type of discourse and conversations that are likely to gain best traction.

## Findings 3: What are the barriers to preventing child sexual abuse?

Experts in the US felt that child sexual abuse is a preventable, treatable, public health issue and all were keen to challenge the fatalistic view that child sexual abuse cannot be stopped. Emerging from the conversations and interviews were some consistently identified issues and barriers to the prevention of child sexual abuse – most, if not all, resonate with experiences in the UK.

### Shared common and consistent themes

Below are four of the most common and consistent issues we discussed that are currently obstacles to preventing child sexual abuse.

#### 1) **Social stigma and low rates of victims telling someone about the abuse**

The majority of child sexual abuse in North America and the UK remains hidden and under-identified. We know that in many cases victims and survivors tell someone about the abuse they have suffered decades later<sup>9</sup>, and there are many reasons why children cannot or do not tell someone about their abuse. The most common reasons given by adults for not telling anyone about the abuse they experienced in childhood were embarrassment and thinking that they would not be believed (Office for National Statistics: Crime Survey England and Wales, 2020). Survivors of sexual abuse often also experience self-blame and shame, due to the violation of social norms around what is appropriate and acceptable, and this can lead to feeling less willing to talk about what has happened or seek help and support.

#### 2) **Conceptual fragmentation of child sexual abuse and siloed responses**

In 2019, we coined the term ‘conceptual fragmentation’ (Hackett, Branigan and Holmes, 2019) to refer to the siloed response across the UK when responding to distinct types of child sexual abuse. This is also a notable feature of the responses across the US, where child sexual abuse is often felt to be compounded by limited inter-agency guidance, unclear information-sharing procedures, and siloed working practices and protocols of the various professional bodies involved. This can make support and any treatment inaccessible and hidden behind unclear and inconsistent service thresholds. This can be potentially retraumatising as a lack of cross-system case management and integration can lead to families and children having to retell their stories and experiences many times.

In order to reduce child sexual abuse a coordinated, consistent and multiagency approach to deterrence is needed. Agreeing service and early help thresholds across frontline agencies, and among those caring for and educating children and young people on a daily basis, is one of the key challenges of an effective inter-agency response.

In 2015 the Children’s Commissioner highlighted that many victims and survivors of child sexual abuse in the family environment are not placed on a child protection plan for sexual abuse, but instead may be placed on a plan for another type of abuse (such as neglect or emotional abuse). Many children identified as having experienced or being at risk of child sexual abuse will also be placed in the care of a local authority, rather than being on a child protection plan.

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<sup>9</sup> Research by the All-Party Parliamentary Group on Adult Survivors of Childhood Sexual Abuse indicates that the average time for victims and survivors to disclose abuse is 26 years.

My own experiences of developing child sexual abuse prevention initiatives, frameworks and professional training across the UK concur with recent research from colleagues at the Centre of expertise on child sexual abuse which highlights the lack of adequate local and regional responses to address child sexual abuse. Most UK local authority child sexual abuse strategies are not based on local accurate prevalence and incidence data about victims or those who pose a risk to children, data doesn't inform service responses or workforce development, and the majority of the activity is not focused on prevention. Few have meaningful priorities, targets or even action plans that will ultimately reduce the burden of child sexual abuse.

### **3) Policy focused on the criminal justice intervention**

In the US there is an industry of policy and law enforcement agencies devoting vast amounts of resources to criminal justice interventions focused on identification, prosecution, punishment and post-release control of offenders. However, experts I spoke to felt there was little evidence supporting the preventative efficacy of these wide-ranging policies – instead these policies were reactions to high-profile media cases that had shocked public opinion, rather than being informed by scientific evidence. One example given at the ATSA 2022 plenary session was the focus on the sex offender public registration programmes across the US, which aim to protect children against sexual crimes carried out by strangers. Stranger sexual abuse is only a small fraction of the incidence of child sexual abuse; in both the US and the UK, it is child sexual abuse in the family environment (intrafamilial sexual abuse) which constitutes the largest portion of all (contact) offending. The Office of the Children's Commissioner estimates that approximately two-thirds of child sexual abuse reported to the police is perpetrated by a family member or someone close to the child<sup>10</sup>. Furthermore, studies in the US have shown that even the most effective criminal justice responses would prevent only a small percentage of the crimes, as 95% of such crimes are committed by individuals with no prior history of sexual crime conviction. The prevailing recommendation, among the US experts in child sexual abuse I spoke with, would be to focus on efforts to understand the *circumstances that increase or decrease* the likelihood of child sexual abuse perpetration.

