

Health Working Group Report on Child Sexual Exploitation

An independent group
chaired by the Department
of Health focusing on:
Improving the outcomes
for children by promoting
effective engagement of
health services and staff

January 2014

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We would particularly like to thank to following people for their involvement in making this report happen:

- Martin Teff, Department of Health
- Amy Nicholas, Department of Health
- Christine Christie, Safeguarding Consultant
- All members of the Health Working Group

The group had members representing the following organisations:

- Association of Chief Police Officers
- Barnardo's
- British Association for Sexual Health and HIV
- Brook
- Cambridgeshire and Peterborough Clinical Commissioning Group
- Child Exploitation and Online Protection Centre
- Children's Commissioner's Office
- College of Emergency Medicine
- Department of Health
- General Medical Council
- Kings College London
- Leeds Community Healthcare NHS Trust
- National Treatment Agency
- National Working Group for Sexually Exploited Children and Young People
- NHS England
- Platform 51
- Royal College of Nursing
- Royal College of General Practitioners
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Royal College of Psychiatrists
- St Mary's Sexual Assault Referral Centre

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Foreword

Child sexual exploitation is a form of child abuse that has only been fully recognised in recent years. It is an abhorrent crime that this Government is determined to stamp out. In the past, all too often, these crimes were largely hidden but now child sexual exploitation is rightly centre stage as an issue we must tackle.

The impact of child sexual exploitation can be devastating, often proving detrimental to victims' physical, psychological and emotional wellbeing. The signs are varied, from children going missing from their homes or care, to experiencing mental health problems, sexually transmitted infections, pregnancy, terminations, misuse of drugs or alcohol, physical injuries and coming into contact with the police. In spite of disconnecting with many other potential support networks, many continue to use health services. Child sexual exploitation can affect any child, and while most perpetrators are identified as adults, there are growing concerns regarding exploitation by other young people.

Health professionals, and those concerned with improving the health and welfare of their local population have a responsibility to tackle child sexual exploitation. Agencies and organisations from different sectors need to work together to engage children, young people and local communities to do this effectively. Through commissioning of services which accurately reflect need, health commissioners can provide services which are accessible, high quality and evidence-based. Health care professionals are central to the prevention and identification of child sexual exploitation. Furthermore, they are able to provide a range of interventions and including signposting to specialist services and providing longer term support and rehabilitation.

The members of this working group have practical experience of working with and commissioning services for victims of child sexual exploitation. The recommendations are built on experience and expertise and should be acted on appropriately. Through making such changes, health practitioners can make a real difference that will help protect children from sexual exploitation, identify and intervene in cases of child sexual exploitation, and provide the help they need to reclaim their lives.

A handwritten signature in black ink that reads "Jane Ellison". The signature is written in a cursive style and is underlined with a single horizontal line.

Jane Ellison
Parliamentary Under-Secretary of State for Public Health

Introduction

A good response to child sexual exploitation requires a multi-agency approach because each agency has specific responsibilities and expertise:

- *the police interrupts and investigates the perpetrator/s*
- *children's social care intervenes to promote positive relationships and living arrangements for the child*
- *education connects or reconnects the child with learning and achievement*

and

- *health care staff can identify the victims as well as the physical, psychological and emotional health consequences of the abuse and help the child with recovery.*

Children need individual agency contributions to be competent and confident at every point along the child sexual exploitation care pathway – from prevention, through protection to recovery and from information sharing, through joint working to review. See diagram 1 in the 'Intervention and interruption' chapter.

This report is designed to support a competent and confident response from health services.

Vision and Purpose

Our shared vision is to prevent the sexual exploitation of children and to promote the best possible recovery for children who do suffer sexual exploitation.

The report is relevant to:

- NHS and non NHS organisations
- people who work at a national, regional and local level
- people involved in the planning, commissioning and provision of health and social care and support at local level such as clinical commissioning groups, Health and Wellbeing Boards, local authorities, the voluntary sector,

NHS trusts, NHS foundation trusts, healthcare providers, care and support providers. People in national government and its arm's length bodies, national professional bodies and the Royal Colleges.

