University of Suffolk

AN EVALUATION OF THE SERVICES OFFERED BY RESTITUTE:

Well-being, Confident Parenting & Caring and Physical Health

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Acknowledgements

I would like to thank Restitute's clients who agreed so willingly to share data to enable the evaluation to proceed - without your trust in the evaluation process, and the research team, this report would not have been able to be written.

I would also like to sincerely thank the seventeen participants who agreed to have a research interview with a complete stranger, and discuss things that were, and are, deeply painful and traumatic. Thank you for being so trusting.

Whilst child sexual abuse, domestic violence and other violent crimes, have devastating impacts for families, both in the short and longer term, the evaluation evidenced that there is hope, that with the right support, given at the right time, which responds to individuals' unique needs, better times are in reach.

Dr Jo Finch

(Principal Investigator)

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Executive Summary

Introduction

Restitute is a non-profit Community Interest Company set up in 2019 by Cath Pickles (CEO). Restitute aims to support third-party victims of crime, in particular:

- Parents, carers, siblings, and other family members who support children who are survivors of sexual abuse
- Non-abusing partners or children of those arrested for sexual offences against children (including online)
- The loved ones of adults who have survived sexual assault as an adult or who were sexually abused as children
- Family and friends who are supporting someone who has suffered violence, including domestic violence

The organisation operates under the premise that by providing support to parents and caregivers, they will be better equipped to offer sustained care for their loved ones over the longer term. Further, by enabling parents and caregivers to develop confidence, strategies and skills to manage the negative impacts of abuse, the aim is to mitigate against the potential for future familial challenges and intergenerational trauma.

Restitute offer a casework service, with the potential for referral to therapy services. To date Restitute has worked with 478 clients. The casework service is flexible, client-led and highly responsive to the needs of third-party victims of crime. The average length of support is around 12 months. At the time of writing, 72% of Restitute's clients are third-party victims of Child Sexual Abuse.

The evaluation

The organisation received funding in 2023 from the Home Office via the Support for Victims and Survivors of Child Sexual Abuse Fund, to employ a partner to undertake a two-year evaluation of the services offered. The evaluation aims to explore the impact of the services offered by Restitute on individuals and families who are a) currently known to the service and b) have finished working with the organisation, with a focus on:

1. Exploring the impact and outcomes of the casework and therapeutic services offered in terms of well-being, physical health and parent/carer confidence in the short and longer term
2. Understanding the characteristics and needs of the individuals and families that come into the service
3. To consider the longer-term support needs of individuals and families
4. To consider future service development and funding requirements

Key messages from research

Research estimates that 1 in 6 girls and 1 in 20 boys are lively to have experienced Child Sexual Abuse (GovUk, 2022). Other estimates suggest that 7.6% of the adult population will have experienced CSA (ONS, 2020). In terms of domestic violence, The Crime Survey for England and Wales estimated 2.1 million people aged 16 years and over (1.4 million women and 751,000 men) experienced domestic abuse in the year ending March 2023 (ONS, 2023). Refuge, a charity that supports victims of domestic violence, argue that 1 in 4 women will experience domestic violence in their lifetime in the UK (Refuge, date unknown).

In terms of violent crime, the ONS (2024) estimate that there were 583 homicides in England and Wales, and 2.1% of people aged 16 years and over experienced sexual assault and attempted sexual assault. All these estimates are, however, likely to be an under-estimation as many of these crimes often go unreported. The impact on victims/survivors of these crimes is significant, as are the wider impacts on friends, family and the wider community. The "costs" therefore of these crimes are also significantly high.

Methodology and methods

The overall evaluation design is a mixed method, encompassing three states of data collection.

Stage 1 - Qualitative Analysis of casework notes.

Stage 2 - Qualitative Analysis of 17 interviews with clients.

Stage 3 - Quantitative Analysis of pre and post assessment measures used by Restitute (Well-being, Parent & Carer Confidence and Physical Health) in their casework service, and two validated measures, PQH-9 (depression) and GAD 7 (anxiety) used in the therapy service.

Findings

1. The evaluation evidenced that there were improvements in clients' wellbeing, parent and carer confidence and health. The therapeutic interventions evidenced that their clients experienced reductions in depression and anxiety.
2. The evaluation evidenced that experiencing such events caused clients, from whatever socio-economic background, significant financial strain.
3. The evaluation also showed that many parents and carers are living with psychological and physical ill health, all of which are likely to be caused by the traumatic event or indeed exacerbated by the traumatic event.
4. Many parents and carers, and indeed their families, become considerably isolated, with former social and familial networks becoming fractured.
5. Parents and carers will likely experience intense guilt, stigma and shame, alongside other difficult, challenging, and conflictual emotions.
6. Parents and carers are managing very difficult behaviours in their loved ones.
7. Parents and carers sometimes have very negative experiences of other agencies, including the criminal justice system, family courts and safeguarding systems and processes. Interactions with professionals, for example the police and social workers, appear to cause secondary harms.
8. The evaluation evidenced the short- and medium-term support needs of parents. This often includes urgent practical support (housing, financial, safety advice, household management, liaising with other agencies) as well as longer term emotional support (managing loved one's behaviours and response, referral to other agencies, safeguarding) and managing the harms caused by the various systems.

9. The evaluation identified that more needs to be known about the longer-term needs of parents, cares and loved ones, not least given the long criminal justice and family court processes, as well as supporting the changing needs of their loved ones.
10. Given the prevalence of CSA, DV and other violent crimes, it is likely that there is a large group of third-party victims of crimes, who are supporting their loved ones would benefit from the services at Restitute. Funding, however, remains a significant concern as well as commissioning restraints.

Recommendations

Restitute

1. Develop existing policies and procedures further, relating to case recording.
2. Revise the assessment measures used in the casework service to ensure further rigor.
3. Articulate and publish more explicitly "The Restitute Model."

Systemic opportunities and risks

1. This evaluation cannot ascertain with any certainty what the longer-term outcomes for clients and their loved ones may be. Therefore, collecting data in the form of post-service surveys as recommended earlier would be incredibly useful.
2. The needs of non-abusing siblings have been identified as somewhat overlooked in the existing research literature. Restitute workers were also indirectly supporting siblings through their work with the primary carer. Their needs, however, do require further exploration as well as recognition that they are also third-party victims of crime, as are other family members, i.e., Grandparents.
3. It was noted that other agencies, such as the police or social services, had access to counselling services for victims, or could refer individuals. This appeared to happen relatively soon after the disclosures, but the therapeutic value could be marred by the timing of intervention, which happens too early on in the process, or there were fears of contaminating evidence which made usual therapeutic practices challenging, i.e. lack of liaison between child therapists and parents. This was particularly the case if parents were also witnesses.
4. Additionally, services declined to offer therapy once they were aware that criminal proceedings were in progress. Given the length of time it takes for criminal proceedings to take place, this means individuals who require therapeutic input are not getting the service they require.
5. It is important to note that when individuals are in therapy, there can be an escalation of internalising and externalising behaviours and carers and other professionals need to be cognisant of this possibility.
6. For several of the clients Restitute works with, there is evidence of intergenerational trauma. This is indicative of the continuing impact of abuse and possibly is not accounted for in estimates of the "costs" of such crimes.
7. The significant delays in the criminal justice system and indeed family courts, have negative consequences.
8. There appears to be a need for more awareness of the wider needs of third-party victims of crime who are caring or supporting their loved ones. They are also victims/survivors.
9. The evaluation identified good practice amongst a range of professionals, but also highlighted poor practice, including professionals who did not follow safeguarding protocols and procedures in relation to children and giving out advice that is potentially harmful to children.

Next Steps

The process of evaluation has highlighted further areas where research is indicated:

- A cost benefit analysis to be undertaken by an appropriately qualified person as there is evidence that the casework service, the range of work it is doing, and its positive impact on individuals, are diverting those individuals away from other services.
- The needs, if any, of clients from racially minoritised backgrounds.
- Longitudinal research to understand the longer-term needs and requirements of carers.
- Longitudinal research to explore the longer-term impact of Restitute's service and approach.
- The short, medium and longer-term needs of wider family members, particularly siblings, is indicated.

Conclusion

The work undertaken by Restitute is complex, working directly with individuals and indirectly with family members who are all experiencing significant stress, living in crisis, and living with psychological and physical ill health. The approach to the casework intervention may appear simple but is highly sensitive to the needs of the individuals. It is responsive and adaptable, and the work encompasses several models of intervention, including task centered, trauma-informed, crisis intervention and strengths based. Further, the casework services offers the provision of a safe, containing and non-judgemental space, which whilst not therapy as such, nonetheless, had a therapeutic effect. The lived experience of workers further enhances the service offered and helps build trust and rapport with individuals, whose trust in others has often been shattered.

Main Report

About Restitute

Restitute is a non-profit Community Interest Company set up in 2019 by Cath Pickles (CEO). Restitute aims to support third party victims of crime, in particular:

- Parents, carers, siblings, and other family members who support children who are survivors of sexual abuse.
- Non-abusing partners or children of those arrested for sexual offences against children (including online).
- The loved ones of adults who have survived sexual assault as an adult or who were sexually abused as children.
- Family and friends who are supporting someone who has suffered violence, including domestic violence.

The organisation operates under the premise that by providing support to parents and caregivers, they will be better equipped to offer sustained care for their loved ones over the longer term. Further, by enabling parents and caregivers to develop confidence, strategies and skills to manage the negative impacts of abuse. The aim is to mitigate against the potential for future familial challenges and intergenerational trauma.

The organisation has supported 478 individuals to date and offers two services, a casework service and therapy. For individuals who have agreed to share data for this evaluation (74%) the following was identified:

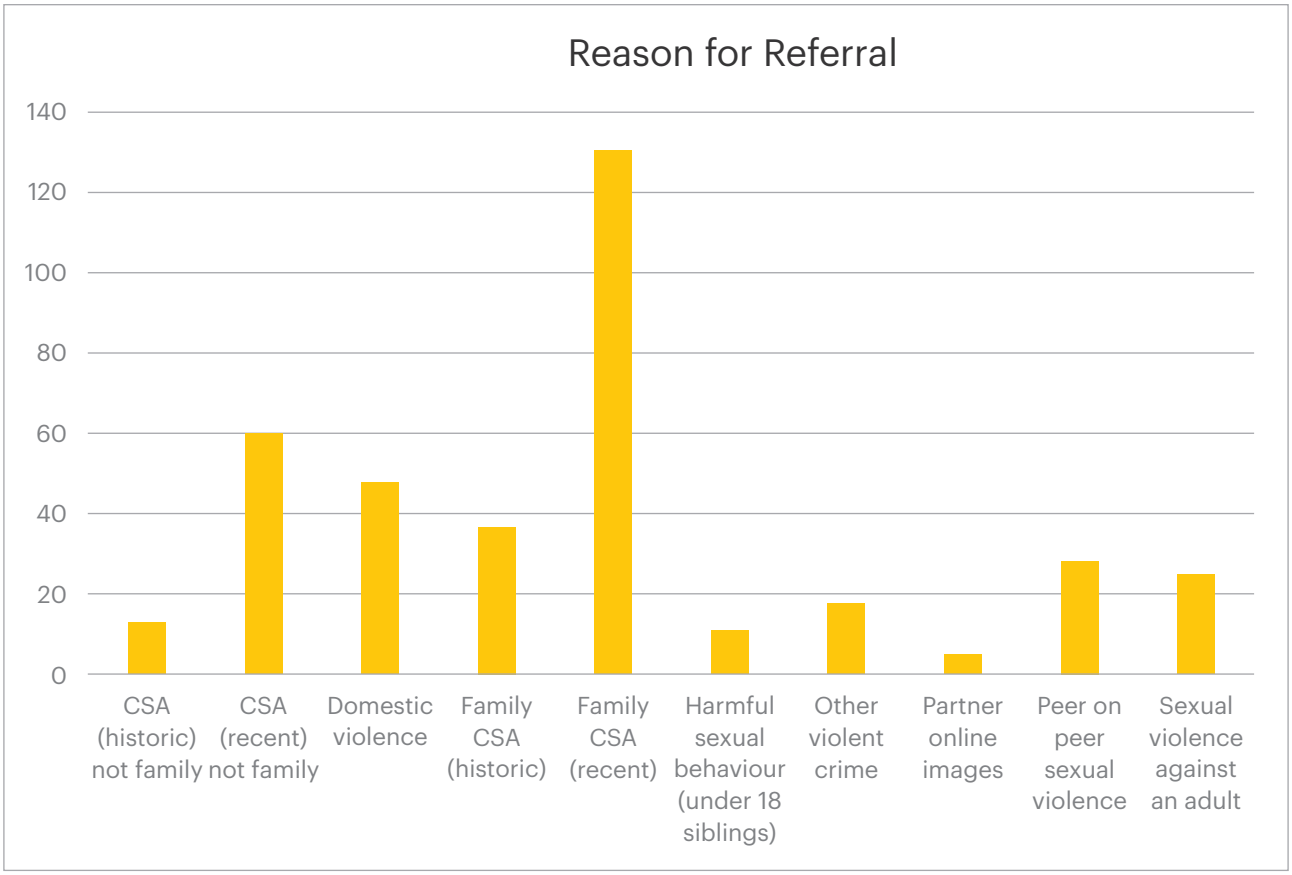
- Most Number of contacts with one individual: 372
- Least amount of contact with one individual: 1
- Average amount of contact per client: 26.1
- Average contact time per casework session: 57 mins
- Average contact time to assist with claiming disability benefits: 3.5 hours.

The service largely works with individuals from the East Anglia region but works with clients across the UK. Internal data shows the development of the geographical spread of the client base, as the service has developed. For example, in 2021, Restitute worked with clients from 3 broad geographical areas, namely, East Anglia, the Southwest and the Northwest. At the time of writing, Restitute has additionally worked with clients from Yorkshire and Humber, Greater London, the Southeast and Midlands, Wales and Scotland.

Reason for referrals

The graph below details the reasons for referral into the organisation:

Figure 1 - Reason for Referral



In terms of percentages of each category they are as follows:

Table 1 - Percentage of Referrals

	Percentage of All Referrals
Familial CSA (recent)	34%
Non-Familial CSA (recent)	16%
Domestic Violence	13%
Familial CSA (historical)	10%
Child on child sexual violence	8%
Sexual Violence Against an Adult	7%
Non familial CSA (historical)	4%
Other violent crime	5%
Harmful sexual behaviour (under 18s)	3%
Partner viewing online CSA images	1%

The most common reason for referral is recent familial child sexual abuse (34% of all referrals) followed by recent non familial child sexual abuse (16% of all referrals)[1]. The organisation thus works predominately with parents or carers of loved ones who have experienced CSA.

The organisation is funded through a range of funders, including the National Lottery, The Home Office, Suffolk and Police Crime Commissioner, Essex County Council and Suffolk Community Foundation. Restitute is staffed as follows; 1 CEO and 9 part-time support workers and two part-time administration staff. The organisation now has 9 (formerly 5) non-executive directors, including 4 former clients. As can be seen, it is a small organisation.

Client Journey through Restitute

In terms of referral to Restitute, people can self-refer, or professionals can refer individuals. About 50% of referrals are self-referrals although of these. At the time of writing, there is approximately a 12 week wait for services, with urgent referrals triaged to provide a crisis response.

Casework Service

Clients will be allocated a caseworker, where an initial assessment takes place, alongside completion of a range of tools and scales depending on the presenting issue. The tools and scales utilised focus on:

- Well-being
- Parental/carer confidence
- Health
- Household management
- Finances and benefits
- Work
- Caring for a child or young person who has survived CSA
- About other siblings or children in the family

These survey tools were co-produced with families and carers during the initial research and development of Restitute during 2019. They were designed to encourage carers to think about the questions that mattered to them and that they wished they had been asked when they were initially dealing with the aftermath of a disclosure. During COVID additional questions were added to ensure that Restitute was part of the national response to encourage vaccinations.

Intervention from caseworkers comes largely in the form of video calls, usually starting with weekly sessions, which decrease in frequency in line with the clients' needs and preferences. Clients can opt later to have telephone calls if it meets their preferences. Contact is also sustained through text messages. As will be explored later in this report, the average time clients spend with the casework service is approximately 12 months. The flexibility of the service, in terms of no fixed length of intervention, is something participants spoke very positively about, as will be explored in the findings section of this report.

The survey tools analysed for this evaluation were well-being, parental/carer confidence and health. It is acknowledged that these are not validated survey tools and so it is not possible to compare Restitute outcomes with another organisation, given the co-produced nature of these locally produced surveys and measures.

1 CSA - Child Sexual Abuse, Harmful sexual behaviour between under 18 siblings that occurs within the home, child on child refers to under 18s sexual abuse outside of the home.

Therapeutic Service

Restitute do not provide therapy within the organisation but contract out the initial therapeutic assessment service to Balance Psychotherapy, who then refers the client to the most appropriate form of therapy. The therapeutic modalities Restitute clients' have been referred to include Cognitive Behavioural Therapy, Eye Movement Desensitisation and Reprocessing (EMDR) and Art Therapy.

To date 80 clients have been referred to a therapeutic service. Restitute pay for 12 sessions of therapy and in exceptional circumstances, may fund further sessions. The following pre and post validated tests are utilised, depending on the presenting issues:

- Public Health Questionnaire 9 (PQH9) (used to assess depression) and is freely available to use and is self-administered.
- Generalised Anxiety Disorder Questionnaire (GAD7) which is publicly available to use and is self-administered.
- PCL-5 - is a checklist for Post Traumatic Stress disorder which is free to use for qualified health professionals and researchers[2].
- The Impact of Event Scale–Revised (IES-R)[3] is a questionnaire that measures symptoms of post-traumatic stress disorder (PTSD). This is a self-report tool that can be used to assess the impact of a traumatic event on an adult or senior.

Defining terms

The organisation employs the term "client" to describe individuals they work with. The term "loved one" is also utilised with the organisation to refer to the client's family members. These terms will be used interchangeably within this report alongside other familial terms (i.e. mother, father, sister) when appropriate.