### **4) Mandatory reporting**

In 2011 rumours of abuse surrounding Jerry Sandusky, an assistant coach for the Penn State Nittany Lions football team, began to emerge. More than a decade before, an assistant football coach told his supervisors that he had seen Jerry Sandusky sexually assaulting a young boy in the shower. When this was revealed during Sandusky's criminal trial in 2012, it prompted public outcry as to why no one had reported the systematic abuse earlier. Sandusky was ultimately found guilty of 52 counts of child sexual abuse, stemming from incidents that occurred over a period of at least 15 years. He was sentenced in 2012 to a minimum of 30 years in prison.

In response, Pennsylvania lawmakers enacted sweeping reforms to prevent anything like it from ever happening again. Most notably, they expanded the list of professionals required to report when they suspect a child might be in danger, broadened the definition for what constitutes abuse and increased the criminal penalties for those who fail to report. An unintended effect was that it led to a strained child welfare system and more unsubstantiated reports against low-income

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<sup>10</sup> Excluding indecent image offences.

families. I spoke to academics and researchers at Penn State who outlined a growing movement of family lawyers, researchers and child welfare reform advocates calling for radical change in the approach to child protection in the US, starting with the abolition of mandatory reporting. This idea has grown in popularity at both ends of the political spectrum – both progressive activists and conservatives oppose what they call ‘excessive government intrusion’ in the lives of families. Other critics support less dramatic reforms, such as limiting which professionals are required to report and providing better training for mandated reporters.

This is highly relevant to help shape our thinking in the UK as, on 20 October 2022, the Independent Inquiry into Child Sexual Abuse published its final statutory report. In accordance with the Inquiry's Terms of Reference, the report sets out the main findings about the extent to which state and non-state institutions failed in their duty of care to protect children from sexual abuse and exploitation and makes recommendations for reform. One of the top three central recommendations is the introduction of a statutory requirement of mandatory reporting. In effect, it requires individuals in certain employments (paid or voluntary) and professions to report allegations of child sexual abuse to the relevant authorities. Failure to do so, in some circumstances, could lead to the commission of a new criminal offence of failure to report an allegation of child sexual abuse when required to do so.

### **5) Policy resistant issues for adopting a public health approach**

Professor Elizabeth Letourneau, at the Bloomberg School of Public Health in Baltimore, helpfully outlined three ‘policy resistant’ aspects of adopting a public health approach to child sexual abuse. This is crucial in terms of understanding why such a potentially obvious approach of public health might appear to become less visible or evident in wider national policy and practice both in the US and UK.

- 1) The first resistant aspect is the complexity of child sexual abuse. This complexity adds to the perception that child sexual abuse arises from unpredictable and unalterable dynamics as, unlike child neglect, child sexual abuse can be perpetrated by virtually anyone of almost any age against any child. This leads to wider public perception that little can be done to prevent child sexual abusers harming children, other than custody after the abuse has happened. This impacts on the first two components of the violence reduction public health model, i.e. identifying the problem and identifying the risk, and protective factors.
- 2) The second policy resistant aspect is the relatively limited research associated with child sexual abuse, compounded by the paucity of research on prevention of sexual abuse offending initiatives (as compared with the research bases for other public health problems such as obesity, alcoholism and heart disease). This cuts across the third component of the violence reduction public health model – programme development and evaluation.
- 3) Thirdly, and perhaps most emotively, is the hostile context of much public debate on the subject of child sexual abuse (which demonises perpetrators as ‘monsters’ and often labels professionals working in the field in negative terms).