The report is also addressed to key non health stakeholders, including police and crime commissioners, the police, local authorities and education, who can improve safeguarding and community safety through effective partnerships.

Tackling Child Sexual Exploitation Action Plan 2011

This report responds to the commitment in *Tackling Child Sexual Exploitation Action Plan 2011* that, the 'Department of Health, as part of its work programme on violence against women and children, will work with its partners to see whether more can be done to highlight the particular needs of children who have been sexually exploited.'¹

Terms

The terms 'child' or 'children' in this report includes children and young people up to their 18th birthday.

'Child sexual exploitation' is a term which covers a broad range of sexual violence and abuse, which includes emotional and physical abuse. It falls within the overall category of child sexual abuse.

The document refers to health organisations and professionals throughout. It should be noted that we are referring to 'health' organisations in the broadest sense – they can be NHS and non NHS, they can be statutory or voluntary bodies. As long as they are delivering a health function then this report and its recommendations are relevant.

Sexually exploited adults

Although the report applies to sexually exploited children there are many adults who are also victims of sexual exploitation. The warning signs and indicators can be similar. For some adults the sexual exploitation started when they were children and continued

¹ Department for Education (2011) *Tackling Child Sexual Exploitation: Action Plan*

past their 18th birthday into adulthood. For others, vulnerability to sexual exploitation has its roots in the experience of childhood sexual abuse. Whilst this report does not focus on adults' needs, much of what we say applies to adults, particularly those with learning disabilities and mental health difficulties.

Report sources

The footnotes in this report reference source material largely from central or local government, the Office of the Children's Commissioner and specialist agencies working with violence against women and children. Footnote references can be easily linked to source material via a web search.

Context



*'Good progress is being made but more needs to be done. That is why this Government has taken urgent steps to review what more we can do to improve our response to combat sexual violence against children and vulnerable people.'*²

The current focus of concern and activity on child sexual exploitation provides momentum for health services and staff to aim for a step-change in their response to child victims, both in a single and multi-agency capacity.

Health staff at all levels need to be aware of:

- **Children's rights and legislation**
- **Current activity**

Children's rights and legislation

Safeguarding children legislation in the UK is based on the *United Nations (UN) Convention on the Rights of the Child*.³

The *UN Convention on the Rights of the Child*⁴ provides the fundamental rationale for this report and for all government action to tackle child sexual exploitation, across a number of its provisions. The Convention provides an early intervention directive – to promote the development of each child; and specifically requires States Parties to protect all children from sexual exploitation and abuse, also to give each child a voice in matters concerning them and to promote the physical and psychological recovery and social reintegration of all child victims.

This is reflected in section 11 of the *Children Act 2004*, which places a duty on a range of key organisations (including health services), to ensure that their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.⁵ Section 10 of the Act places a duty on these organisations to co-operate to improve the wellbeing of children.

² House of Commons Home Affairs Committee (2013), *Child Sexual Exploitation and the Response to Localised Grooming*, Second Report of Session 2013-14

³ United Nations (1989) *Convention on the Rights of the Child*

⁴ UNCRC Articles 6, 12, 34 and 39

⁵ *Children Act 2004*. <http://www.legislation.gov.uk/ukpga/2004/31/contents>

Sexual offences legislation in the UK assumes that children under 13 do not have the capacity to consent to sexual activity.⁶ The legal age for consent to sex is 16. Children less than 16 years old are unlikely to be prosecuted for mutually agreed peer sexual activity where there is no evidence of exploitation.⁷ Children over the age of 16 now have some additional protection under the new definition of domestic violence.⁸

Current activity

In recent years, the issue of child sexual exploitation has gone from being largely hidden and rarely acknowledged to the subject of significant media and political attention and concern. There are now a number of groups within and outside government, at national and local levels, which are focusing on improving the response to child sexual exploitation and to preventing it.

It is therefore important to note that the work of this group and the recommendations of this report complement the positive work that is already happening or planned.