Purpose and aims of the evaluation

The organisation received funding in 2023 from the Home Office, via the Survivors and Victims of Child Sexual Abuse Fund, to employ a partner to undertake a two-year evaluation of the services offered. The evaluation aims to explore the impact of the services offered by Restitute on individuals and families who are a) currently known to the service or b) have finished working with the organisation, with a focus on:

1. Exploring the impact and outcomes of the casework and therapeutic services offered in terms of well-being, physical health and parent/carer confidence in the short and longer term
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2 Due to methodological limitations, these have not been analysed for this evaluation
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Literature review

A brief overview of the relevant literature is provided, not least to understand what is known already about the needs of third-party victims of crime, but also to situate the longer term potential negative impacts of child sexual abuse, sexual offending and other violent crime, on third parties/loved ones, as well as the victims/survivors themselves. The potential for negative outcomes thus adds a compelling rationale for why such services are urgently required, that meet the needs of individuals in both the short and longer term. The literature review begins with definitions.

Child Sexual Abuse (CSA)

Defining familial CSA

There can be inconsistency in the use of the term familial child sexual abuse as there is a lack of a universally agreed definition. The terms inter-familial or extra-familial CSA (Scott, 2023) can also be deployed. The Crown Prosecution Service (2022) defines inter-familial as when someone is living in the child's own home and assumes a position of trust or authority over that child, and considers relationships such as blood ties, adoption, fostering or living together. Of importance for this evaluation, Restitute uses the term familial CSA to include those living within and outside of the children's family home, who are related in the ways suggested above in the CPS definition. Non familial sexual abuse refers to those who are not related and would include family friends. Some organisations utilise the term Child Sexual Abuse and Exploitation.

The prevalence of childhood sexual abuse

The report into the Independent Inquiry into Childhood Sexual Abuse (2022) identified the concerning levels of childhood sexual abuse in the UK. The report estimated that 1 in 6 girls and 1 in 20 boys experience child sexual abuse before the age of 16. The Office for National Statistics in 2020 estimated that 3.1 million adults had experienced sexual abuse before the age of 16, which is around 7.5% of the population ages 8 to 74. The NSPCC (2025) identifies that girls across all age groups are more likely to be sexually abused (although this might also be a consequence of lower reporting amongst boys). The National Chief Police Council (NCPC) (2024) note that sexual offending involving male victims are more common in offences involving indecent images and younger children. The estimates therefore of the prevalence are an estimation and the likely prevalence is much higher. CSA remains a significant issue therefore, which can cause a range of negative short- and longer-term consequences as will be explored later in this report.

The perpetrators of childhood sexual abuse

The NCPC reported that 82% of all CSA offenders are men, predominantly abusing females (79%). The ONS, utilising data from the 2019 Crime Survey for England and Wales, estimate that 92% of people who have experienced child sexual abuse will have been abused by males, 4% experienced sexual abuse committed by both males and females, and 4% experienced sexual abuse by females only (ONS, 2020). The ONS (2020) found that those sexually abused before the age of 16 were most likely to have been abused by family members, friends or acquaintances of oneself or one's family (37%). Around 30% were likely to have been abused by a stranger. The ONS (2020) further estimate that:

- Girls are around five times as likely as boys to have experienced sexual abuse by a stepfather, at 7.5% compared with 1.4%
- Girls were more likely than boys to have experienced sexual abuse by a family member that was not a parent or step-parent, 24% compared with 15%
- Boys were more likely than girls to have experienced sexual abuse by a person in a position of trust or authority, such as a teacher, doctor or youth worker, at 16% compared with 6%.

It is estimated that 1 to 5% of children have been sexually abused by a sibling in the UK (Brown, 2024). Yates and Allardyce (2021) confirm that sibling CSA can be equally harmful as sexual abuse perpetrated by a parent or other adult and can have short and longer-term consequences for the victim/survivor.

In terms of child on child under 18 sexual abuse, data from police forces in England and Wales between 2019 and 2022 estimated that there was a 40% increase in reports of sexual assaults and rapes where the victim and perpetrator were under 18. A 33% increase in rape reports and a 26% increase in reports where the allegation was against a child aged under 10 and that more 2,700 recorded incidents took place on school property in 2022. (Savage, 2024)

The impact of childhood sexual abuse

A rapid evidence review (2017) detailed very starkly the initial and enduring impact of childhood sexual abuse on individuals. Such negative impacts include:

1. Poor physical health
2. Poor mental health
3. Negative externalising behaviours (i.e. substance misuse, offending behaviours)
4. Poor or negative interpersonal relationships
5. Social-economic impacts
6. Loss of faith or spiritual beliefs
7. Vulnerability to further victimisation

(Fisher et al, 2017)

The impact on non-abusing parents

It is interesting to note that research in this area remains relatively sparse in comparison to the impact of children sexual abuse and the impact of domestic violence on the primary victims. In terms of the impact of CSA on third party victims, in this case, parents and carers of children who have been sexually abused, The Independent Inquiry for Child Sexual Abuse (2022) conducted a rapid evidence review and found a range of adverse impacts which included:

1. Poor Physical health
2. Poor mental health
3. Damage to personal relationships
4. Employment and financial challenges
5. Vicarious trauma and trauma
6. Compromised parenting

The inquiry noted that the primary and third-party victims of CSA all experience considerable family upheaval and stress when CSA is disclosed or becomes known. Restitute thus provides supports clients through these likely negative impacts, both in the short term and medium term.

Research by McElvaney and Nixon (2020) found that parents and carers struggled to make sense of the abuse, with resulting emotional distress, struggled to negotiate their identity as parents and caregivers, not least how their identity as a protector had been damaged, and struggled with hypervigilance and overprotectiveness. Lastly, navigating services was experienced as highly stressful alongside feelings of isolation and feeling alone. Indeed, these findings emerged in this evaluation. Cyr et al (2018) focused on the health impacts of non-offending parents following disclosure of CSA and found significant negative physiological and psychological impacts which remained significant 18 months after disclosure. Indeed, these impacts are seen in this evaluation. A report by Sabin and Sheath (2023) indicated the effects on parents and caregivers can include, loss of a partner, and the impact of parental separation, potential ostracisation within the community with associated shame

and stigma, and high levels of household stress. The non-offending parent will likely experience a wide range of very challenging feelings and emotions, which may feel conflictual. The non-offending parent may also feel under scrutiny from other professionals. The findings of the evaluation accord strongly with the literature as will be explored later in the report.

The impact of childhood sexual abuse on non-abused siblings

The impact of CSA on non-abused siblings has had less attention than the impact on the victim/survivor but research nonetheless has identified the impacts can be significant. The Independent Inquiry on Child Sexual Abuse noted adverse impacts for non-abusing siblings of survivors of child sexual abuse, including impacts on mental health, similar internalising behaviours and externalising negative behaviours experienced by primary victims/survivors, for example drug and alcohol use, behavioural changes, depression and anxiety. Schreier et al (2017) also identified that non-abused siblings can also display internalising and externalising negative behaviours, similar to those that victims/survivors of CSA may experience. Given the family stress and often significant familial disruption, siblings will undoubtedly be impacted adversely. Schreier et al (2017) argue strongly that siblings should be routinely considered in terms of treatment, support and indeed in research. A study conducted in Ireland, by McElvaney et al (2021) identified the three main impacts on siblings, which included experiencing intense emotional reactions, the negative impact and strain on relationships and the challenges inherent in managing sometimes fractured family dynamics post disclosure. The study concluded that support for siblings is vital, not only to support them in their own right with the impact of sibling CSA disclosures, but because of the potential protective and supportive role that siblings can undertake with their abused sibling. Indeed, the authors are strong in their assertion that supporting family members, to support the longer-term psychological well-being of those who have experienced CSA, may be more beneficial than providing individual therapy for the survivor. Indeed, Restitute is premised on the perspective that in supporting parents and carers to support their loved ones following abuse, this can provide longer term stability and mitigate against the widely documented adverse impacts in both the short and the longer term.

Financial costs of child sexual abuse

The financial and societal costs of childhood sexual abuse are also significant. The Home Office (2021), for example, identified that the costs relating to children whose sexual abuse began or continued in the year ending March 2019 would exceed £10 billion. Services that can effectively support families and individuals who have been impacted by childhood sexual abuse are therefore considerably important to offer urgent mitigation against the high costs, individually, as well to society. The costs as identified in the report include:

- Expenditure on protective and preventative measures such as costs of education and training, as a preventative and in anticipation of CSA occurring.
- The physical and emotional harms to victims and survivors, in terms of lost economic output, and the costs of health and victim services.
- Costs incurred by the police and criminal justice system, and the costs of safeguarding victims/survivors in response to disclosure of CSA.

The report estimates that victims/survivors bear 64% of these costs, followed by government (criminal justice, safeguarding, health etc.), and then costs to the voluntary sector including preventative interventions. Overall, the report estimates that for each person who has experienced CSA, the cost is £89, 240 (2019 costings). This does not, of course, measure the additional financial costs to parents/carers or other family members, nor does it account for the costs of inter-generational trauma and abuse. The financial impacts emerge strongly in the evaluation findings as will be explored later. Whilst the majority of work at Restitute centres on the impacts of CSA, it is important nonetheless

to document briefly the impact of domestic violence, not least a number of clients at Restitute have themselves experienced being a victim of domestic abuse.

Domestic Abuse:

Domestic violence is defined by the UK Government as:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological, physical, sexual, financial, emotional as well as coercive control. Parental conflict refers to situations when conflict is intense, frequent and poorly resolved or addressed." (from The Domestic Abuse Act 2021)*

Domestic violence is a significant issue for many people in the UK. The Crime Survey for England and Wales estimated 2.1 million people aged 16 years and over (1.4 million women and 751,000 men) experienced domestic abuse in the year ending March 2023 (ONS, 2023). It is estimated that significant numbers of children in the UK witness domestic violence, around 1 in 5 children. The impact on those subject to intimate partner violence and abuse is significant, and can have short- and long-term physical, emotional, psychological and sexual negative consequences (The WHO, 2024).

Increased risk of childhood sexual abuse to children exposed to domestic abuse or violence

Of import to this evaluation is the link between domestic violence and child sexual abuse. Research suggests that between 40-70% of child sexual abuse occurs within families where domestic violence is present (Farmer and Pollock, 1998, Hester and Pearson, 1998). Humphreys and Stanley (2006) in an analysis of CSA case files, found 50% also featured domestic violence.

Physical and psychological impacts

Children's and young people's physical health will be impacted by the threat of being physically abused and the subsequent injuries this may cause. There is considerable research evidence that suggests that children living with domestic violence often experience physical health complaints, many of which are psychosomatic. For example, Lamers-Winkleman et al (2012) found that children exposed to domestic violence had more health complaints than children not exposed to violence within the home. Overlien (2010) found that children who are either direct or indirect victims of domestic violence experience a range of adverse mental health outcomes including depression, anger, anxiety and increased risk of post-traumatic stress disorder symptoms. McGee (2000) argued that the impact of living with secrecy and stigma can adversely impact children's self-confidence, self-esteem and capacity for making positive and supportive relationships. This may increase the child's sense of isolation, which makes them further vulnerable to abuse, including CSA or gang membership (NSPCC, 2007, Khan, et al, 2018).

Methodology and Methods

The evaluation utilised a mixed method design, using both quantitative and qualitative research techniques and approaches. The evaluation design incorporated a three-stage approach to data gathering.

Stage 1 – Casework data analysis

Anonymised casework data was provided by the organisation, utilising their case recording system (Lamplight). The data spanned two periods, January 2021 to November 2023 with initial coding

undertaken in 2024, and then from November 2023 until February 2025, with the analysis carried out at the end of the project. The focus was on exploring the methods of intervention used, identification of clients' needs and the impact of the service. The utilisation of casework recording in social work and social care research has had limited use in adult social care research (Kuorikoski, 2022) but has been widely used in children and families social work and social care research (see for example Larid et al, 2017).

Stage 2 - One-to-one, semi-structured interviews with 17 clients:

Apart from one interview that was carried out by phone, all interviews were undertaken online using MS Teams. The online meetings were recorded, a transcription produced that was then checked for accuracy. Once this process had been completed, the recordings of the interviews were deleted. The phone interview was recorded via a digital voice recorder and then transcribed and subsequently deleted.

Stage 3 - Analysis of pre-and post-test data

Clients complete a number of surveys/tests when they first come into service. These include a parent/carer confidence survey, a well-being survey and a health survey. These surveys/tests are repeated during the intervention and at the end of the work. For those receiving therapy, the PGH9 and GAD7 tools were analysed using pre- and post-test techniques. An analysis comparing the improvements of all clients, as well as comparing those who only were given casework compared to those who had received casework and therapy.

Recruitment

Restitute acted as gatekeepers for all phases of the research. Restitute emailed all clients (former and current) and required them to opt in to allow their anonymised casework data and pre and post survey/test data to be shared with the research team.

Data and casework consent

354 clients agreed for their anonymised data to be shared, out of a total of 478 (74%). Restitute also acted as gatekeepers to assist the research team with recruitment of the participants for the one-to-one interviews. Participant information, consent forms and the debriefing protocol were circulated by Restitute via email and individuals were asked to make direct contact with the Principal Investigator. Restitute remain unaware of the participants of the interviews.

Interview Participants

17 people agreed to be interviewed, 10 participants were former clients and 7 were current clients. The reasons they were involved with Restitute was for the following reasons:

Table 2 - Reason for Involvement

Reason for Referral	No of participants N=17
Familial CSA -recent	12 (71%)
Familial CSA - Historical	2 (12%)
Domestic Violence	2 (12%)
Violent Offence	1 (5%)

Table 3 - Relationship to the Victim

Reason for referral	Relationship	No of participants (N=17)
Familial CSA - recent	Parent or step-parent	11 (65%)
Familial CSA - recent	Grandparent	1 (5.9%)
Familial CSA - historical	Parent or step-parent	1 (5.9%)
Familial CSA - historical	Grandparent	1 (5.9%)
Domestic Violence	Daughter	1 (5.9%)
Domestic Violence	Parent	1 (5.9%)
Violent Offence	Parent	1 (5.9%)

Data Analysis

Stage 1 and 2 - Qualitative analysis of case notes and one-to-one interviews

Thematic analysis (TA) (Braun and Clarke,2020) was used to analyse the one-to-one interviews transcripts. TA is an approach which aims to explore deeper meanings, and interpretations within the data, rather than relying on statistical factors in the data (i.e. counting numbers of incidences or occurrences). TA involves coding of qualitative data into groups or clusters of similar themes, or conceptual categories. It aims to identify any patterns and relationships between themes. It is an approach ideally suited to identifying the experiences, perceptions, feelings and needs of individuals. Further, it can be a particularly useful data analytical approach in ensuring the perspectives and experiences of individuals who might be marginalised in society, or indeed, have not heard their voices heard in policy discourses previously (Labra et al, 2022). Such an approach therefore has clear resonance with the research being undertaken, not least the hidden nature of child sexual abuse sexual and other violent crime. Like all qualitative data approaches, TA is an inductive approach which assists researchers to identify theoretical explanations of the phenomenon under study. The steps therefore involved in TA include:

- Familiarisation with the data set
- Coding
- Generation of initial themes
- Developing and reviewing themes
- Refining, defining and naming themes

(Braun and Clarke, 2022, p35)

Atlas TI, a qualitative software tool was used to code the data.

Stage 3 - Quantitative Analysis of pre-and post-tests.

For the quantitative analysis, the difference in the earliest and latest recorded outcomes on Restitute' s scales and the two validated measures were analysed. Restitute created questions which were divided into three themes: wellbeing, health and carer's confidence. The scales were given to all clients at the beginning and end of their interventions, and the aim was to analyse improvements in the outcomes over time. An additional aim was to examine any effects of the casework intervention and therapy intervention on each measure. Further mixed effects analyses were also conducted only on the therapy clients to investigate whether their scores on two validated measures - the GAD7 (a measure of anxiety) and PHQ9 (a measure of depression) - improved from their first to last session. Only clients who have

completed their time at the service were included in the analyses. For all analyses, the earliest record was used, which was usually their first session (although there were variations) and the last recorded session (which may have been the last session, or the last session in the data set).

All analyses and data visualisation were conducted in R[4]. For questions with responses on a 1-5 scale and for the GAD7 and PHQ9, linear mixed-effects models were employed using the lme4 R[5] package. For binary (yes/no) outcomes, fitted generalised linear mixed-effects models were used, using the glmer function of lme4 with a binomial (logit) link function. All models included random intercepts for participant ID, to account for individual differences between clients. However, in one question where inflated standard errors were observed, Firth's penalised logistic regression was used without random intercepts, using the logistf R package. This method reduces bias in small-sample logistic models and produces more stable estimates. For all models, we report fixed-effect estimates, standard errors (SE), t/z values, and p-values. In logistic models, results are additionally presented as odds ratios to assist with interpretation. All graphs were also created in R using the ggplot2 package

Methodological Limitations

As with all evaluative research, there are methodological limitations. In terms of utilising casework recordings in social research, a long-standing criticism is that often the objectives of the research and the objectives of the case notes often differ (Hochwald, 1952). Further, as Kuorikoski (2022) has identified, the varying quality of case notes and other related problems may impact on how such artifacts can be used effectively in research or evaluation contexts. Concerns about subjectivity and bias in case record, inconsistency, and uncompleted records have also been noted (Hoyle et al, 2019).

In terms of the scales used, to measure well-being, parent and carer confidence and physical health, as documented earlier, these are unvalidated scales, A validated scale on the other hand would have been rigorously tested and proven to accurately measure the intended construct, demonstrating its reliability and validity through research. This can therefore make it suitable for use in research or clinical settings (Bland and Altman, 2002).