### **Re-framing the issue of child sexual abuse prevention**

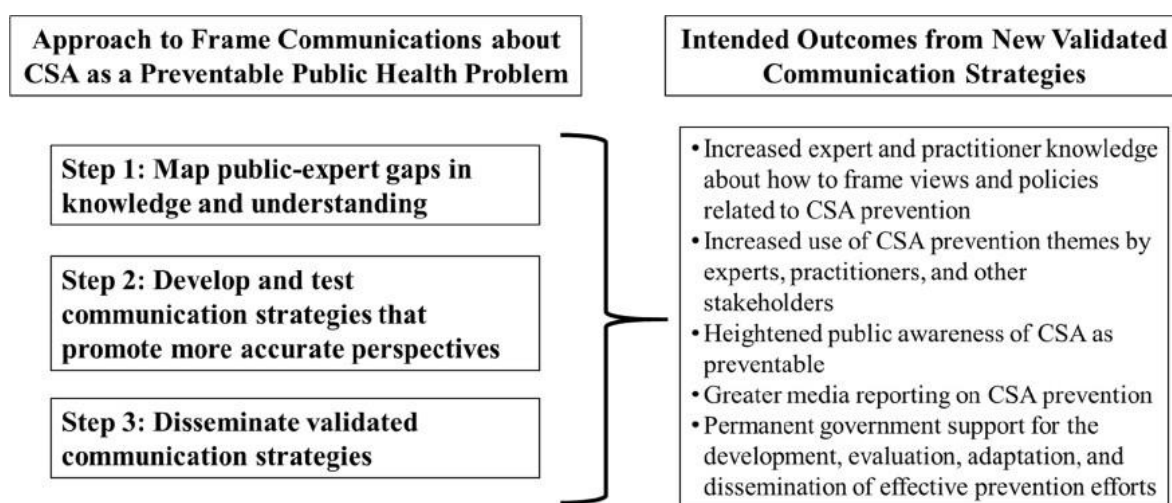
In the past decade, child sexual abuse has been increasingly in the public eye. In the US there has been a big focus on sexual abuse on campuses following some high-profile media cases. In the UK, after Saville, there has been an ongoing series of high-profile historic cases widely reported in the media. UK public awareness of child sexual exploitation (one type of child sexual abuse) has also

grown following exposure about large-scale abuse in Rotherham, Rochdale, Oxford, Northern Ireland and other areas. There is a greater understanding of the need to tackle online child sexual abuse as social media and internet access grows and the Online Safety Bill grinds its way towards legislation at glacial pace through Parliament. In the UK, Professor Kieran McCarten's (University of West England) research with the public shows that although there are concerns about child sexual abuse, the public's actual understanding of sex offenders, aetiology, treatment and, most importantly, what can be done to prevent sexual abuse is extremely limited (McCarten et al, 2015).

Child sexual abuse is a complex issue and recognising and articulating this complexity in a non-complex way is the challenge we are faced with when trying to educate the public, professionals, media, policymakers and government officials. One way to attempt to do this typically in a public health approach is to use public health campaigns and the power of mass media. The 'Spectrum of prevention' model (Cohen and Swift, 1999) originally highlighted the six key components of a successful public health campaign: influencing policy and legislation, changing organisational practices, fostering coalitions and networks, educating providers, promoting community education, and strengthening individual knowledge and skills. However, all public health campaigns and prevention messages only get through to their target when the public *believes that it relates to them*, otherwise they disengage from or dismiss the messages.

Work at the Bloomberg Institute of Public Health in Baltimore is looking at this issue really closely and working with the Frameworks Institute in Washington DC to find solutions to understanding how to get the public to understand that child sexual abuse can be prevented. I spoke with Dr Rebecca Fix and her team at Johns Hopkins about the work and the need to (in her words) 'change the paradigm'. The work aims to firstly improve understandings of child sexual abuse held by experts and the public and then map the gaps between these two stakeholder groups to identify where perspectives converge and diverge. Following this mapping of gaps and issues, they hope to develop and test some communication strategies to close these gaps, such as explanatory metaphors. Finally, the aim is to equip those working to prevent child sexual abuse to embed validated communication strategies into the public debate.

**Figure 6. Johns Hopkins/Frameworks Institute 3-step approach to framing CSA as a preventable public health problem**



Source: Johns Hopkins Bloomberg School of Public Health

The development of explanatory metaphors has a precedent in the UK where it was used as part of the UK Early Years Better Start initiatives to help enhance the public's understanding of why child neglect

happens. To overcome the issue of complexity, the researchers developed the overloaded lorry (truck in the US) metaphor.