National Group on Sexual Violence against Children and Vulnerable People

In April 2013, the Home Office established a National Group of experts from across Government, delivery agencies, inspectorates, the Police, voluntary and community sectors to coordinate and implement the learning from recent inquiries into historical sexual abuse and current sexual exploitation cases and issues around sexual violence more widely. This group is led by the Minister of State for Crime Prevention and reports regularly to the Prime Minister on progress.

⁶ *Sexual Offences Act 2003*. <http://www.legislation.gov.uk/ukpga/2003/42/contents>

⁷ The Crown Prosecution Service. *Rape and Sexual Offences: Chapter 2: Sexual Offences Act 2003 - Principal Offences, and Sexual Offences Act 1956 - Most commonly charged offences*. Legal Guidance http://www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/soa_2003_and_soa_1956/

⁸ Home Office (2013), *Circular 003/2013 New government domestic violence and abuse definition*; from Violent Crime Unit

Tackling child sexual exploitation is at the heart of the work of the National Group. The cross-Government lead on Child Sexual Exploitation transferred to the Home Office when the National Group was established.

The National Group is improving cross Government delivery, identifying problems and solutions and acting swiftly to resolve them. It has already identified nine key areas for action and is prioritising action to prevent abuse happening in the first place, protecting children online, make sure the police can identify and deal with problems and ensure victims are at the heart of the criminal justice system.

The Department of Health is leading on a workstream considering how people can be protected from sexual abuse whilst they are receiving publicly funded care. The National Group's progress report and action plan were published in July 2013, demonstrating the impact the work was already having.⁹

The recommendations that are made in this present report will be considered alongside the work of this National Group.

Tackling Child Sexual Exploitation Action Plan

In 2011 Barnardo's published the report *Puppet on a string: The urgent need to cut children free from sexual exploitation*.¹⁰ In it they called for a cross-Government action plan with Ministerial oversight to ensure that progress is made on this issue. This led to the Department for Education co-ordinating the cross-Government *Tackling Child Sexual Exploitation Action Plan*,¹¹ first published in November 2011 with report on progress in 2012.¹¹

The actions relating to the Department of Health are set out in Annex B of this report.

⁹ Home Office (2013), National Group Progress report and Action Plan, Home Office

¹⁰ Barnardo's (2011), *Puppet on a String: The urgent need to cut children free from sexual exploitation*

¹¹ Department for Education (2012), *Tackling Child Sexual Exploitation Action Plan: Progress report*

Office of the Children's Commissioner Inquiry into Child Sexual Exploitation by Gangs and Groups^{12, 13}

The *Office of the Children's Commissioner (OCC) Child Sexual Exploitation by Gangs and Groups (CSEGG) Inquiry* is the most in-depth investigation into child sexual exploitation that has taken place in the UK so far. It focuses specifically on exploitation by gangs and groups. The CSEGG Inquiry sought to find out what is being done, and should be done to: address individual cases; strategically approach the issue locally and nationally; and to address societal problems that underpin child sexual exploitation.

The final report, *If only someone had listened*, found that despite increased awareness and a heightened state of alert regarding child sexual exploitation, children are still slipping through the net and are continuing to fall victims.¹² Serious gaps remain in the knowledge, practice and services required to tackle child sexual exploitation and while there are pockets of good practice, much still needs to be done to prevent thousands more children falling victims.

Academy of Medical Royal Colleges (AMRCs)

The Academy of Medical Royal Colleges (AMRCs) (representing 220,000 doctors across all fields of medicine) has established a working group which will build on the work of this report. It will consider what specifically the Royal Colleges can do to raise awareness of child sexual exploitation and its consequences, and provide support and recovery services for those who have been identified as victims. The primary audience for this work will be frontline clinicians. There will be a focus on promoting good practice in training and on how victims can be helped to access physical health services and/or psychological health services as required. The group will be issuing a report in spring.