Ethics

Given the sensitivities around the organisation's work, close attention was paid to ethical research practices. For stages 2 and 3, a data sharing agreement was set up between University of Suffolk and Restitute which conformed to all GDPR requirements. The shared data excluded information that could potentially identify individuals or families, and so personal data was removed by Restitute, i.e. names, dates of birth, postcode, addresses etc. The data was then stored on a secure SharePoint site accessible only by the organisation and the research team. For stage 3 of the evaluation, ethical approval was given by The University of Suffolk ethics committee on 5th November 2024.

All ethical research practices were strictly adhered to including privacy, anonymity and confidentiality of all participants. Restitute acted as gatekeepers for all stages of the research and clients were required to opt in to allow their anonymised data to be analysed. It was vital to ensure that in the evaluation, clients would not be at any risk of harm, and in this case, there was potential for re-traumatisation in terms of the one-to-one interviews, which was a key consideration. To mitigate against this, the participant information sheets were candid about the potential risks in taking part in the interviews, and a debriefing protocol was put in place. Participants were reassured they could stop the interview at any time and were free to follow up with the Principal Investigator after the interview if needed, and/or seek support from other agencies, including Restitute. All names in the findings

4 R is an open-source statistical software programme used to analyse data and create data visualisations, such as graphs.

5 Two key packages were used: lme4 is a package which can undertake specific analyses in R and ggplot is a package used to create graphs.

section are pseudonyms and care has been taken to ensure that there are no risks that the participants can be identified. As such names and locations of organisations have been anonymised. This is of the utmost importance anyway in terms of ethical research practice but given many of the participants are currently involved in ongoing criminal court proceedings, or family courts, this is even more pertinent.

Findings

Stage 1 - Casework notes analysis

The impact on parents and carers

The case notes evidenced the challenging situations many parents and carers found themselves in. Clients expressed in their meetings with their caseworker a range of challenging and negative emotions. These included:

- Guilt
- Anger and rage
- Frustration
- Anxiety
- Sadness
- Despair
- Feeling overwhelmed
- Suicidal ideation
- Grief and loss
- Isolation and loneliness
- Fear
- Shame and stigma

Of particular importance to parents and carers, were repeated reassurances that the challenging emotional reactions and strong and sometimes conflictual feelings were "normal" and to be expected given the traumatic events that had occurred both recently, or indeed, historically. Clients often experienced intense guilt in relation to CSA disclosures made by their children, that they had not spotted the signs or that they should have known, or having been in relationships with individuals who were domestically abusive which was witnessed by their children. One client, for example, described to her caseworker how:

> *"She was raped at 15 plus all the domestic violence she has suffered and she felt even though she was aware of those sort of situations, she feels guilty that she didn't protect her two girls from a similar situation."*

A caseworker records the following whilst working with a mother of a child who had been sexually exploited for two years:

> *"She has become hypervigilant and anxious, and she had a very difficult conversation with her ex about what had happened to her as a young person. [Name of client] felt extremely guilty and said "I didn't protect her, I didn't do my job."*

Similarly, another case note states:

> *"[name of client] says she is racked with guilt and struggles to communicate with her daughter which she says saddens her."*

There was evidence of intense work in this area by Restitute workers, reinforcing the message consistently and frequently, that they were not to blame for the abuse of their children by someone else. For example, one case note stated:

> *"[name of client] still feeling guilty and says she will never trust her own judgement again. I reassured her again that this isn't her fault and not to put any blame on herself."*

Evidence of the impact of this work was noted in one example where the case records noted:

> *"[name of client] is shocked that she is able to accept that she is not to blame for what happened to [name of daughter] and could not have prevented it. This has left a bit of a hole in her belief system that she is 'dealing' with."*

Case notes often reported that clients were sad, and this sadness was caused by many factors, the abuse itself, other associated and non-associated losses, including loss of familial relationships, deaths of relatives, and other losses. One caseworker records for example:

> *"[name of client] said she was really sad today" and another records "[name of client] says she feels very sad about her daughter's abuse."*

The case notes recorded repeated incidents of clients feeling "overwhelmed", whether in relation to disclosures or consequences of abuse. For example, one casework recording notes that the client needed to complete a mandatory reconsideration form to appeal against the refusal of the Personal Independence Payment (PIP) but is "overwhelmed and doesn't know where to start." One client cancelled a meeting with a caseworker via text, stating:

> *"I need to cancel today; I just need to shut the world away. Don't worry, I am safe, just overwhelmed and need a nap."*

Similarly, another case note states:

> *"[name of client] says she feels overwhelmed and as if nothing she does helps."*

For those with more recent traumatic events, clients were also required to undertake other significant tasks, which are stressful in and of itself, for example, moving house, which may include having to sell a jointly owned home, no longer being able to afford the rent, or indeed afford daily living costs, finding new nurseries, schools or colleges for children, former familial or friends support no longer available or having to either leave work, go off sick or find new jobs. All these factors added to a sense that many clients felt constantly "overwhelmed." Caseworkers managed a balance between empowering and encouraging clients to undertake important and at times, urgent tasks by themselves, whilst intervening and supporting with tasks. Caseworkers thus regularly built in measures within their interventions to ensure tasks had been done, i.e. asking clients to text them when a certain task had been completed.

Several clients expressed suicidal ideation. One casework note, for example, states:

> *"[name of client] wouldn't tell me her plans for suicide but did tell me that she had the same plan for 3 years and doesn't feel she needs to use it but likes to know she has an exit plan. Asked her to keep a picture of her children on her at all times so she can look at it if she feels really low."*

In the aftermath of disclosure, another entry states:

> *"I required medication to help with my anxiety and sleep. I battled with anxiety and suicidal ideation for months afterwards"*

A further example states:

> *"Already low, read Facebook by Ex. Very upsetting. Considering suicide but at the moment able to hold off until after Christmas in order not to upset/damage grandchildren. Still keeping it as an option after Christmas. Reminded her she can text any time and ask for a call!"*

A further impact on parents and carers, and indeed loved ones, were the isolation they felt in the aftermath of the traumatic event, coupled with a fracturing of familial relationships in the aftermath of disclosures. Indeed, as one case note states:

> *"Socially, we have lost some of our support network, including some of the children's most significant friendships, as a result of the social stigma attached to this offending. Together with the fact that there were other identified victims of my husband's crimes. I have also withdrawn socially due to my ensuing anxiety and trust issues."*

Clients often reported feeling lonely, for example one text message states:

> *"I feel so lonely and isolated."*

Similarly, another case note states:

> *"She [client] feels really alone and has no friends to talk to."*

Feelings of shame and stigma also were experienced by clients, and indeed their loved ones. One case note states for example:

> *"[name of client] still feels a sense of guilt around what has happened as well as shame."*

Several families were also living in fear of reprisals from members of the local community or the public, which in turn contributed to anxiety, withdrawal, exacerbating further feelings of isolation. Indeed, one case note states this explicitly:

> *"Vigilantes have attacked the family before, and it has started again big time because the case has been in the news of [name of client's]'s ex being a paedophile."*

Similarly other clients had to move houses because of local community hostility. For other clients, they were advised to put in protective measures. As one client reports:

> *"We were advised of possible vigilante action should the charges against [name of perpetrator] to be reported in the media. This had included eradicating my online presence and ensuring there are no online listings containing my address, changing our IP address, changing our names, requesting an LOI marker [this means emergency services will be urgently dispatched] be placed on our property and investing in personal safety measures such as a decoy camera and personal alarm."*

As evidenced in both the literature and indeed, in the data presented here, parents and carers urgently require immediate, and indeed, ongoing support to manage very complex, painful, distressing and conflictual emotional feelings.

Health and disability

The case notes identified health issues or other diagnoses the clients were experiencing or living with including:

- Diabetes (often with associated physical health conditions)
- Depression

- Anxiety including panic attacks
- Autism
- ADHD
- Dyslexia and Dyspraxia
- Headaches
- High blood pressure
- Gastrointestinal disorders
- Skin disorders
- Suicidal ideation
- Asthma
- Long COVID
- Chronic Fatigue
- Brain fog
- Eating disorders
- Substance use/misuse
- Heart problems

Depression and anxiety were very common health conditions noted in the case notes. For example, one case note stated, "[name of client] said her "anxiety is through the roof" and another stated:

> *"[name of client] said that her levels of anxiety are higher since her ex was released from prison last year. She is hypervigilant and it does not take a great deal to make her panic."*

The anxiety that clients were experiencing sometimes caused panic attacks as one note stated:

> *"She [client] is experiencing more and more panic attacks."*

Similarly, another case note stated:

> *"[name of client] was in an agitated state when we first spoke today. She said she was having daily panic attacks and everything was too much at the moment."*

In terms of depression, many clients had diagnosed depression and were taking medication. For example, one case note read:

> *"[name of client] explains she is currently on anti-depressants and feels very low in spirit."*

Similarly, another case note stated:

> *"[name of client] explained she is unable to work at present due to the depression and anxiety she feels was brought on by the disclosure. [client name] has been prescribed antidepressants by her GP."*

The health and range of disabilities the parents and carers had is important to note in terms of identifying the distinct needs of this group. For many, these conditions predated the abuse but for others, health conditions were exacerbated by the traumatic event, as well as the impact of living with chronic stress. This was identified in the literature review as potentially significant. Thus, clients were supported by Restitute workers to address their own health, ensure they had the correct diagnoses and to seek on-going medical support. Caseworkers frequently advised clients to visit their GPs. For example, as one case note states:

> *"[name of client] to ring GP for appointment & let me know when she has done it. To discuss: - Antidepressants, EGC & general health checkup."*

It was further evident in the case notes that Restitute workers supported clients to address their possible health concerns for themselves as well as their loved ones. For example, one case note stated:

> *"[name of client] confirmed he had been to the GP. He has high blood pressure and is now on medication. His GP also wanted to put him on a high dose of medication for his depression but [name of client} is not keen, I advised that he talked again to his GP on Friday when he goes for and ECG."*

The case note later states:

> *"Called [name of client] to check that he had made appointment with GP for his Health issues. He said he had spent about twenty minutes talking to the GP and he felt a huge weight lifted off him as he has been putting that off for years."*

In terms of more general well-being, it was evident that clients were encouraged to engage in well-being activities more generally, for example, going out with friends, attending clubs, walking or sports. For example, one case note entry records:

> *"Self-care: To try really hard to do at least one thing a day for herself & enjoy/mark it as her time. Nice bath, time for coffee & a magazine, coffee with a friend, power walk with friend."*

The case notes evidenced success in this area, with clients reporting engaging in activities they had undertaken that they had enjoyed, such as attending a choir, yoga, the gym or having pamper nights. As a case note records:

> *"Positives & achievements. Going to Yoga, seeing friends and having at least one relaxing bath with candles & nice smellies & music."*

Evidence of one consistent practice to emerge in the case notes, aimed at supporting well-being more generally, was sending bunches of flowers, pamper packs, or chocolates to clients, when they were particularly low in mood, or lots of challenging life events were occurring in quick succession, or to recognise their significant progress and achievements. For example, a case note detailing a text message from a client reads:

> *"Have just received your card, flowers and chocolates... I have never felt so supported in my life. You keep doing what you do... you are changing people's lives for better."*

Similarly, another case note states:

> *"Flowers to be delivered to [name of client] tomorrow on her birthday."*

And:

> *"To send flowers to [name of client] who has been feeling extremely low, anxious, is off work..."*

The challenges of supporting a loved one

A significant stressor for many parents and carers, was managing the negative internalising and externalising behaviours of their loved one. Internalising behaviours are directed inwards and can be characterised by feelings of anxiety, withdrawal, depression, and at times, somatic complaints, for example, stomach aches, pains, headaches where there are no medical causes (Zilanawala, 2019, Nikstat and Riemann, (2020). Externalising behaviours on the other hand, may include behaviors such as bullying, aggression, inattention, hyperactivity, oppositionality, defiance, substance use, and disruptive behavior (Peterson, 2024). Such behaviours were seen in children and adult loved ones. Casework intervention thus also focused on supporting clients to understand why their loved ones may be behaving the way they were, as well as supporting clients to develop strategies to manage the behaviours exhibited.

Caseworkers therefore sent resources on managing challenging behaviours to clients or gave advice in casework sessions - often around the importance of consistency in parenting and maintaining boundaries and rules. Example of such advice includes the following:

> *"Still feel she [client] lacks some self-belief and confidence so trying to reassure her that she has what it takes and can go for the life she wants. [name of son] has been pushing his luck and back chatting, she said he tries to guilt trip her by saying everything is her fault. We spoke about keeping the boundaries in place and standing her ground as it isn't her fault."*

Similarly, one case note states:

> *"Explained the importance of having ground rules in place and how some can be negotiable and some can't and that keep getting expelled from school due to having no respect should come with some action. I asked him [client] if he feels confident with his parenting which he does but he does worry that she [daughter] won't like him. We went over how teenage girls are hard work and I told him that she will push her luck, but it is really important that he doesn't back down on what he has said no matter how hard he finds it. [name of client] knows that something has to change, and he is going to try some of the ideas we discussed."*

Loved ones at times were reported to engage in aggressive behavior which was experienced as threatening and frightening. One case note for example reads:

> *"[name of client] has had a bad week. Daughter punched the wall, and they ended up in hospital all weds night. Thankfully nothing broken but [name of client] is concerned that [name of daughter's] behaviour is getting worse."*

Several clients were also assaulted by their loved ones. For example, one case noted /detailed an assault on a mother by her son. It states:

> *"Contacted [name of client] to see how she was feeling following an incident yesterday when [name of son] punched name of client] in the throat. [name of client] said she had pain by her ear and down her neck, but she wasn't too bad"*

This was followed two weeks later by:

> *"Last weekend [name of son] attacked [name of client], pulling her hair and pushing her downstairs. She could not fight him off. He ran out of the house down the road shouting "Help me Help me." [Name of client] called the police who brought him home in handcuffs. She says they didn't really say anything about the attack apart from saying that [name of son] needed help."*

It is important to note therefore that child-to-parent violence or adolescent to parent violence may be a particular risk for this client group.

Further stressors were self-harming behaviours including, substance abuse, cutting, risk taking behaviours and suicide ideation and attempts. As one case note states:

> *"[Name of daughter] has not cut herself or self-harmed for four weeks...it seems what has put [name of daughter] off cutting herself was one of her nephews who is 3 years old asking about why she's cutting herself. One of the challenges that I set [name of client] was for both her and [name of daughter] to do the 'what would you do if you had unlimited time and money' question. [Name of daughter] might give [name of client] an inroad to ask [name of daughter] and therefore get her talking."*

Similarly, one case note states:

> *"The last two years have been really hard in knowing how to support her daughter. [Name of daughter] still self-harms and has cuts on her arms and neck and legs. She is also on the anorexic spectrum and never eats with family. She weighs about 6 stone but GP says her weight is consistent so won't refer her."*

Loved ones were also attempting suicide or experiencing suicidal ideation. For example, one case note states:

> *"[name of client] talked about how difficult it was for him when [name of daughter] attempted suicide because his brother took his own life six years ago."*

Similarly:

> *"[name of client] said this had been a horrendous few days. [name of daughter] has made at least three attempts to take her life, one of which was in school when she tried to hang herself in the toilets."*

Loved ones were also sometimes engaging in sexually harmful behaviours and practices. A letter sent to a client expressed the caseworker concerns about the daughter, it states:

> *"Currently she [daughter] is at great risk of negative influence, exploitation, experimenting with drink and tobacco or other risky behaviours."*

Loved ones, and indeed other family members, were using drugs and alcohol with negative impacts. For example, one case note states:

> *"[Name of client} said that she was concerned that [daughter]was taking drugs although she has not been drinking heavily lately."*

A later entry for the same client notes:

> *"When [name of client] got home she went into [name of daughter's] bedroom and there was very clear evidence that she had been drinking (empty vodka and wine bottles) and using drugs (white powder on the dressing table and empty wraps in the bin)."*

Similarly, another case note states:

> *"[name of client] is worried about [name of daughter's] drinking habits, and the fact she goes to the pub and gets bought drinks by other people; mostly old men."*

A number of clients also were using alcohol as a coping mechanism. Caseworkers suggested strategies to reduce alcohol consumption. One case note details a text message from a client which reads:

> *"I'm irritable, not sleeping well, drinking too much, brain fog is awful, confidence shot to shit."*

Restitute workers were continually reinforcing the strengths and positives of parents and carers' abilities. For example, a casework entry notes:

> *"One of the things I told her [client] in everything she does, it shows and it comes across who her priorities are in life and it's her two boys. I also extolled her what a fantastic job she is doing as a mum. I don't think enough people tell her that."*

The importance of being believed

The case notes identify a number of clients who had previously left abusive relationships, and then children made disclosures of CSA. As the research evidence indicated, there is an associated risk of being subject to CSA whilst living in a domestically abusive situation. One client for example, when her child disclosed details of sexual assault in a very explicit manner and was engaging in inappropriate sexualised behaviour felt that police and social services did not her concerns seriously. The case note states:

> *"The disclosures of sexual abuse kept coming. This was reported to the police. However, it was alleged as hearsay. The local authority haven't been helpful and dismissed allegations as [name of client] putting words into [name of son's] mouth, citing that the breakdown of the marriage was the cause of [name of son's] behaviour."*

Restitute staff therefore recognise the importance of belief and there were several references in the case note speaking to this. One case note for example notes:

> *"I encouraged [name of client] that whatever the verdict, she believed [name of daughter], the Police believed [name of daughter] and the CPS believed [name of daughter] because they had put the matter before the Court."*

Similarly, another entry reads:

> *"I spoke [to the client] about how the justice system works and it isn't that she [daughter] isn't believed, it's all down to evidence."*

This is an important intervention therefore, given the importance of belief for both primary and third-party victims of abuse.