*"When a lorry carries too much weight, it can be overloaded to the point of breaking down. And when parents are burdened with stresses like poverty or lack of support, the weight of these problems can overload their mental and emotional capacity to take care of their children's basic needs. Over time, carrying and managing heavy burdens puts a strain on people, and can weaken their ability to care for children. And when an especially large burden is loaded onto a person who is already overloaded, it can cause a breakdown in care. However, just like we can unload an overloaded lorry by sharing the load with other lorries or offloading cargo in other ways, we can provide social supports that offload sources of stress from overloaded parents and improve their capacity to care for their children."*

(Kendell-Taylor et al, 2015)

Frameworks Institute carried out short 10-minute interviews with samples recruited in public spaces who are asked to reason about an issue (in this case 'why does child neglect happen?') unaided by a metaphor. Then they are presented with an explanatory metaphor and asked a parallel series of questions to establish whether exposure to the metaphor affects their thinking and reasoning about the issue.

#### *Implications for the UK*

Given the public's increasing concern about keeping children safe from all forms of child sexual abuse, there is a growing disconnect in how we are communicating what can be done to prevent child sexual abuse in the first place.

Research into the understanding and development of communication strategies that are culturally appropriate and resonate with the UK public is needed – potential collaboration and work with the Frameworks Institute would be an excellent first step but would require funding and pilot sites. The Together for Childhood cities of Plymouth and Stoke-on-Trent might be suitable candidates for such a project.

## Conclusion and recommendations

Public health provides a useful framework for helping the UK to think about how we should focus our efforts on prevention in order to reduce the incidence and prevalence of child sexual abuse. It helps us articulate the right questions and provides a model for considering various levels of prevention and intervention. It moves us on from models that focus entirely on individuals, to those that stress the importance of communities and the social context in which sexual abuse occurs.

There is no single identifiable cause of child sexual abuse. The causes are multiple and complex, being rooted in the social determinants of health and behaviour. That is why our response will have to be multi-pronged as well, with the key spine being the role of prevention.

Prevention frameworks exist, and whilst there has been adoption in the UK and US, notable gaps remain in primary child sexual abuse prevention activities in both countries. This report has explored some of those gaps and advocates combining preventative frameworks into a coordinated public health model of preventative activities based on evidence, to achieve a broader balance in addressing all types of child sexual abuse. To do this we need more research and evidence about what works. There was strong consensus among all about the need to further develop, implement and evaluate evidence-based initiatives, activities and ideas for the prevention of child sexual abuse.

But there are challenges. Public health is not a cheap or immediate option. Success also requires real commitment to changing the social determinants, which itself requires political will and a broad coalition of government departments, sectors and other key stakeholders. However, ultimately it will not be governments, experts or professionals who eradicate child sexual abuse, but rather individuals, families and communities.

It is time to change the societal conversation on child sexual abuse in the UK from one focused on reaction, punishment and criminal justice to one which includes a proactive, change-oriented and preventative message about what is possible. However, this understanding is not yet broadly shared by the UK public and policymakers, which severely hampers efforts to support and mobilise around policies that can effectively prevent child sexual abuse.

Reframing the idea that child sexual abuse can be prevented will harness the potential to change the public discourse, something that is then owned by society as a whole and something which can be addressed via information, education, and future public funding for further research.

The practical purpose of this Churchill Fellowship report is to signpost how a widely adopted and accessible public health framework can be developed into a practical, accessible offer, through a UK collaboration and development group. The first direct output will be to use the contents of this report to inform and guide the creation of the Terms of Reference for the collaboration and development group (see Appendix for the suggested working draft). Alongside the public health prevention framework development, the second output will be the reframing work to position child sexual abuse as something that is preventable, as well as shine the light on some of the broader social issues that link child sexual abuse to other types of child maltreatment. This will aim to empower and guide policymakers about the key role of prevention in eradication of child sexual abuse. It will focus efforts on the most promising areas to target and fund, and to ultimately consider the best interest of the UK public, as opposed to broadcasting a 'tough on crime' solution, which is fundamentally too late.

## Recommendations

This report makes two key recommendations.

Firstly, the **development of an evidenced-informed public health model incorporating prevention frameworks to address child sexual abuse in the UK** – informed and updated by learning from primary prevention initiatives across the US and internationally. The target audience for the framework would be local authorities, safeguarding partnerships and government departments in the UK and would help inform local and national child sexual abuse policy and practice, ensuring a preventative focus on the future funding of activities and priorities.