Non-progression of criminal cases

It was identified in case notes that a number of clients and their loved ones were adversely impacted when decisions were made by the police or the Crown Prosecution Service, not to progress cases to trial. Clients expressed their anger, and how unjust such decisions were, not least because clients and their loved ones felt the reasons given by the police of CPS were not detailed enough, or felt the reason was inadequate or not sufficient to justify the lack of charging decision. For example, one case note states:

> *"The police have upheld the original decision regarding taking [name of perpetrator] to court. They say it's not in the public interest due to his age and the fact that he has already done a series of courses to address his behaviour in relation to sexual assault."*

Such decisions impacted adversely on parents/carers and their loved ones' recovery journeys. Casework thus centered around supporting clients through these processes, either practically, advising clients to seek reassessment of such decisions, or emotionally. For example, as one case note states:

> *"[name of client] said she wants to appeal or at least ask for a case review. The Police Support Worker is not being very helpful and she still hasn't got a report into the assault. We had a discussion about what is in the public interest and how she should approach going forward."*

In some cases, the CPS chose not to proceed. As one case note states:

> *"She [client] said that Police had taken the case to CPS 5 times but each time the note came back NFA as they couldn't guarantee a conviction"*

Clients experienced these decisions as "unjust" and noted a deterioration in their loved ones' behavior. For many, there was a sense that justice had not been achieved, through the non-progression of cases, or indeed, alleged perpetrators being found not guilty at court. Indeed, one case note reports:

> *"[name of client] continues to be distraught and shocked by the Not Guilty verdict last week."*

Another states:

> *"The jury reached a verdict of Not Guilty. The whole family were devastated but [name of son] was particularly affected."*

The impact of the verdict continued to impact adversely on the client. Indeed, a later case notes states:

> *"She [client] had been through an awful lot in the last year and had waited five years for the case to come to Court only to have a Not Guilty verdict."*

For this particular client the court case caused later post-traumatic stress disorder symptoms to return, i.e. flashbacks, anxiety and intrusive thoughts. Indeed, other clients reported similar post traumatic stress symptoms when court cases were concluded.

The Impact of delayed criminal proceedings

The case notes evidence repeated delays in the initial police investigations, acknowledging that some of the evaluation data covered the Covid era when national lockdowns were in force.

Police investigations were felt to take far too long with clients in a perpetual state of uncertainty. One case note reports for example:

> *"The lack of progress on the court case for [daughter's] rape is taking a toll on them [parents] both emotionally and physically."*

Similarly, a client, whose daughter had been sexually assaulted two years ago was:

> *"Waiting for the police to contact her and inform her of the process with the person who assaulted her daughter and it is hard waiting and wondering what is going to happen."*

Caseworkers encouraged clients when appropriate to take positive action when there are delays. For example, one case note states:

> *"[name of clients] statement has finally been done and then now waiting for the police to pass everything to the CPS, however the main police officer has been pulled off onto another case. I said to [name of client] she can write it too the chief constable and ask when this will proceed."*

When cases were proceeding to the criminal courts, the length of time and repeated delays were raised as a significant concern, as well as cases being adjourned at very short notice. For example, one case note, relating to CSA, states:

> *"The Court case has now been set for March and as the time approaches [name of client] can see her daughters struggling. In the last three years, on a number of occasions, the case has been listed for Court only to be cancelled at the last minute. This has led to all the family suffering emotionally."*

The build-up to court cases were a challenging time for parents and carers as well as their loved ones, with anxiety and stress levels rising. This had a regressive impact on their recovery and gains that

had been previously made. Restitute workers offered additional support to help clients, and indirectly their loved ones, manage the delays and uncertainties. Impending Court cases, in both the criminal and family courts, caused considerable anxiety for clients, as well as loved ones. For example, one case note states:

> *"At the moment, she [client] says she still has anxieties, and the court case isn't until the early part of September."*

Similarly, another note states:

> *"[name of client] said to [caseworker] that she was feeling exhausted, washed out, numb and wanting to get the court date of 22nd over. She said she felt she had been waiting for ever for her ex-husband to be sentenced for sexual assault on her children."*

Parental conflict

The case notes detail that one particular stressor for parents and indeed their children, was continuing conflict with ex partners. This would typically center around financial disputes, i.e. lack of payment of maintenance, privately or through the Child Support Agency, contact arrangements, residency disputes and in a number of cases, allegations of continuing controlling or abusive behaviours perpetrated by ex-partners. These conflicts were then managed by the Family Courts, either through private proceedings or public, which would then involve social workers and if resident in England, CAFCASS (children and family court advisory and support service).

Parent conflict was a significant stressor for parents in itself, but also in terms of the financial challenges that might result, through non-payment of child maintenance or other payments (i.e. mortgage) and often in terms of the significant costs of securing legal representation, for family court services, which added to families often challenging financial circumstances. For example, one casework entry states:

> *"[name of client] text me this morning asking if I could call her as she needed to talk to someone. I phoned and she was crying and in a mess, she was at work but was sat in an office as she was so bad. She said she had to go home ill yesterday and her solicitor had emailed her stating that she wanted more money, £3500 and wants to increase her agreed monthly payments from £240 to £400. [name of client] replied saying she couldn't do that as she had to pay the barrister £3500 in 2 days and she's borrowed money from several different family members to scrape this together..."*

Parental conflict also impacted negatively on children within the family. Casework intervention therefore centred on signposting clients to appropriate agencies for support with these specific issues, as well as ongoing emotional and practical support. Concerns were also noted about children being caught up in parents' potentially manipulative behaviour. Overall, such parental conflict contributed to continuing high levels of stress, with accompanying internalising and externalising behaviours.

Other agency involvement

Clients were often engaged with a wide range of other agencies and professionals. These included:

- Psychologists
- Psychiatrists
- Hospital Consultants
- Police
- Criminal justice personnel
- Independent Domestic Violence Advisors
- Adult Independent Sexual Violence Advisors

- Counsellors
- Therapists
- Social workers
- Mental Health support workers
- Family support workers
- Occupational Therapists
- Physiotherapists
- Headteachers and other key school personnel (i.e. SENCOs, Pastoral care leads)

A range of national and local voluntary organisations were also involved in clients and their loved ones' lives. Restitute workers thus helped clients navigate the professional networks, would attend meetings with them where appropriate and practical (i.e. some workers do not live in the same areas as the clients given the national spread of clients). Restitute workers would also refer clients and their loved ones to appropriate local services.

Challenges identified in the case notes, were the costs involved in taking loved ones to various appointments. Many clients struggled with the costs of public transport or petrol. For others, if working they sometimes struggled to navigate paid time off work to attend various appointments and meetings or indeed were reluctant to reveal why the time off was needed, and felt managers were unsupportive. It was evident in the case notes that at times, the challenges of multi-agency working were revealed. This took the form of differing professional perspectives on what were the key issues or concerns, repeated incidences of workers in all agencies leaving, impacting adversely on the client or their loved ones, some of whom had developed good working relationships with other professionals. Professional involvement in individual lives also was a source of stress and anxiety at times, not least when social services were involved because of safeguarding or child in need concerns. Whilst it is not within the remit of this evaluation to comment on other agencies' practices, the case notes evidence both very positive and helpful practices and interventions from a range of professionals, as well as concerning practices. For example, casework entries note serious concerns about the accuracy of social workers reports. In an email written to social service, it notes:

> *"I am now working with another client with another inaccurate report that has cherry-picked information sent and is again following a preconceived narrative decided prior to that of the evidence. It also has a history as previously this parent won in court and social services were heavily criticised by the judge. Fundamentally, this is putting children at risk and undoing the hard work the client, myself and other agencies have put in."*

Another entry details an email sent to social services about concerns about unsupervised contact.

> *"The section 37 report is recommending a move towards unsupervised contact over weekend and holidays with no supervision order. I am deeply worried that the combination of a parent with chronic drug misuse, four traumatised and/or disabled children with extremely challenging behaviour and a new-born baby may lead to a serious incident."*

The police also came in for criticism. For example, one entry reads:

> *"[name of client] said that during the investigation she felt the Police treated her more like a suspect than a victim and they were very accommodating to him. She was made to feel that she was the one in the wrong and she was the perpetrator and the Police were on his side."*

Similarly, schools and colleges were also criticised, not being understanding or flexible enough to deal with the challenging externalising behaviours. For example, one case note comments:

> *"School currently not being that supportive. [name of child] has a restricted timetable but sometimes doesn't manage this. A teacher told her to remove her jumper in class. She refused because she has cuts on her arms so she clashed with the teacher and came home."*

Other criticism centered on resistance to Education Health Care Plans[6] or lack of provision of what was included in them. It was also important to note that schools were often praised for their supportive and flexible stance towards loved ones.

For many clients therefore, there was a significant amount of professionals in their lives, which given the clients and loved ones range of needs, was not surprising. It is important to note that many of these professional interventions were found to be beneficial, equally many were not experienced as beneficial.

Casework interventions

The case notes documented the wide range of practical and supportive interventions regularly undertaken by caseworkers. These included the following:

- Managing over stimulation for those living with autism, i.e. use of noise cancelling earbuds
- Posting out relevant literature to help manage children's behaviours, or child centred resources
- Texting positive quotes
- Advice regarding sleep, i.e. use of podcasts, natural sleep remedies, good sleep hygiene
- Advising on techniques for managing anger, i.e. punch bags
- Help with prioritising tasks and time saving suggestions
- Provision of diaries, wall planners and notebooks
- Text reminders to undertake self-care activities, i.e. swimming, walking
- Advice regarding benefits, and support to appeal decisions relating to disability benefits
- Financial and debt advice
- Therapeutic letter writing
- Parenting advice
- Support to liaise with a range of other agencies and professionals
- Support during family court cases (private and public)
- Support through criminal court cases
- Suicide prevention tools
- Support with health and well-being
- Referrals to food banks
- Sourcing emergency funding
- Provision of vouchers, gift cards and other items

As can be seen, the caseworkers intervene in a number of ways and help support clients deal with a significant number of issues and concerns as has been highlighted so far in this report. What was also evident throughout the case notes were caseworkers giving positive feedback to clients, reminding them of what they had achieved, practically and emotionally, as well as their strengths. These positive messages and affirmations were often repeated throughout the intervention. Examples of this recorded in case notes include the following:

> *"[name of client] said that it was lovely to actually see how far she had progressed. She said "I forget where I was and to have that visual picture of progress is really encouraging. It really put a smile on my face."*

6 An EHCP is an Education, Health and Care Plan, which is a legal document that helps children and young people with disabilities or special educational needs, get the support they need.

And:

> *"I again encouraged [name of client] as to how far she has progressed from the person who would only speak to me, for the first six weeks, from underneath a duvet."*

It is also important to note that caseworkers were involved in safeguarding referrals in relation to the clients they worked with, because of concerns about harm to clients' children or other family members, indeed some of the children of clients were removed into foster care by social services. Restitute workers were also required to address adult safeguarding concerns, for example, domestic abuse and suicidal ideation or self-harming.

One area where impact can be seen is the provision of vouchers, for example, vouchers for leisure activities, i.e. cinemas and restaurants. These relatively small financial gifts were welcomed by families who were often in significant financial distress. They also assisted however, with well-being more generally, and being in a different and relaxing environment with loved ones and other family members. For example, one case note states:

> *"Have purchased tickets for the indoor play area that her children love in [name of town] for tomorrow. Also put £50 into her bank account for petrol and pizza hut."*

Similarly:

> *"It's [name of son's] birthday soon and Dad was worried that he had no money to do anything. I asked [name of worker] if we could provide a voucher for pizza hut so that he could take them out and relieve a little stress from the bill.... we have sent voucher to cover a buffet. [Name of client] was very shocked and very grateful."*

Clients were also supported with larger items, i.e. replacement white goods, when other avenues of financial support had been exhausted. Skips were provided to help clients remove clutter, indeed remove items or furniture associated with the perpetrator, or for when individuals were moving house and needed to sort possessions out. The impact this had on clients was positive. Indeed, one case note reports:

> *"For [name of client] the one thing that would really help her mentally is to get a skip to clear her garden which is full of rubbish and mattresses. She can't sit out there as it depresses her."*

Often noted in the case files, were references to Christmas hampers being sent to clients, and how well received they were. For example, one case note records:

> *"The first thing [name of client] said was how lovely it was to receive the hamper for Christmas from Restitute. She said that she, [husband] and [daughter] explored the hamper together and loved everything they found. She said she felt it was a lovely thing to do."*

Similarly, one client in an email to Restitute writes:

> *"Receiving the Christmas hamper today with gifts donated by supportive people has boosted me again with hope."*

A further entry reads:

> *"[Name of client] had received a Christmas Hamper from Restitute and was so appreciative. She said she felt really supported and it had made her cry because she was so thrilled."*

Impact of casework on parents and carers

The casework evidence shows clients' reflections on what they had achieved when they ceased their involvement with Restitute. For example, one case note reads:

> *"Thank you Restitute, your much needed, invaluable support over the last year has been everything I needed to manage my caring role and reclaim my coping skills. I will be forever grateful."*

Another client wrote:

> *"I'm in a really different place to when I started and it's a big part thanks to this service. [Name of caseworker] has been really wonderful, weekly and then every other week, and just knowing there's someone there to share things with when things were difficult reduced the amount of stress I was feeling. It was so helpful talking to someone who had been through something similar and could really understand. It's such a different type of relationship to a counsellor or a professional - so it makes you feel normal, listened to, understood and supported in a very different way .... You don't feel like a 'client' which can be dehumanising sometimes, but just a person."*

Similarly, another client wrote in an email to Restitute when the casework ended:

> *"I just wanted to drop you a line to say how grateful I am to be looked after by Restitute. You and your team have already made such a big difference to my life by just being here for me. I don't feel alone while going through the toughest time of my life. The regular conversations I have with the amazing [name of worker] contribute enormously to my mental wellbeing. I feel that I can be just myself and express my concerns and emotions. [Name of worker] always listens carefully and gives great advice. Supporting me in my day-to-day life, sharing thoughts and experiences make me feel stronger and safer. Hearing from a professional that my son and I will get through this difficult and traumatic time and that there are brighter and happier times ahead mean so much to us."*

Other sources of data also evidence the positive impact on clients' outcomes from their involvement with Restitute as will be discussed later on in the report.

Indirect impact of casework on loved ones

The case notes evidence that many clients felt their loved ones were making progress, although progress was not always linear, as other factors documented earlier in the evaluation might cause the progress to stall or regress. Progress seen in their loved ones included:

- Returning to education
- Forming friendships and being more sociable
- Improvements or lessening of the frequency of negative internalising and externalising behaviours
- Gaining employment
- Better relationships with carers and other family members

For example, one case note stated:

> *[name of client said that is an amazing improvement in both girls as they now have the confidence to be away from home"*

In terms of loved ones making new friends, a casework entry notes:

> *"Something that [name of client] is proud of that despite everything that happens, he's [son} coming out of his shell and building friendships."*

Similarly, a casework note states:

> *"[Name of daughter] stayed overnight at her friends so she's overcoming her anxiety and she might have a job in the near future."*

A significant success for clients was when their children returned to education, after having had difficult previous education experiences, including being permanently excluded. One case note for example states:

> *"[Name of daughter] is back at college and has made loads of friends. She is absolutely loving her time there after being out for a year."*

Another entry notes:

> *"[Name of client] said that over the last six months [name of daughter] has blossomed and is an absolute pleasure to be around. [Name of client} has bought notebooks for [name of daughters] so they can write down their thoughts and anything that is worrying them so that they can be used as conversation starters if necessary."*

Stage 2 - One-to-one interviews

Finding Restitute

Participants identified four ways in which they came to know about Restitute, firstly through their own research efforts, second through recommendations by another organisation or professional third through sheer luck and lastly by personal recommendation from a friend. For many of the participants, they undertook their own research, using online search engines, to find appropriate help and support. For example, Andrew, a father of a child who had been sexually abused by a family member commented:

> *"[On] the evening of the disclosure, we reached out to the [name of national charity], and I was on hold to them for about 45 minutes before being cut off, stating that they've changed their working hours due to high call volume, which was ironic."*

Andrew commented further:

> *"There wasn't much out there and then I think it was a sort of few days later, I stumbled across Restitute, in my many hours of trawling and searching and just filled out their online form."*

For several participants, they undertook their own online search after being referred to organisations, who then could not offer them a service through not meeting the criteria, due to the fact they were not the primary victims. As Milly, a mother of a child who had been sexually abused by a family member, commented:

> *"It was initially suggested that [name of organisation] might be able to support me but actually, I didn't fit the criteria, so I did some research and came across Restitute."*

A range of professionals also let participants know about Restitute, although participants could not recall what organisation had recommended Restitute, which is not surprising given the devastating aftermath of disclosure, and often significant professional involvement. Another way of participants found out about Restitute was a matter of luck, for example, Katie, a mother of a child who made a historical disclosure of sexual abuse, happened to see a member of Restitute staff on a national TV news programme. Similarly, Holly, a mother supporting her daughter who had witnessed parental domestic violence, received a work email with information about Restitute.

Practical support

Participants were asked about the ways in which they were supported by Restitute caseworkers. All participants commented on the provision of what they called "practical support." Indeed, participants spoke about the devastating aftermath of disclosure and the need for very practical support. Amy, for example, spoke about the "family being torn apart" after the disclosure of CSA. She commented further:

> *"We were in absolute turmoil…Restitute sent us diaries…they also sent a weekly planner for the family that we put on the fridge so that we could put what everybody was doing and at what points, and we still use that now."*

Amy added that the family wall planner had been the:

> *"Most helpful out of all the things that she's [daughter] has tried."*

Other participants spoke about this practical, "simple" but bespoke and helpful support which they found beneficial. Milly for example, spoke about experiencing insomnia, in the aftermath of disclosure. She commented:

> *"[name of worker] is great at coming up with loads of different strategies, so one of the things I found hard was I couldn't sleep… I was on high alert the whole time and I found it really difficult to sleep, so one of the things she [caseworker] did was recommend loads of differ things to help me sleep… like meditation apps… she showed me how to put on podcast things, how to put a timer on there."*

Milly discussed the helpful advice regarding developing her own coping strategies and other participants spoke of useful resources being posted with them. Amy spoke about very practical help regarding ensuring the bills were paid and the car insurance up to date. As Amy commented:

> *"In the very initial stages, what was really helpful was practical support with things…making sure we had the car insured."*

Similarly, Andrew spoke of the practical support that Restitute offered in the beginning and the:

> *"…reassurance of when your MOT is, have you got enough money to pay your mortgage, are the cars taxed? Have you got any bills coming up you weren't expecting? Is the house clean? Do you need a skip to come and remove any items that are related to… the perpetrator."*

Overall, the practical support included:

- Encouraging clients to keep a journal.
- Encouraging clients to undertake gratitude exercises.
- Providing information about self-care techniques.
- Encouraging and supporting clients to engage in self-care activities.
- Assistance with claiming benefits and other financial entitlements.
- Support to help clients manage and organise household tasks (through provision of diaries, wall planners).
- Providing resources, i.e., posting out books or information on relevant topics.
- Providing support to help manage other professionals or agencies, i.e. schools, or the police.
- Provision of items, i.e., Christmas hamper, flowers, white goods in emergency situations, emergency payments.
- Accessing other organisations.
- Techniques or suggestions for helping loved ones.
- Provision of Christmas hampers and other gifts.

A number of participants spoke about receiving a Christmas Hamper and the positive impact it had on all the family. Katie for example commented on receiving the surprise hamper and commented:

> *"...they sent me a beautiful hamper at Christmas, which I hadn't been expecting. And that just like, I mean, and the, you know, I say kid, she's quite grown up now, really. But she just loved unpacking it and stuff."*

Similarly, Milly commented:

> *"...it sounds silly, but they sent a hamper, and it had various different things in from pasta to colouring books for the kids...there was chocolate. And it was just...Even now, it makes me emotional because it was just so helpful and the fact that someone had your back... that always stood out and it. Yeah, it was. It was just absolutely lovely."*

Emotional support

All the participants commented positively about the emotional support they had received from their caseworker, and how necessary it was to have a safe, confidential, non-judgemental space in which they could help process their own distressing and challenging emotions. Parents and carers spoke starkly about the aftermath of the sexual abuse disclosure, and the devastation it caused. As Stuart commented:

> *"All of a sudden, your whole world just changes overnight, and you've got no idea what any of this means, you know, navigating the criminal services system and the justice system, navigating the family courts and the social care work system is fundamentally broken."*

Many of the participants spoke about the shame and stigma of child sexual abuse, mental health and domestic violence, and a feeling like they could not talk about what had happened or indeed talk about their feelings to friends and families. Ava for example, in the aftermath of a CSA disclosure, felt she could not tell her friends what had happened, she commented:

> *"It's so sensitive and it's really not something we're shouting about...most people assume that he [husband] left...I am going through the trauma of losing someone, plus my daughter going through a trauma...but I can't openly talk about or grieve...I think that was the hardest part to make sense of, that it was kind of secret and it was so out of the norm."*

Similarly Katie commented that talking about what had happened to her family, and being able to openly talk about it to her caseworker became a form of therapy in and of itself. She commented that:

> *"I was finding that some people shut me down, because they didn't want to hear about it, and it's like, well that's, you know, that's OK, that's your way of coping. But I don't have a choice. This is what we are living every single day."*

Katie commented that she had wished she had found out about Restitute at the time of the CSA disclosures, rather than two years later after the court case had ended. The provision of safe non-judgemental space became even more important when familial relationships became severed or strained in the aftermath of the disclosure. The sessions with the caseworker therefore provided a safe and non-judgemental space, in which clients could talk about what mattered most to them at the time. Lyndsey for example commented:

> *"My first initial call with her [caseworker] was also really supportive, really kind of validating those emotions and that just kind of, all of a sudden, took this massive weight of our shoulders that all of a sudden, we were like, OK somebody is on our side, somebody is helping us."*

This was particularly important for Lyndsey and her husband, as they felt very criticised by social services and the police as will be explored later.

Marissa commented, for example, that in her casework sessions she could:

> *"...pour it all out and have it out there...I talked through my feelings and started to make sense... I could talk about feeling murderous towards [name of perpetrator]. I couldn't say that to a police officer or... a social worker."*

Similarly Louise commented that her caseworker:

> *"Just listened. If I had a shit day, if I was crying, if I needed to swear, they just let you, they just go, just do it and I'm like, are you sure, like really - you don't think that somebody wants to hear you cry... it's like they cheer lead you as well. So, it's letting you express the tearful moments because it's so difficult, it's so tough."*

Participants commented on the difficult and challenging feelings they needed to process, whilst understanding that they had to be "strong" and "functioning" to be able to effectively support their children (or adult relatives in some cases). Katie for example commented:

> *"...I was fighting with all the feelings of guilt, of like... I should have known."*

Katie commented further that what had really made a difference was her caseworker's constant reassurance that she not to blame for the sexual abuse of her child. Katie said:

> *"How did I miss it? Were there things that I missed...and that's where they [Restitute] come into their own...every single phone call, that it wasn't your fault and that there wasn't anything you could have done, you didn't know. It took that repetition and it took that kind of reassurance that I wasn't a bad parent...I hadn't done anything wrong, but I needed to hear that, I need to hear in order to keep going."*

After the court case had ended, Katie commented that she was:

> *"...really struggling... there was no one there to help me pick up the pieces... for the first two years [post disclosure] I functioned on adrenaline alone, getting support in place for her [daughter] and at the point I could actually draw breath, it was like, what about me? I need something, anything."*

Duncan commented on the need to "try and hold it together for the kids" because:

> *"If you could hold it together and the kids can see you holding it together, and they feel better, ...if you're in bits and pieces... it's doing them no good and they think they are upsetting me because of what happened to them...you go round and round in circles, so it's nice to have an hour's chat with someone, and the main thing for me is speaking freely and openly."*

The flexible nature of the support sessions was also seen as positive by the participants, in that knowing there was a booked session meant they could contain things until their session. Equally if they were really desperate, they could make ad-hoc contact with their caseworker.

The emotional support offered was even more vital, and indeed as the casework records evidence, that for a minority of clients, they experience suicidal ideation. Andrew for example was stark in his assessment, he commented:

> *"They [Restitute] was a silver bullet for me and I wouldn't be here without them... I was suicidal."*

Similarly, Katie acknowledged she had felt suicidal at times, but that she could was able to talk through this with her caseworker who she felt "wasn't scared to talk to me about that" and that she could be honest and talk without fear that "I was going to get reported, left, right and centre."

Helping support loved ones

Participants also commented on how the casework service enabled them to help and support their loved ones. Lyndsey, for example, commented:

> *"Had we not had that service...don't know where we would be emotionally, to be able to provide the support to the girls."*

Pam for example commented on the guidance and helpful suggestions the caseworker had made about managing her daughter's behavioural issues. Pam commented:

> *"I trust her [caseworker] guidance in helping...and things were going terribly wrong here. I trusted what she [caseworker] told me do....it was that kind and trust and bond I had with [caseworker]... because I was literally putting the welfare of my daughter, in somebody else's hands."*

Similarly, when Katie's daughter began to regress in terms of age, her caseworker advised her this was "normal" and to go along with it, i.e. to watch Disney films aimed at younger children, to draw and colour in, and spend lots of time together. Several participants had lost confidence in their parenting abilities, and found they needed someone to "bounce ideas" off and offer reassurance they were doing the "right thing." Milly for example recognised this in her session with her caseworker. She commented:

> *"It was through my conversations with her [caseworker] that I thought, I've got really out of practice with decision making and I'd lost so much confidence."*

Participants recounted details of advice other agencies had given them, post disclosure, which they felt to be instinctively wrong. For example, Stuart and Lyndsey were advised by the police not to cry in front of the children or talk about what had happened, in other words carry on as normal. Lyndsey commented:

> *"[name of caseworker] helped us... it's OK for them to see you're upset because they [children] need to learn that actually being upset is OK."*

Such advice was even more important given the children in the family needed adults around them who could model regulating emotions effectively. Police, and at times, other professional anxiety about evidence contamination, meant that potentially emotionally damaging advice was given, as the previous scenario evidenced.

Participants also commented on the support given by Restitute when going through often, long and complicated criminal justice processes as well as the family courts. Milly, for example, had been involved in family court processes for 2.5 years. She commented:

> *"There are times where I am really, really anxious about the case coming up and she [caseworker] will be able to give me advice or she will just let me talk through my worries, just having someone to listen, who gets it is great... she will know what I am talking about, I won't have to go into great detail to explain it."*

Several participants were also engaged in trying to secure diagnoses for their loved one, for example, mental health diagnoses, neurodiverse conditions as well as physical health conditions or supporting loved ones with various diagnoses. Emma, who was supporting her mother commented that her caseworker:

> *"...started off with being able to support me, to support my mum, as having that support made me a lot stronger because I had like backup... This has happened, like where do I go? What can I do? What help? I honestly don't know what I would have done without them [Restitute]."*

Lived experience of workers

Participants were aware that some of their workers may have lived through similar experiences. For all participants, this made the relationships feel safer, and meant trust was established very early on in their involvement with Restitute. Pam, a mother of children who had experienced familial, CSA commented:

> *"I trusted what she [Restitute worker] told me to do, ...I knew obviously she'd [Restitute worker] spoken about her daughter and everything... so that we feel that, obviously, she has been through similar situations, and I thought, well, if she is here and she is alright. She must know what she is talking about, and it did help."*

Similarly, Stuart commented:

> *I definitely say we feel safe. They're [Restitute] very knowledgeable and experienced, sadly... which is awful in just itself."*

Participants commented positively on how workers managed professional boundaries with their lived experience, using it helpfully and with sensitivity at appropriate times, to support and advise the clients they worked with.

Marissa for example commented:

> *"It's so good to talk to somebody who has some understanding."*

Similarly, Louise commented:

> *"...the people in Restitute have lived experience. These people have not necessarily walked in the same shoes but they've walked similar paths, you don't feel alone...I didn't ever get told what the lived experience of that person was, but it was just familiar territory, somebody else has gone through something similar and they listen and they help."*

Approaches to intervention

Caseworkers supported clients utilising a range of intervention models and approaches to skilfully and sensitively meet the needs of the clients they worked with. The approaches or models included:

- Crisis intervention (often at the time of the disclosures when dealing with pressing practical concerns, or when clients were experiencing mental ill health)
- Solution Focused/Task centred - working on issues or concerns that were client led
- Provision of safe, containing and non-judgemental space, which whilst not therapy as such, nonetheless, had a therapeutic effect
- Strengths Based - using the pre-existing skills and strengths of the individuals
- Empowering - encouraging clients to undertake tasks
- Appropriate use of lived experience
- Providing hope and reinforcement that things will get better

It was noted that caseworkers, when required, were directive and worked within professional expectations, not least around safeguarding both adults and children. It was notable from participants (and indeed casework notes analysis discussed earlier) that the service was very flexible to meet the pressing issues and often the rapidly changing needs of the clients, not least from supporting

the shock of disclosures, through the criminal justice systems and the aftermath. The service also indirectly supports other family members, for example siblings. Participants commented on this flexible offering, that leaving the service was very much a negotiated client led process, but they could make contact again with Restitute if needed.

Milly for example commented that she had negotiated leaving the service with her caseworker, at her own pace but knew:

> *"...they're not like saying, that is it, door's closed."*

Participants thus commented negatively about other support services or agencies where they did not meet the "criteria" or "tick the right box" or could only have a limited number of sessions - which was particularly the case with counselling services.

Lastly, and importantly, many participants commented on how they felt their caseworker often highlighted the positive steps clients and their loved ones had taken, would remind them of how far they had come, and would celebrate clients and their loved ones' achievements. Amanda, for example, continued to inform her former caseworker of her continued successes, for example, finding a new partner, getting married, passing qualifications and gaining a new job. Jane spoke about how the caseworkers were pleased to hear about the successes and achievements of their loved ones, i.e. going to university, or getting into college.

Managing secondary trauma and harm

What emerged strongly in the participants' accounts were the secondary harms and trauma caused by other agencies' practices, policies and procedures. Restitute thus worked with clients in relation to the primary harm and trauma caused by the abuse and also worked with clients to support them to manage these secondary harms. The police processes were criticised by a number of participants, in relation to the initial investigation, the lead up to the criminal court case and, the post court case era (in relation to sentences coming to an end).

For participants involved in criminal proceedings, cases often took a long time to come to court. Court cases were adjourned at very short notice, and several participants were highly critical of the police for not updating them in a timely fashion about the progress of cases.

Andrew for example commented on numerous broken promises by the police to keep them updated. He commented:

> *"They [police] just don't see it, they've become so conditioned to the role that what they are doing, they are losing sight of the victim...If you say you are going to stick to a date, stick to it, if you say you are going to contact me, contact me... I felt really let down and the hurt that causes..."*

Ava felt the investigating officer was suspicious of her, and as the case progressed Ava began to feel the investigating officer had lost sight of professional boundaries and indeed:

> *"...was very much on his [perpetrators] side."*

This was seen in the investigating officers request for Ava to transfer some money to the perpetrator so he could find a hotel and was asked to pack up some clothes for the perpetrator because, as the police officer allegedly said, the police "had a duty of care towards the perpetrator."

Ava, like Andrew, felt the police broke promises to keep in touch about the progress of the case. She commented:

> *"Over the course of a few weeks, I kept emailing her [police investigator] and say, look, I still haven't heard from you. What's happening? Constantly looking for the postman, thinking something is going to come through me door, or is it going to be the day that I'm going to hear something every time the phone rings."*

Andrew and Amy felt the police had not undertaken the initial investigation correctly, for example, phones and computer devices were not seized until several months into the investigation and important potential witnesses were not interviewed in a timely fashion. Of most concern was the complete lack of child-friendly spaces or places in which police interviews could take place - not least having to walk into a police station front reception office.

The court case itself, whilst cathartic for some, in that abusers were found guilty and subsequently sentenced with custodial sentences, left others and their loved ones traumatised. Many participants were also witnesses in the court cases, and felt traumatised from being cross-examined, or having to face the perpetrator in court. Arrangements for attending the court were also not felt to be witness or victim friendly, with a lack of parking at courthouses, or car parks being away from courthouses with the resultant fear they might bump into the perpetrator outside, or indeed, in the confines of the courthouse.

This is not to say that all police were criticised, indeed a few participants commented positively about the police investigation and individual police officers. Amanda for example commented:

> *"I couldn't have wished for a better detective. [Name of police officer] has been brilliant. I can sling her text messages, left, right, centre and she'll respond to me when she is back at work or quite quick. I've had messages off her at 12 at night when she has been on nights, just to let me know."*

Schools were criticised by several participants, for not adequately supporting children who were exhibiting challenging behaviours, much of which were caused by mental ill health and often unrecognised neurodiverse conditions. Duncan for example, whose eldest daughter was living with severe mental ill health and had been hospitalised, was also managing the expulsion of his younger daughter from school. He commented:

> *"Last Christmas, because of the anxieties and the stress and everything she just flipped out one day and they expelled her...you can't go into school and go, she is like because of this... she's had a rubbish start to life, and right, she's done something wrong, she got into a fight with someone, and they expelled her straight away...and kicked her out, she's got no social life as well now and lost all her friends."*

Two participants commented that schools had not followed their own safeguarding procedures when children disclosed, with one school sending a child back home after disclosure when the abuser was living there, and another teacher, who was the school designated safeguarding lead, not responding to a disclosure of CSA. Whilst this was reported in a minority of participants accounts, i.e. two examples, it is still a significant concern and caused participants anger and upset

Social services did not appear to have played a significant role in these participants and their loved ones' experiences. In the aftermath of disclosures, social services may have had brief involvement to ensure that the child was safe but then withdrew. For a few participants, this initial contact was not felt to be positive.

Amanda felt that social services misinterpreted her initial reactions to the disclosures, and she felt they accused her of "not accepting what they've [children] said."

Amanda commented further:

> *"I'm accepting what they said, but I just can't get my head around it...when that family member has been involved in your life, virtually all your life, and as somebody you've trusted to look after your children. That is the only thing I think social service need to take from it, listen to parents, understand where we're coming from, instead of being judgemental."*

Similarly, Lyndsey had a negative experience of social services following disclosure which meant her step-children needed to come and live with her and their Dad. She commented:

> *"We felt like we were under investigation the whole time, everything we said was criticised, everything we did was criticised and we were like, hang on, we had no idea this was happening, and we've brought the children into a safe space. And you actually feel like they're against us, not working with us."*

One participant who had longer social work involvement was generally positive about the reason for their involvement, in terms of the children being considered in need.

A minority of participants were currently involved in family court processes, sometimes with alleged abusers, who did not meet the criminal threshold for prosecution, but met the family court standard in fact-finding processes. Participants experienced these processes as long and drawn out, and very expensive as they required the assistance of solicitors and barristers. Such processes inevitably caused significant anxiety and distress.

Participants had variable experiences of other voluntary agencies, although they did not appear to cause the level of distress and trauma as the criminal justice procedures. For several participants the offer or provision of therapy or counselling, for themselves, or their loved one, appeared to come at the wrong time, either too early on after disclosure, or impacted adversely by anxieties about evidence contamination, which meant that there was a disconnect between the therapy their children were having, and forming a necessary relationship with the therapist to be able to more effectively support their children.

Impact on loved ones

The majority of participants all reported improvements in their loved ones, in terms of improved mental health, reduction in externalising behaviours, returning to secondary education, attending college or university, forming friendships, having partners, getting accurate diagnoses with the appropriate medical intervention.

What could Restitute do differently?

The participants were all extremely positive about the service they had received from Restitute and were positive about their individual caseworkers. A number commented on the lack of knowledge about Restitute from other professionals, and generally how organisations often existed to work with victims/survivors but not the carers, parents or families. Indeed, Milly commented that she also felt she was a victim of the perpetrators' abuse of her daughter, and felt the police were resistant to this.