### **Recommendation 1: Development of an evidenced-informed public health model and framework for the prevention of child sexual abuse in the UK**

This would:

- be informed by child sexual abuse theory and composed of the four components of public health approach (identifying the problem, risk and protective factors, development and evaluation of interventions, and implementation)
- outline the essential elements of developing and delivering an integrated and effective child sexual abuse response, that prioritises prevention across every area of society – using primary, secondary and tertiary preventative approaches
- enable local areas to develop prevention-focused and integrated child sexual abuse strategies and policies that will ultimately reduce conceptual fragmentation (i.e. where local areas struggle to understand how sexual abuse links to other types of child abuse and therefore fail to work together to tackle these problems).

Secondly, the prevention momentum building in the US and UK needs the engagement and strategic endorsement of governments, both local and national. Whilst not all professionals or sectors of society are yet able to fully conceptualise the idea of public health methodology, there is much more unity and support for the principles of the prevention of harm and abuse underpinning a public health approach.

Wider engagement and collaboration will come from **the framing of CSA as a preventable public health problem** and strengthen societal resolve that child sexual abuse can be prevented. It is recommended that learning from the Johns Hopkins collaboration with the Frameworks Institute in Washington is used as a blueprint to fund a similar but culturally relevant approach for the UK.

### **Recommendation 2: Commission research to understand and frame child sexual abuse prevention as a public health problem in the UK**

This would aim to:

- increase public awareness that this type of abuse is preventable
- increase media reporting on child sexual abuse prevention
- strengthen government support for dissemination of prevention work.

## Next steps

Throughout the pandemic I have been building contacts across government departments and organisations in the UK. This has resulted in my Fellowship being recognised formally on the National Crime Agency (NCA) and Child Exploitation and Online Protection Command (CEOP) Strategic Action Plan (SAP) for the Prevent and Protect National Board. As such there is cross-departmental support (Department of Health and Social Care, Department for Education, Ministry of Justice, Home Office, Department of Culture, Media and Sport) for the work and I report on progress quarterly to the Board.

Upon my return from my Churchill Fellowship research phase I delivered a seminar for the NOTA Prevention Committee group in December 2022 where I shared top-level findings from this report and outlined the two key recommendations. It was well received and consequently the Chair of the NOTA Prevention Committee (and Director of Partnerships at Barnardo's) has agreed to chair the national group to be convened for the development of the paper's recommendations.

The next step is to set up a national working group (supported in partnership by the NOTA Prevention Committee and the NSPCC) to develop recommendation 1 (development of the evidenced-informed public health) and look to commission recommendation 2 (the child sexual abuse framing research). I have drawn on the NOTA Board to create this UK steering group – currently comprised of key UK organisations (Lucy Faithfull Foundation, Marie Collins Foundation, Centre of expertise on child sexual abuse, Stop It Now, The Children's Society, Barnardo's, Internet Watch Foundation, the police and NHS Safeguarding) with observers invited from central government departments (Home Office and Department for Education). The draft Terms of Reference is in the report appendix.

The work of the national group is likely to take place from spring 2023 to December 2023 – with three main meetings planned and the commissioning of working sub-groups to drive the development of the model forward. This is employing a similar approach to the development of the national operational Harmful sexual behaviour framework that I developed in 2016.

The work has also attracted international interest and I was invited to the Scottish Parliament to speak with the Scottish Government about child sexual abuse prevention in March 2023, as well as delivering a keynote presentation at the NOTA Annual International Conference 2023 in Cardiff and a plenary session at ATSA 2023 in Colorado. All this will be excellent for awareness about this Churchill Fellowship report and its findings, and for gathering support for dissemination of the public health model once it is co-created.

## Appendix

### **A public health approach (PHA) framework for prevention of child sexual abuse development group**

#### **DRAFT Terms of Reference**

##### **Background:**

- The World Health Organization recognises child sexual abuse as a preventable public health issue that substantively contributes to the global disease burden.
- In The UK 7.5% of adults are estimated to have experienced sexual abuse before they were 16 (Tackling Child Sexual Abuse Strategy, Home Office 2021). This translates to an estimated 3.1 million people having experienced child sexual abuse in England and Wales – 700,000 men and 2.4 million women.
- The most recent data (February 2023) from the CSA (Child Sexual Abuse) Centre of Expertise states that in 2021/2022, local authority children's services in England recorded concerns about child sexual abuse in 33,990 assessments of children, a 15% increase on 2020/2021; and police forces in England and Wales recorded 103,055 child sexual abuse offences, the highest-ever level and a rise of 15% on the previous year.
- Being a victim of child sexual abuse increases the risk for a multiple of physical, mental and behavioural problems through individual's life-course. In the absence of support and ongoing protective factors, those who have been the victims of child sexual abuse can experience short and long-term impacts on their health and wellbeing. Survivors of sexual abuse are more likely to experience mental health issues (including depression, anxiety and post-traumatic stress disorder), have difficulty in forming healthy interpersonal relationships, experience disrupted psychosocial development (e.g. engaging in compulsive or inappropriate sexual behaviours, or experiencing intrusive and disturbing sexual thoughts), and experience feelings of guilt, shame and self-blame.
- Supporting the public health case to prevent child sexual abuse is a UK economic one; NSPCC research estimated that the cost of child sexual abuse to the UK in 2012 was between £1.6 billion and £3.2 billion (Saied-Tessier, 2014). If we consider an inflation related uplift, for 2023 this figure can now be estimated to fall between £2.1 billion to £4.2 billion at current prices. This figure in addition to personal costs, is also composed of shared financial costs for communities and the nation in terms of healthcare costs, productivity costs, child welfare costs, costs to the justice system and education.
- A political shift in focus from treating often entrenched problems to intervening early in the life of a problem came in 2008 with a cross-party paper on early intervention. The paper provided the groundwork for two independent government reviews of early intervention by Graham Allen MP, published in 2011. Over a decade later, despite the amount of good work done and being developed across the UK by local authorities, private, voluntary and independent organisations, more coordinated action is needed to create a common framework of preventative policies and high-quality evidence-based preventative programmes to bring about social change and eradicate child sexual abuse in the UK.
- If child sexual abuse is understood and approached as a public health problem – in that it

affects all communities, its impacts can be multiple, long lasting, and costly, and it can be prevented from occurring in the first place – this can provide a helpful framework through which prevention activity can be planned and delivered. It is therefore logical that we can stop child sexual abuse before it occurs by employing a public health approach.

### **Purpose of the development group:**

The idea of applying public health approaches to areas such as road safety, knife crime and violence is not new; but still the term is being used to mean different things and no nationally agreed definition of a 'public health approach to child sexual abuse' currently exists. Prevention frameworks have been developed and adopted in the UK and US, but gaps remain in primary child sexual abuse prevention activities in both countries.

- The aim for this development group is: **The development of an evidenced informed public health model and framework for the prevention of child sexual abuse in the UK.**

This would:

- be informed by child sexual abuse theory and composed of the four components of public health approach (identifying the problem, risk and protective factors, development and evaluation of interventions and implementation)
- outline the essential elements of developing and delivering an integrated and effective child sexual abuse response, that prioritises prevention across every area of society – using primary, secondary and tertiary preventative approaches.
- enable local areas to develop prevention focused and integrated child sexual abuse strategies and policies that will ultimately reduce conceptual fragmentation (i.e. where local areas struggle to understand how sexual abuse links to other types of child abuse and therefore fail to work together to tackle these problems).

### **A public health framework approach will:**

- focus on whole population, not just on high-risk individuals
- put emphasis on prevention, on 'upstream' interventions that are aimed at the causes of the problem, not at its treatment
- promote a whole system-wide approach, including action by all parties and stakeholders (such as, primary care, education, and a wide range of government departments)
- put an emphasis on collective responsibility for health and a significant role for the state (not just individual responsibility)
- put an emphasis on working in partnership with the population being served. Public health is undertaken with and for communities
- focus on tackling underlying inequalities as a major cause of health inequalities
- champion data driven interventions. Understanding the characteristics and needs of the population are key, and actions should be evidence-based
- ensure decisions are taken that require long-term commitment.

It is important for agencies to recognise that by adopting the framework they are not being asked to take on something beyond the scope of their core business, but rather to address more effectively a child protection issue that complements and enhances their existing roles and duties.

**Conceptualizing child sexual abuse as a public health problem will:**

- situate child sexual abuse within the personal/familial context (as opposed to the stranger/predator stereotypes)
- recognise of child sexual abuse as a correlate or consequence of other social issues, such as inequality, neglect and education
- and finally shift activity, research and policy (and society's) attention to prevention rather than reaction.

It is important for agencies to recognise that by adopting the framework they are not being asked to take on something beyond the scope of their core business, but rather to address more effectively a child protection issue that complements and enhances their existing roles and duties.