Participants noted the constant challenges of funding voluntary organisations and the potential challenges of growing the organisation whilst maintaining its uniqueness, person-centred and co-production approach. Whilst not directed at Restitute itself, a number of participants spoke about the need for services for siblings of those who had experienced CSA, and possible need for support in the future, in relation to how children/young people might manage relationships with perpetrators in the future.

Stage 3 - Quantitative Results

Wellbeing

The quantitative analyses looked at how each client's responses to the Wellbeing questions created by Restitute changed from their first to last session while receiving support. It also analysed the initial scores of clients who were sent for therapy compared to those who were not, and the interaction between therapy and the session time – to investigate whether those in the therapy group improved more than those not in the therapy group. The analyses conducted also account for individual differences by including a random intercept in each linear mixed effects model, which means the model accounts for each person starting at a different baseline level of wellbeing.

The number of clients who had responses for both the first and last session, and so were included in that analysis, varied from 35 to 36 for those in therapy and 129 to 134 for those not in therapy (as can be seen in Table 1 under N). Treatment duration ranged from 1.46 to 28.63 months for those receiving non-therapeutic support (M=10.85, Median = 10.47, SD=5.95) and from 0.53 to 32.80 months for those receiving therapeutic support (M=16.70, Median = 15.50, SD=8.02).

Table 4 shows the results from each model with each estimate indicating the size of the relationship. The t-value measures how strong the effect is compared to random variation, and the p-value tells us if the change is statistically significant (if the p value is less than 0.05). Standard Error (SE) measures how precise the estimate is: smaller SE means more confidence in the result.

The estimates for the intercepts indicate where participants not in therapy started on their first session, on average. For example, for the first question, the intercept of 3.05 suggests that, on average, clients began with a positivity and cheerfulness score of 3.05, which is just above the middle of the 1-5 scale. This was the case for most questions other than not self-medicating and drinking at recommended levels, where most clients not in therapy did not self-medicate or drink problematically at the first session, leading to lower initial scores.

The other coefficients show that clients made similar improvements whether they were in therapy or not. Since lower scores reflect higher wellbeing on each measure, the results seen in the column labelled "Last session" suggest that clients in both groups, for all questions showed improved wellbeing between their first and last session. The strongest relationship which emerged, being tearful, had a coefficient value of -1.24. This means, on average, participants in their last session had decreased by 1.24 points on the 1-5 scale, compared to those in their first session. All p-values for the session variable were below 0.05, meaning the changes between session are unlikely to have happened by chance.

The therapy column shows that, on average, clients who were assigned to therapy did not have significantly different scores from those who were not. The only case where they had higher scores was for headaches and other minor ailments, where those in therapy had higher scores by 0.51 points, suggesting more minor ailments than the non-therapy group. However, as the interaction between the groups was not significant, these results suggest that there was not a difference between the therapy group and general support group in their last sessions. This suggests that both interventions were equally beneficial to the groups that received them.

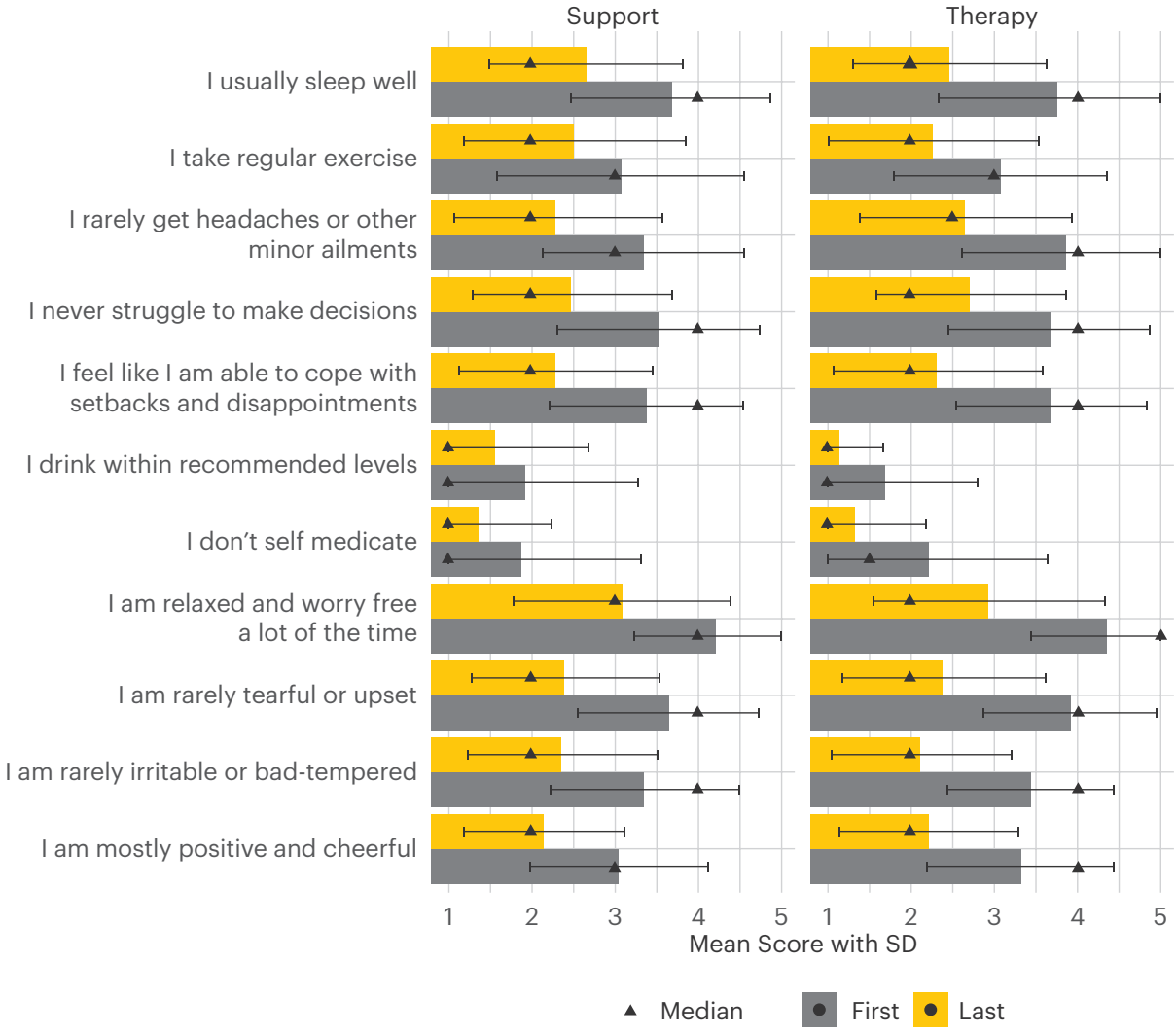
Table 4 - Results from Linear Mixed Effects Model for Each Well-being Question

Question (N Non-Therapy, N Therapy)	Intercept (SE)	Last Session (SE, t)	Therapy (SE, t)	Last Session x Therapy (SE, t)
I am mostly positive and cheerful (132, 36)	3.05 (0.09)	**-0.89 (0.11, -8.22) *****	0.28 (0.19, 1.45)	-0.22 (0.23, -0.92)
I am rarely irritable or bad-tempered (130, 36)	3.37 (0.10)	**-0.99 (0.12, -8.09) *****	0.08 (0.21, 0.36)	-0.31 (0.26, -1.19)
I am rarely tearful or upset (130, 35)	3.65 (0.10)	**-1.24 (0.12, -10.21) *****	0.26 (0.21, 1.25)	-0.27 (0.26, -1.04)
I am relaxed and worry free a lot of the time (132, 36)	4.22 (0.10)	**-1.12 (0.13, -8.79) *****	0.14 (0.22, 0.66)	-0.30 (0.28, -1.07)
I don't self-medicate (134, 36)	1.90 (0.10)	**-0.53 (0.11, -4.67) *****	0.33 (0.22, 1.48)	-0.36 (0.25, -1.46)
I drink within recommended levels (131, 36)	1.94 (0.10)	**-0.35 (0.10, -3.50) *****	-0.24 (0.22, -1.12)	-0.18 (0.22, -0.82)
I feel like I am able to cope with setbacks and disappointments (131, 36)	3.38 (0.10)	**-1.08 (0.11, -9.61) *****	0.31 (0.22, 1.44)	-0.28 (0.24, -1.14)
I never struggle to make decisions (131, 36)	3.53 (0.10)	**-1.04 (0.12, -8.60) *****	0.13 (0.22, 0.59)	0.09 (0.26, 0.36)
I rarely get headaches or other minor ailments (133, 36)	3.35 (0.11)	**-1.03 (0.13, -8.14) *****	**0.51 (0.23, 2.21) ***	-0.16 (0.27, -0.60)
I take regular exercise (134, 36)	3.08 (0.12)	**-0.54 (0.13, -4.32) *****	0.00 (0.26, 0.00)	-0.26 (0.27, -0.95)
I usually sleep well (132, 36)	3.67 (0.10)	**-1.01 (0.12, -8.28) *****	0.08 (0.22, 0.34)	-0.27 (0.26, -1.03)

Note: ***p <.001, **p<.01, *p<.05. Significant relationships highlighted in bold.

The pattern of results described above can also be seen in Figure 2 below. This graph shows the means for each question as coloured bars, the medians as triangle marks, and the standard deviation from the mean included as error bars. The means for every question are higher in the first session compared to the final session, showing an improvement in wellbeing on all questions. This was the same pattern for both therapy and other forms of support.

Figure 2 - Means and Standard Deviations for first sessions compared to last sessions with the service for the group who received therapy and the group who received other support



Parent and Carer Confidence

The analysis focused on how each client's responses to the Carers Confidence group of questions changed from their first to last session while receiving support, as well as comparing the group who received therapy to the group who received other support. All analyses included a random intercept to account for each person starting at a different baseline level. The number of clients who had responses for both the first and last session, and so were included in that analysis, varied from 35 to 36 for those in therapy and 129 to 134 for those not in therapy (as can be seen in Table 2 under N). Treatment duration ranged from 0.47 to 28.07 months for those receiving non-therapeutic support (M=10.63, Median = 9.73, SD=5.71) and from 3.83 to 32.80 months for those receiving therapeutic support (M=17.23, Median = 15.50, SD=7.59).

Table 5 shows the results from each model. The estimates for the intercepts indicate where participants not in therapy started on their first session, on average. For example, for the first question,

the intercept of 2.37 suggests that, on average, clients began with a confidence in first aid of 2.37, which is almost directly in the middle of the 1-5 scale. There was higher baseline confidence for these questions compared to the wellbeing questions, especially in feeling safe with their loved one and being confident in an emergency.

The estimates for the predictors show that all clients improved from the first to last session. The strongest relationship which emerged in this set of questions was having an emergency plan in place. This result suggests that, on average, participants in their last session had decreased by 1.03 points on the 1-5 scale compared to the first. All p-values for the session time variable were below 0.05, meaning the changes are unlikely to have happened by chance.

The therapy column shows that in most cases, on average, clients who were assigned to therapy did not have significantly different scores from those who were not. There were two questions where those who were assigned to therapy were less confident than those who were not: "I am confident I know what to do in an emergency" (0.53 points less confident) and "My loved one knows who to contact in an emergency if I am not there and I am confident they will do" (0.66 points less confident). There was, however, only a significant interaction for the client knowing what to do in an emergency. The estimate shows the difference between 'First' and 'Last' sessions was, on average, 0.51 units smaller for those who had therapy compared to those who had more general support. This suggests that the change over time was more pronounced for the therapy group in this one area.

Table 5 - Results from Linear Mixed Effects for each Carer Confidence Question

Question (N Non-Therapy, N Therapy)	Intercept (SE)	Last Session (SE, t)	Therapy (SE, t)	Last Session x Therapy (SE, t)
I am confident giving first aid (100, 26)	2.37 (0.12)	**-0.41 (0.11, -3.65) *****	0.40 (0.27, 1.46)	-0.32 (0.25, -1.30)
I am confident I know what to do in an emergency (102, 27)	1.66 (0.09)	**-0.30 (0.12, -2.57) ***	**0.53 (0.20, 2.64) ****	**-0.51 (0.26, -1.98) ***
I am coping well as a carer (102, 26)	2.97 (0.10)	**-0.91 (0.13, -6.76) *****	0.03 (0.23, 0.13)	-0.05 (0.30, -0.17)
I am happy my loved one is getting the care and support they need from professionals (102, 27)	2.37 (0.12)	**-0.34 (0.14, -2.49) ***	0.41 (0.26, 1.55)	-0.40 (0.30, -1.32)
I feel safe with my loved one (100, 26)	1.65 (0.09)	**-0.29 (0.10, -2.98) ****	0.27 (0.21, 1.31)	-0.25 (0.21, -1.16)
I have a good relationship with people working with my loved one (101, 27)	2.36 (0.12)	**-0.52 (0.12, -4.29) *****	0.24 (0.25, 0.94)	-0.29 (0.27, -1.09)
I have an emergency plan in place for if I have an accident or am delayed (100, 26)	3.09 (0.13)	**-1.03 (0.15, -6.68) *****	0.33 (0.28, 1.19)	-0.20 (0.34, -0.59)
I know the names and contact details of professionals working with my loved one (101, 28)	2.06 (0.11)	**-0.46 (0.12, -3.92) *****	0.01 (0.23, 0.05)	0.06 (0.25, 0.25)
My loved one has a care plan and a risk assessment if necessary (99, 27)	2.79 (0.13)	**-0.55 (0.14, -3.77) *****	0.43 (0.29, 1.52)	-0.45 (0.31, -1.46)
My loved one knows who to contact in an emergency if I am not there and I am confident they will do (99, 26)	2.18 (0.11)	**-0.61 (0.13, -4.58) *****	**0.66 (0.24, 2.78) ****	-0.36 (0.29, -1.23)

Note: ***p <.001, **p<.01, *p<.05. Significant relationships highlighted in bold.

The pattern of results described above can also be seen in Figure 3 below. This graph shows the means for each question as coloured bars, the medians as triangle marks, and the standard deviation from the mean included as error bars. The means for every question are higher in the first session compared to the final session, showing an improvement in carers' confidence on all questions.

Figure 3 - Means and Standard Deviations for first sessions compared to last sessions with the service for the group who received therapy and the group who received other support

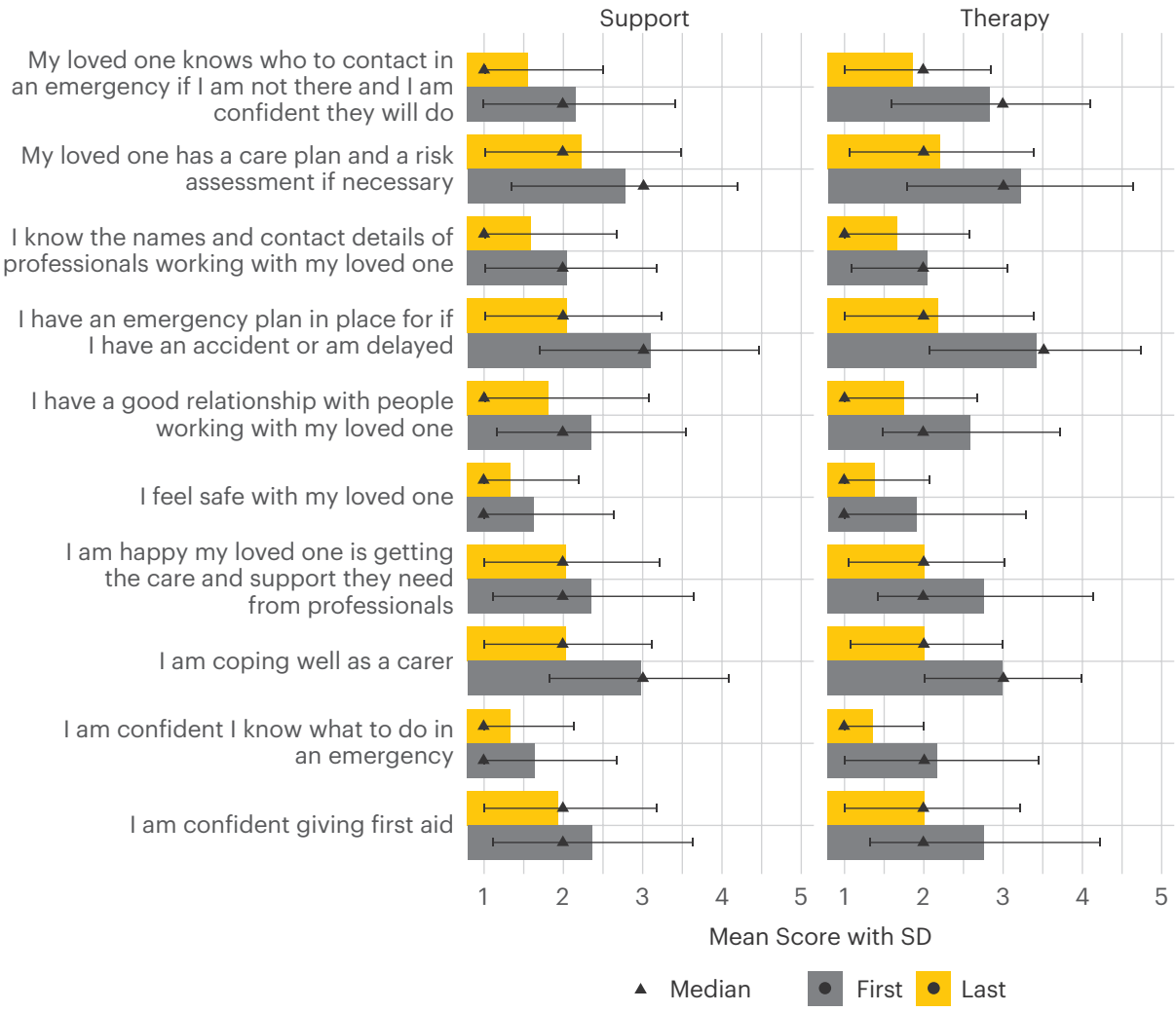


Table 6 shows an additional model which was conducted on a final carer's confidence question. In this case, the clients only had two options: "Yes/No." As this question has a binary outcome of only yes or no as possible responses, we used logistic regression with a random intercept for ID to analyse this question. In this case, the intercept and estimate are in log odds and the treatment duration also had a z-value rather than t-value to calculate the significance level. The intercept for this question (-3.14) represents the log odds of having an accurate carers assessment in the first session for the non-therapy group. This can be converted into an odds ratio of 0.04. The odds ratio can be interpreted as the probability of an accurate assessment at baseline being 4%. However, none of the predictor estimates were statistically significant, so any change is likely due to random variation or noise in the data. This means it is unlikely many more clients had an accurate care assessment by the end of their time with Restitute.

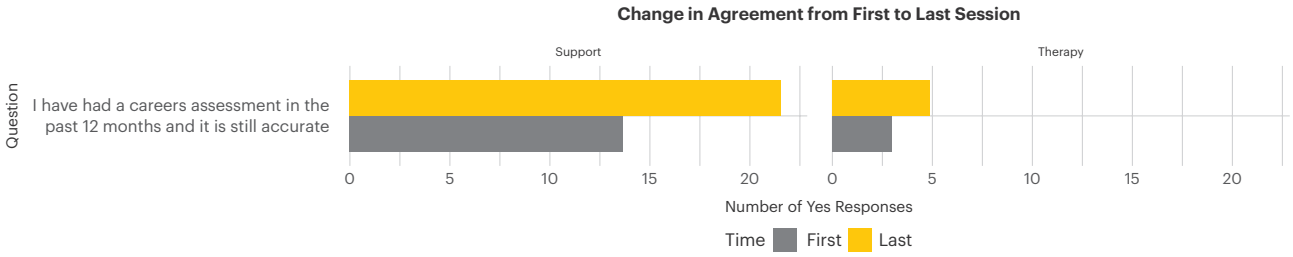
Table 6 - Results from Logistic Mixed Effects Model for the Carer Confidence Question

Question (N Non-Therapy, N Therapy)	Intercept Log Odds (SE, OR)	Last Session Log Odds (SE, z, OR)	Therapy (SE, z, OR)	Last Session x Therapy (SE, z, OR)
I have had a carers assessment in the past 12 months, and it is still accurate (97, 26)	-3.14 (1.16, 0.04)	0.84 (0.51, 1.65, 2.33)	-0.44 (1.02, -0.43, 0.65)	0.07 (1.09, 0.06, 1.07)

Note: ***p <.001, **p<.01, *p<.05. Significant relationships highlighted in bold.

In Figure 4, there is a slight increase in the number of yes responses to having had a carers assessment in both therapy and the general support group. But, as explained above, this is not a strong enough effect to be considered statistically significant.

Figure 4 - Counts of "Yes" responses for first sessions compared to last sessions with the service for the group who received therapy and the group who received other support



Health

The analyses explored how each client's responses to the health group of questions changed from their first to last session while receiving support, as well as comparing the group who received therapy to the group who received other support. All analyses included a random intercept to account for each person starting at a different baseline level. As above, the numeric responses were analysed with linear mixed effects models and the binary (yes/no) responses were analysed using logistic regression. The analyses account for individual differences with a random intercept for ID.

The number of clients who had responses for both the first and last session, and so were included in that analysis, varied from 27 to 31 for those in therapy and 93 to 115 for those not in therapy (as can be seen in Table 6 under N). Treatment duration ranged from 0.47 to 28.07 months for those receiving non-therapeutic support (M=10.33, Median = 9.50, SD=5.74) and from 1.50 to 32.80 months for those receiving therapeutic support (M=17.64, Median = 17.43, SD=7.36).

For the linear models, the intercepts show the average baseline score for clients in their first session in the non-therapy group, with most being around the midpoint of the 1-5 scale other than the questions referring to gambling, alcohol, and drugs, which were low on the scale. This suggests these behaviours were not common. This could have led to the lack of significance for the question referring to gambling, as this did not seem to be an initial concern with this population. Other than this, all health behaviours significantly improved from first to last session. The strongest relationship which emerged with this set of questions was improvements in the caring role not affecting clients' physical

health, with a coefficient of -0.93, suggesting an average decrease of nearly 1 point from their first to last session.

Table 7 - Results from Linear Mixed Effects Models for Each Health Question

Question (N Non-Therapy, N Therapy)	Intercept (SE)	Last Session (SE, t)	Therapy (SE, t)	Last Session x Therapy (SE, t)
I am happy with my weight (115, 30)	3.46 (0.13)	**-0.47 (0.13, -3.60) *****	0.31 (0.29, 1.05)	-0.23 (0.29, -0.80)
I don't have a problem with gambling (114, 30)	1.22 (0.07)	-0.05 (0.09, -0.60)	-0.09 (0.15, -0.58)	-0.08 (0.19, -0.42)
I don't self-medicate with alcohol or prescription medication (114, 30)	1.92 (0.11)	**-0.54 (0.13, -4.17) *****	0.15 (0.25, 0.59)	-0.23 (0.28, -0.82)
I don't take recreational drugs (114, 30)	1.49 (0.09)	**-0.29 (0.11, -2.74) ****	-0.02 (0.20, -0.12)	0.16 (0.23, 0.68)
I have a healthy relationship with food (114, 30)	2.67 (0.12)	**-0.52 (0.12, -4.29) *****	**0.63 (0.27, 2.35) ***	-0.12 (0.26, -0.44)
I have never smoked (113, 30)	2.58 (0.15)	**-0.14 (0.07, -2.02) ***	0.15 (0.33, 0.46)	0.21 (0.15, 1.36)
I take regular exercise or work in a physically demanding job (113, 30)	2.77 (0.13)	**-0.54 (0.13, -4.00) *****	0.40 (0.28, 1.42)	-0.53 (0.29, -1.79)
My caring role is not impacting on my physical health (103, 29)	2.94 (0.12)	**-0.93 (0.15, -6.19) *****	0.40 (0.25, 1.61)	-0.38 (0.32, -1.18)
My diet is good (114, 30)	2.58 (0.11)	**-0.29 (0.11, -2.59) ****	0.32 (0.24, 1.35)	-0.14 (0.24, -0.59)
My physical health is good (115, 31)	2.79 (0.12)	**-0.27 (0.12, -2.28) ***	0.02 (0.25, 0.06)	-0.09 (0.26, -0.33)

Note: ***p <.001, **p<.01, *p<.05. Significant relationships are highlighted in bold.

The pattern of results described above can also be seen in Figure 5 below. This graph shows the means for each question as coloured bars, with the standard deviations included as error bars. The means for every question are higher in the first session compared to the final session, other than smoking for the therapy group. The gambling question shows only very small differences (likely due to random noise in the data). However, most questions show a clearer decrease in scores, associated with health improvements.

Figure 5 - Means and Standard Deviations for first sessions compared to last sessions with the service for the group who received therapy and the group who received other support

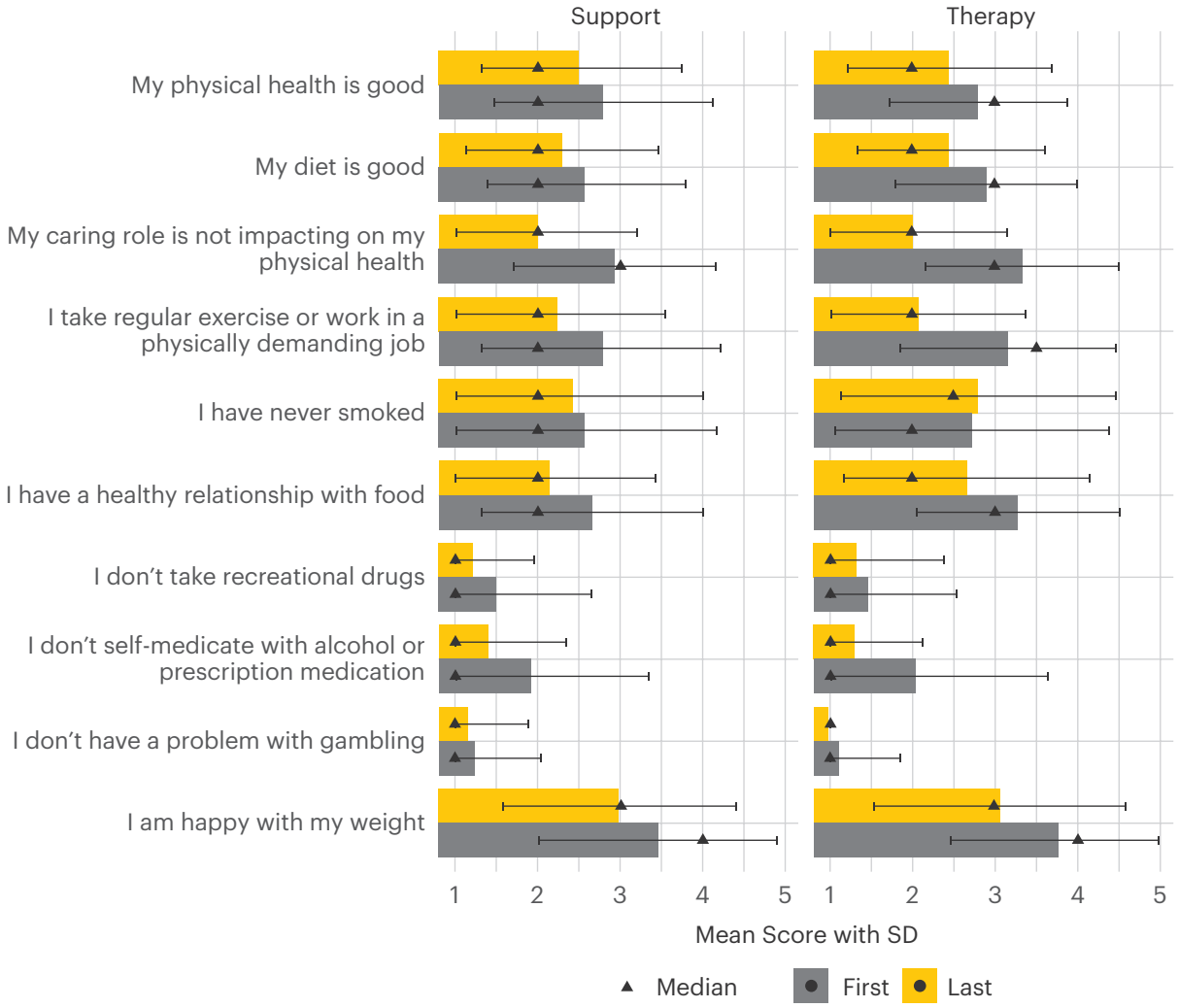


Table 8 shows additional models which were conducted on questions with only two response options: "Yes/No." Again, due to the binary outcome, we used logistic regression with a random intercept for ID to analyse these questions. As such, in these models, the intercepts and estimates are in log odds so require different interpretation.

In these models, only visiting an optician and their GP being aware they are a carer increased from the first to last session. The odds ratios suggest clients were 2.36 or 136% times more likely to have visited an optician and 2.16 or 116% more likely to have their GP be aware they are a carer in their final session, compared to their first. The results also suggest there were no significant differences on any question between the group given therapy and the group who was not.

There was a significant interaction for the blood pressure and cholesterol question, however, the results also showed inflated estimates and errors, suggesting bias in the model. It is likely this results

from the low number of "no" responses in both first and last treatment records. This suggests most clients had a normal range of these measures throughout treatment. However, to investigate the increase in "yes" responses further, a second model was run on this question to improve the estimates. The weights of 1 for "yes" and 3 for "no" in a Firth penalised logistic regression without random intercepts to reduce the bias in the model and make the output more interpretable. The results of this model show the baseline log odds for the group who did not have therapy in the first session was 0.79 – which is 2.20 times (SE = 0.12) or 120% more likely to answer yes. The results suggested there was not an overall improvement from the first to last session (log odds = 0.13, SE = 0.17, p =.44). However, the therapeutic group were overall more likely to answer that they had high blood pressure and cholesterol (log odds = 0.71, SE = 0.31, p = .014). Using odds ratios, this means those who had therapy were 2.04 or 104% times more likely to answer "yes" to this question, compared to those not assigned to have therapy. The interaction log odds were 1.52 (SE = 0.64, p = .009) which suggests that in the last session, those who had been given therapy were 4.56 times or 356% more likely to answer that their blood pressure and cholesterol were normal. This suggests greater improvement for the therapeutic group on that measure.

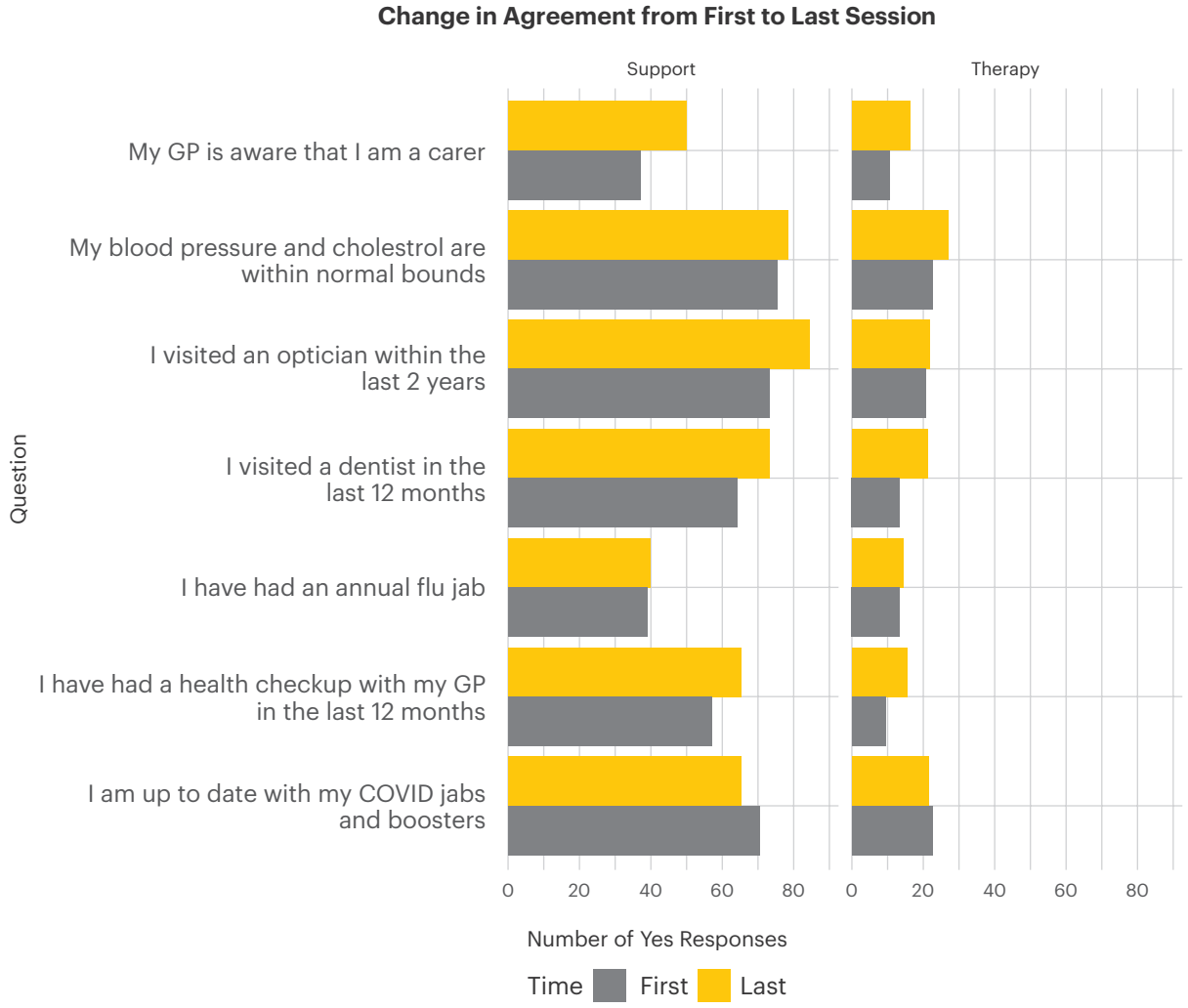
Table 8 - Results from Logistic Mixed Effects Model for the Health Questions

Question (N No Therapy, N Therapy)	Intercept Log Odds (SE, OR)	Last Session Log Odds (SE, z, OR)	Therapy (SE, z, OR)	Last Session x Therapy (SE, z, OR)
I am up to date with my COVID jabs and boosters (105, 27)	1.69 (0.61, 5.40)	-0.44 (0.43, -1.03, 0.64)	1.96 (1.06, 1.85. 7.12)	0.00 (1.03, 0.00, 1.00)
I have had a health checkup with my GP in the last 12 months (111, 31)	0.07 (0.26, 1.08)	0.41 (0.32, 1.26, 1.50)	-1.08 (0.58, -1.87, 0.34)	0.69 (0.69, 0.99, 1.99)
I have had an annual flu jab (113, 31)	-2.57 (1.45, 0.08)	0.10 (0.45, 0.22, 1.11)	1.82 (1.65, 1.10, 6.15)	0.28 (0.98, 0.28, 1.32)
I visited a dentist in the last 12 months (114, 31)	0.91 (0.58, 2.47)	0.82 (0.44, 1.85, 2.26)	-1.32 (1.15, -1.15, 0.27)	2.07 (1.16, 1.79, 7.91)
I visited an optician in the last 2 years (113, 31)	1.33 (0.48, 3.76)	**0.86 (0.41, 2.08, 2.36) ***	0.26 (0.82, 0.32, 1.30)	-0.58 (0.85, -0.68, 0.56)
My blood pressure and cholesterol are within normal bounds (109, 28)	7.05 (1.06, 1158.38)	0.61 (0.65, 0.93, 1.83)	0.67 (1.56, 0.43, 1.96)	**5.08 (1.85, 2.74, 160.67) ****
My GP is aware that I am a carer (93, 27)	-0.56 (0.29, 0.57)	**0.77 (0.36, 2.14, 2.16) ***	0.04 (0.59, 0.08, 1.05)	0.47 (0.74, 0.64, 1.61)

Note: ***p <.001, **p<.01, *p<.05. Significant relationships are highlighted in bold.