In furthering the purpose of developing the PHA framework, the development group will:

- Create a working group to explore and develop a pragmatic planning framework
- Meet regularly to bring together the members of the development group to share views, experiences and agree joint work and action points
- Act as a vehicle for sharing information and ideas
- Work collaboratively to avoid duplication and maximise impact
- Produce evidence that might inform joint briefings and position statements and to collect evidence to support positions and policy
- Monitor policy and legislation
- Identify gaps in the information and evidence base
- Pool information on activities of members
- Pursue issues through working groups that report-in to the development process
- Work in an atmosphere of transparency and tolerance
- Share examples of good practice through the promotion and implementation of the framework
- Develop an implementation and evaluation plan for the framework

## 1) Membership

Proposed membership<sup>11</sup> of the **development group** is:

Name	Organisation
Jon Brown (Chair)	Director Barnardo's/NOTA Prevention Lead
Pat Branigan (Vice-Chair)	Assistant Director, NSPCC
	Durham University
	University of West England
	Lucy Faithfull Foundation
	UK Police
	CSA Prevention and Early Intervention  Tackling Child Sexual Abuse Unit, Tackling Exploitation & Abuse Directorate, Public Safety Group – Home Office
	NHS, Nat Dep Lead (head of safeguarding) Department of Health
	Stop It Now UK and Stop It Now Scotland
	Contextual Safeguarding Network
	Centre of expertise on child sexual abuse (CSA Centre) expertise
	Police Plymouth
	Together for Childhood
	ADCS Associate Member and Director, Research in Practice
	NCA, CEOP
	The Children's Society
	Co-Founder and Director of Listen Up, a company established to amplify lesser heard voices in child safeguarding research, practice, and policy

It is expected that members should participate fully in the work of the Forum by attending most meetings and being actively involved in working groups and other work of the development group as this reflects the action-orientated nature of this body and work.

Interest in membership should be directed towards the Chair of the development group in the first instance.

## 2) Chair of the groups

Jon Brown will act as Chair of the development group. Pat Branigan will act as Vice-chair of the group.

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<sup>11</sup> Members names redacted for the purposes of this report.

### 3) Secretariat of the group

Secretariat will be provided by NSPCC (Partnerships and Development Directorate) and is responsible for:

- Servicing meetings of the group (consult about agenda, circulate minutes, arrange venue etc).
- Setting a timetable for the group throughout the year.
- Circulating information to group members arising from the work of the Forum.
- Maintaining the mailing list for the group and circulating information specific to the group.
- Co-ordinating joint activity of the group, such as the preparation of position statements and the 'signing-off' of any joint statements or positions. This does not necessarily mean that the NSPCC secretariat writes the statements or takes the lead. Rather that it has an understanding of who is doing so and that it ensures that other group members are aware of this. The Chair (Jon Brown) has the final role of 'signing-off' any statements or position papers produced on behalf of the group.
- Co-ordinating the work of any working groups.
- Co-ordinating external contacts made in the name of the group.
- Receiving any expressions of interest in membership of the group and sharing this with the chair for consideration.

### 4) Forum meetings

Full meetings of the development group should occur at least three times over the next six months. The dates will set out from 2023.

Meeting type	Where	When
Inaugural strategic development group	TBC	Late Spring 2023
Full group meeting development group and practice working group	TBC	Summer 2023
Final group meeting development group and practice working group	TBC	Autumn 2023

### 5) Working groups and presentations

Working sub-groups of the full group can be formed from the membership to take forward specific tasks or activities relating to the work of the development group.

Experts and experienced practitioners will be invited to present ideas and findings to the group meetings to stimulate thinking and discussion where relevant.

The development group will report progress through the NCA/CEOP Prevent and Prepare Strategic Action Plan and quarterly Board updates.

#### **6) Speaking/writing in the name of the development group**

Work done in the name of the group, such as joint statements, responses etc can only be issued after consultation with members and will be coordinated through the group secretariat. If for some reason consensus cannot be reached, then certain aspects of the work may be taken forward in the name of a more defined group of agencies within the full group. At all times such work of the Forum must be undertaken in an atmosphere of trust and transparency.

#### **7) Resources**

The work is made possible by the time, commitment and skill given by the members. In this sense all of the above will be shaped by how much of that time is available at any given moment.

#### **8) Review of these Terms of Reference**

These Terms of Reference should be periodically reviewed, ideally on a quarterly basis.

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