In Figure 6, there is a similar pattern, where "yes" responses for GP being aware of carer status and visiting the optician and dentist increased from first to last session. The other increases were not significant in the above models. Overall, it seems that routine health behaviours increased, but many were not significantly impacted.

Figure 6 - Counts of "Yes" responses for first sessions compared to last sessions with the service for the group who received therapy and the group who received other support



Therapy Clients on Validated Scales: GAD-7 and PHQ9

The analyses above used unvalidated developed by Restitute. However, those clients who were given therapy were also assessed on validated scales. In addition to being more widely used, these are useful to investigate the effects of therapy on the client group further. In the analyses above, the clients assigned to therapy did not usually improve to a greater extent than those who did not, suggesting both therapy and other forms of support were equally effective for both client groups. However, this could be due to the needs of those receiving therapy being more complex. Therefore, it is useful to investigate whether this group of clients also improved on validated measures of mental health which would not be covered in the other questions.

As such, this group of analyses looks at how the scores on two validated measures - the GAD-7 and PHQ-9 - changed in the clients who were given therapy from their first to last recorded session. The GAD-7 is used as a measure of general anxiety and the PHQ-9 as a measure of depression. The number of clients who had responses for both the first and last session, and so were included in that analysis, were 30 for the GAD-7 and 28 for the PHQ-9. For the clients included in the analyses, casework

duration ranged from 1.57 to 25.47 months, with an average of 7.58 months (Median = 6.63, SD = 5.70). The analyses look at the difference from the first to last session in these two measures and also account for baseline individual differences between clients with random intercepts for ID.

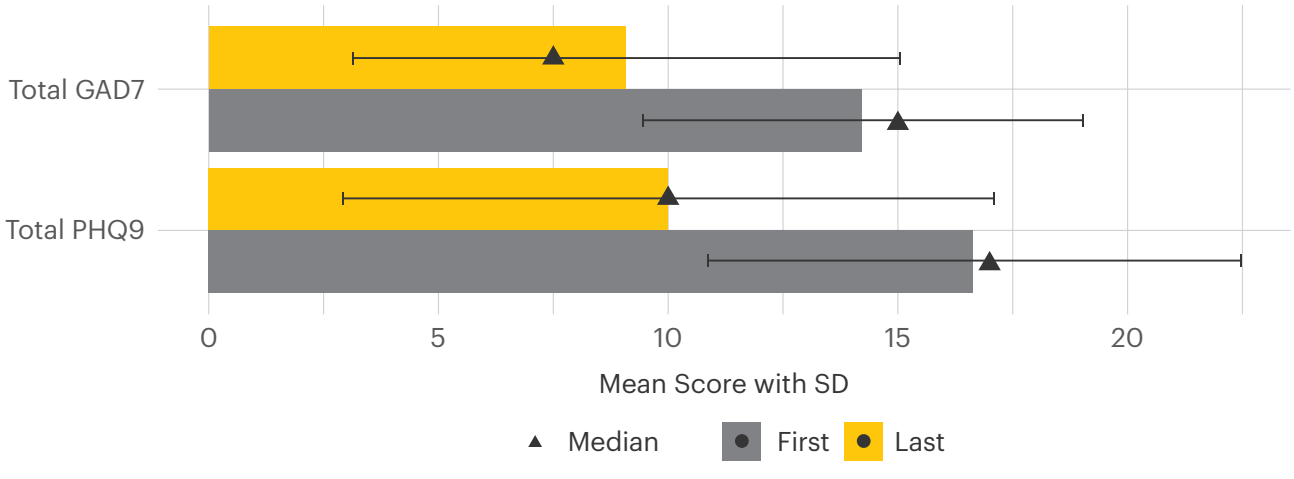
Table 9 shows the results from each model. The intercepts show where clients started on average. Scores on the GAD-7 can range from 0-21, meaning the midpoint is 10.5. The PHQ-9 can range from 0-27, meaning the midpoint is 13.5. Scores above or equal to 10 are considered indicative of anxiety (GAD-7) or depression (PHQ-9). The intercepts here suggest clients started with scores suggesting anxiety and depression may be present as both were above 10: 14.23 for anxiety and 16.65 for depression. Notably, scores above 16 on the PHQ-9 are considered severe depression and scores above 14 are considered moderate anxiety. The coefficients suggest that anxiety scores are reduced by 5.13 points on average and depression scores by 6.66 points. In both cases, that suggests a reduction to below the benchmark of 10, where their symptoms would now be considered mild.

Table 9 - Results from Linear Mixed Effects Models for Each Scale

Scale (N)	Intercept (SE)	Last Session (SE)	Last Session t-value	Last Session p-value
GAD-7 (30)	14.23 (0.97)	-5.13 (1.10)	-4.65	<.001***
PHQ-9 (28)	16.65 (1.18)	-6.66 (1.28)	-5.198	<.001***

In Figure 5, the means and medians show a reduction from the first session to the last session. The GAD-7 scores can range from 0-21 and the PHQ-9 can range from 0-27. This means that both measures showed an average above the midpoint before treatment and below the midpoint afterwards. Taken together, this suggests that therapy had a valuable impact on the level of anxiety and depression in this group of clients.

Figure 7 - Means and Standard Deviations for first sessions compared to last sessions with the service



Overall Findings

The impact and outcomes of the casework and therapeutic services offered

The quantitative data shows improvements on all measures, well-being, physical health and parents/carer confidence from initial contact with Restitute to leaving Restitute. As the analysis evidenced, the average duration of the casework service was around 12 months.

The case notes evidence self-reported improvements across these three areas and the interviews contain self-reported evidence of improvement across these areas. The case notes and the interviews, evidence parents and carers, self-reports of improvement for their loved ones, in terms of well-being.

The therapeutic work evidenced improvements in depression and anxiety levels.

What the evaluation cannot evidence at this stage are the longer-term outcomes and impacts, i.e. what happens when the casework service comes to an end and the question of whether clients sustained the improvements over time, and the extent to which the gains in therapy can be sustained. This is an area that would require further research utilising longitudinal approaches.

The characteristics and needs of the individuals and families that come into the service

Within the existing research evidence in this area and the evaluation, evidence shows that clients come from a range of socio-economic backgrounds. The evaluation evidenced that for the majority of clients, whatever social-economic background they were from, the impact of current or recent abuse caused significant financial strain. The evaluation further identified that many parents and carers are themselves living with mental and physical ill health, some of which was pre-existing but all likely exacerbated by the traumatic events. A minority of clients also had suspected or recently diagnosed neurodiverse conditions, such as ADHD and autism. They therefore require approaches to intervention which meet their particular needs.

The evidence suggests that for the majority of parents and carers, in the aftermath of disclosures of CSA, they experience social isolation, loss of friendships and family relationships. Those with friends felt they neglected them or could not “burden” their friends with details of what had happened. Former sources of familial support, in the aftermath of disclosures, were often no longer available and family relationships became very fractured indeed. Parents and carers also experience stigma and shame. Indeed, several parents and carers had their residences attacked, graffiti sprayed, and windows broken because of the perpetrators’ behaviour. This caused significant fear and alarm. These feelings, shame, stigma and fear of public anger, were also significantly exacerbated when the press ran stories about the perpetrator which also impacted on carers, siblings and the loved ones - who would sometimes get bullied by peers as a result.

For those surviving domestic violence, by the very nature of being in a coercive and controlling relationship meant familial relationships and friendships had already been severed or adversely impacted. There is a need therefore to help clients re-establish or find positive support networks.

What the evaluation has not been able to ascertain at this current moment, are the particular needs if any, of clients from racially minoritised backgrounds.

The longer-term support needs of individuals and families

The evaluation has been able to evidence the short- and medium-term support needs of parents but not the longer term needs. It is clear that support at the outset is very important to deal with the devastating consequences of disclosure of CSA. It is also clear that criminal justice processes take a very long time, so it would not always be possible to support clients throughout the whole process, i.e. from disclosures through the criminal justice process to sentencing. It is also clear that families may need continuing support after sentencing, when perpetrators are released from custodial sentences,

or indeed at key transition points in young people's lives, i.e. puberty, becoming independent or leaving home. The longer-term support needs are something that requires further research, not least to see how effective caring strategies and improvements in parent/carer confidence remains in the longer term to mitigate against the impacts of abuse.

Future service development and funding requirements

The literature review starkly identified the prevalence of CSA and domestic violence. Therefore, it is highly likely that there is a large group of parents and carers who would benefit from the services at Restitute. Whilst Restitute is better known in the East Anglia region, the organisation is not well known in other parts of the UK. Indeed, the findings evidenced how for many clients, they found out about Restitute through their own research efforts or through personal networks. The organisation also needs to manage a balance between maintaining the flexible and client-led casework service, with the expansion of the service. There may also be challenges in terms of commissioning agencies who may require specific time-limited interventions, which may also curb the broad range of work Restitute workers currently support clients with.

Recommendations

Restitute

Recommendations fall into three primary areas: data collection, case recording and identifying practices. It should be acknowledged that the breadth of data collected by Restitute is vast. It is unusual for such data to be accessible to researchers. This is a rich resource that with the permission of Restitute and its clients merits further research and analysis that could serve to influence national policy and practice, as well as develop the research on the vital need to support third party victims of crime.

Data Collection

1. It is acknowledged that as the organisation has developed and grown, relevant information gathering has improved considerably, so important data is now routinely collected, i.e. who the clients', loved ones are. This will help with national efforts to understand prevalence, who the victims are and who is providing care.
2. It may be useful to record separately who the perpetrator is alleged to have been, this may help ongoing national efforts to assess prevalence and identify who the perpetrators are more accurately.
3. Well-being, parent/carer confidence and well-being scales. These might currently encourage social desirability bias if, for example, clients liked the person they were working with to say they have improved, even if they had not. The ideal would be to have an external provider, so workers do not have access to the individual data, and for the data collection to happen outside of sessions with the service. This of course has cost implications and may put clients off from completing them.
4. In terms of the above scales, which were co-produced with people with lived experience, there may be merit (as well as drawbacks) in using validated scales, which might assist with "benchmarking" the service compared to other services, if they indeed use them but it may set a precedence of good practice. It would also mean the questions would have already been validated on different samples of people with different characteristics or larger groups and be connected to theory or other research. There is a balance to be struck between meeting the needs of clients and producing evidence to show impact, versus methodological considerations.
5. In the scales used, if there were more consistent time points for data collection this would make analysis more accurate, but in a busy organisation, this is recognised as being very challenging to achieve.

6. If the current scales continue to be used, they might benefit from revision, as issues have been noted as follows:
    a. Many of the questions are double barrelled (e.g., "my loved one knows who to contact in an emergency and I am confident they will do") which can be a problem for participants (e.g., if I have told my loved one who to contact but they – for example – panic and forget during emergencies, so I am not totally confident they will actually do it).
    b. The smoking question cannot change over time unless someone started smoking – i.e., if you answer "no" to "I have never smoked" at point 1 then give up smoking by point 2, you still can't answer "yes" because you had at one time smoked.
    c. Participants may not be able to answer some questions – e.g., my blood pressure and cholesterol are in normal ranges - because they may not know.
7. If the scales are to be amended, then it would be useful to maintain existing clients on the old scales, as these provide good evidence of outcomes for clients, pilot a new set and analyse the data, then introduce them for all new clients. Any further analysis of the data will be able to use the two approaches to the measures.
8. Given the obvious willingness of the majority of Restitute's clients to share their data in order to aid the development of the organisation, as well as feed into research, it would be useful to undertake follow-up surveys to see if improvements are maintained over time.

Case recording

- Case notes remain a source of rich data for research purposes as well as other purposes, i.e. ensuring safety, managing risk and for quality assurance purposes. The case notes currently have therefore provided significant evidence for this evaluation.
- It may be useful more generally, for Restitute to think about what the purpose of case recording is, i.e. for whose benefit does it serve and what things should be recorded and how. It may be useful to further enhance existing polices and procedures on case recording.
- To make the case notes even more useful, it will be useful going forward to ensure consistency amongst workers, so one suggestion is to be clearer about the mode of intervention, so if support is recorded, how that is done is not always clear, i.e. video call, phone call, text, email. This leads to inconsistencies in case recording, with repeated information at times, lack of clarity at times about whether it is contemporaneous "case notes", copies of emails or texts.
- There is sometimes use of abbreviations, which are not always obvious or could have ambiguous meanings.
- In some case note entries, guidance from supervisors is included, but this was rare, so there is a need to think about how supervision guidance/instructions are added to the case notes.
- At times, frustration with other agencies is a little evident in the case recordings. The organisation may want to encourage employees to maintain more of a neutral stance within case recordings, i.e. focus on factual recording.
- All of the above amendments will also be useful and helpful for clients or loved ones who may in the future request access to case notes.

Identifying Practice Interventions

As identified in the evaluation, caseworkers are employing a wide range of interventions. Models and approaches, in a flexible manner, and one that responds sensitively and thoughtfully to clients presenting needs and circumstances. It may be useful to articulate the overall approach, i.e. develop more explicitly "The Restitute Model" with the aim of:

1. Offering further training to support a range of professionals to understand the needs of clients and their loved ones.
2. Ensuring new employees understand the approach.
3. To further enhance existing quality assurance methods.

Systemic opportunities and risks

1. This evaluation cannot ascertain with any certainty what the longer-term outcomes for clients and their loved ones may be. Therefore, collecting data in the form of post-service surveys as recommended earlier would be incredibly useful.
2. The needs of non-abusing siblings have been identified as somewhat overlooked in the existing research literature. Restitute workers were also indirectly supporting siblings through their work with the primary carer. Their needs, however, do require further exploration as well as recognition that they are also third-party victims of crime, as are other family members, i.e., Grandparents.
3. It was noted that other agencies, such as the police or social services, had access to counselling services for victims, or could refer individuals. This appeared to happen relatively soon after the disclosures, but the therapeutic value could be marred by the timing of intervention, which happens too early on in the process, or there were fears of contaminating evidence which made usual therapeutic practices challenging, i.e. lack of liaison between child therapists and parents. This was particularly the case if parents were also witnesses.
4. Additionally, some services declined to offer therapy once they were aware that criminal proceedings were in progress. Given the length of time it takes for criminal proceedings to take place, this means individuals who require therapeutic input are not getting the service they require.
5. It is important to note that when individuals are in therapy, there can be an escalation of internalising and externalising behaviours and carers and other professionals need to be cognisant of this possibility.
6. For several of the clients Restitute works with, there is evidence of intergenerational trauma. This is indicative of the continuing impact of abuse and possibly is not accounted for in estimates of the "costs" of such crimes.
7. The significant delays in the criminal justice system and indeed family courts, have negative consequences.
8. There appears to be a need for more awareness of the wider needs of third-party victims of crime who are caring or supporting their loved ones. They are also victims/survivors.
9. The evaluation identified good practice amongst a range of professionals, but also highlighted poor practice, including professionals who did not follow safeguarding protocols and procedures in relation to children and giving out advice that is potentially harmful to children.

Next Steps

The process of evaluation has highlighted areas where further research is indicated:

1. A cost benefit analysis should be undertaken by an appropriately qualified person as there is evidence that the casework service, the range of work it is doing, and its positive impact on families and individuals is diverting away from other services.
2. Research on the particular needs, if any, of clients from racially minoritised backgrounds.
3. Longitudinal research is required to understand the longer-term needs and requirements of carers.
4. Longitudinal research is also indicated to explore the longer-term impact of Restitute' s service and approach.
5. The needs of wider family members, including siblings, requires further research.
6. Given the literature identifies children being more at risk of CSA, when living in a domestically abusive situation, there is a need to explore the prevalence and timing of disclosure when the abusive partner is no longer living with the family and whether the disclosure is subsequently believed by professionals.

Concluding Comments

The work undertaken by Restitute is complex, working directly with individuals and indirectly with family members who are all experiencing significant stress, and who can be considered to be living in crisis. These stressors include; financial concerns, dealing with relationship breakdown with partners, supporting children presenting with a wide range of needs, including physical health concerns, learning disabilities, and mental health concerns, some of which are a direct effect of living with domestic violence, being subject to sexual abuse or, living in a family where this has been a significant violent crime. The primary carers are often female, single, or if in a relationship, are often carrying the "burden." Families are often facing moving houses, claiming benefits, and managing the aftermath of significant traumatic events. For several of the primary carers, the trauma experienced by their children has also reawakened their own childhood traumatic incidents. Primary carers are often living with mental and physical ill health. They are supporting loved ones who in many cases have had, or continue to have, mental and physical ill health that has significant impacts on their lives.

Parents and carers sometimes have very negative experiences of other agencies, including the criminal justice system, family courts and safeguarding systems and processes. Interactions with professionals, for example, police and social workers, caused secondary harms.

The approach to the casework intervention may appear simple but is highly sensitive to the ends of the individuals, is responsive and adaptable, and the work encompasses a number of distinct models of intervention, including task centered, trauma-informed, crisis intervention and strengths based. Lived experience of workers enhances the service offered and helps build trust and rapport with individuals, whose trust in others has often been shattered.

The evaluation has evidenced very strongly, despite usual methodological limitations, that the service offered by Restitute has the following impacts:

- Improved well-being
- Improved parent/care confidence
- Improved physical health
- Improvements in depression and anxiety levels.

The evaluation also evidenced that for many individuals and their loved ones, recovery was, and is, possible and that individuals, both primary and third-party victims and survivors of abuse in all its various forms, can continue to grow in strength and confidence.

Lastly, Restitute are to be congratulated for their foresight in their approach to measuring impact, through their consistent use of various measures and scales. The approach to casework recording is of a good standard overall and has been incredibly helpful in this evaluation.

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