¹² Children's Commissioner (2012), *I thought I was the only one. The only one in the world. The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups. Interim Report*

¹³ Children's Commissioner (2013), *If only someone had listened. The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups. Final Report*

Home Affairs Select Committee Report

On 10 June 2013, the Home Affairs Select Committee issued a report on *Child sexual exploitation and the response to localised grooming*.² There are a number of recommendations relevant to health, in particular recommendations 27-29, which include issues of recording children's attendances at accident and emergency, training for health professionals, better regional information sharing across sexual health services and the importance of child and adolescent mental health services in supporting victims' recovery.

The publication of this report responds directly to one of the Home Affairs Select Committee report's recommendations.¹⁴

¹⁴ Child sexual exploitation and the response to localised grooming: The Government response to the second report from the Home Affairs Committee session 2013-2014 HC68; CM 8705 <http://www.official-documents.gov.uk/document/cm87/8705/8705.pdf>

Responding Well – Understanding and evidence



Understanding and evidence

*'The lack of curiosity about child sexual exploitation shown by all official agencies has been a running theme... professionals did not recognise the existence of the exploitation, were not aware of the scale of the abuse and were not sharing information, this was partly due to assumptions that victims were engaging in consensual relationships and the inability to engage with them.'*²

Having an awareness of child sexual exploitation includes knowing its prevalence, how it impacts on health, and how health care professionals can work with other professionals and agencies to support victims to recover well.

There is a strong need to improve understanding of child sexual exploitation in terms of:

- **recognising child sexual exploitation**
- **prevalence and profile**
- **impact on health and wellbeing**
- **improving the evidence base**

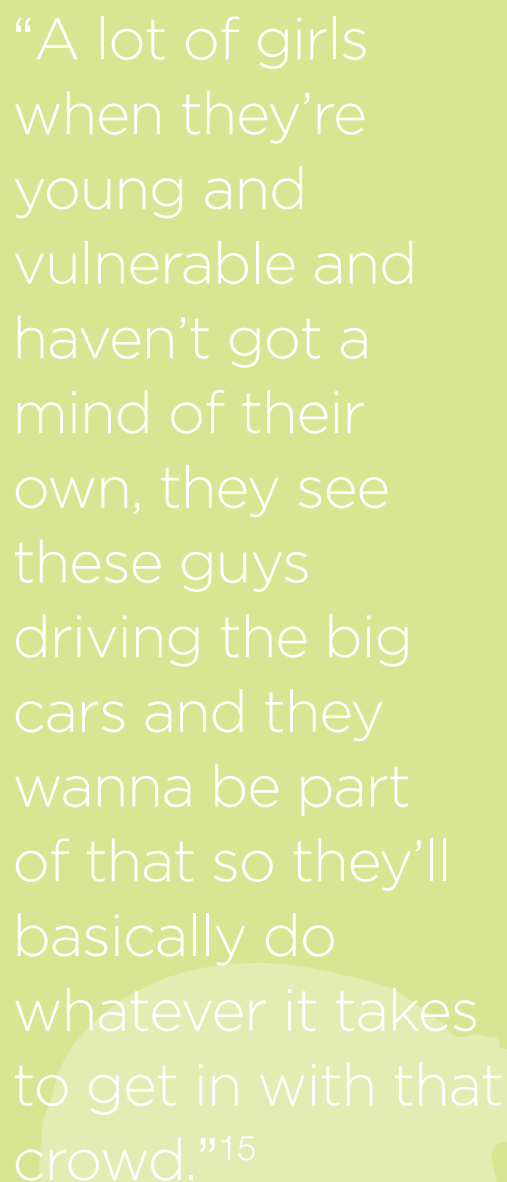
Recognising child sexual exploitation

Child sexual exploitation is the term used for contact or non-contact child sexual abuse when there is any actual or attempted abuse of a child's vulnerability or trust and an opportunity for the abuser to enhance their social standing or receive payment from third parties.

*"A lot of girls when they're young and vulnerable and haven't got a mind of their own, they see these guys driving the big cars and they wanna be part of that so they'll basically do whatever it takes to get in with that crowd."*¹⁵

Child sexual exploitation is a safeguarding matter. The particular circumstances of child sexual exploitation mean that co-ordinated responses are needed from multiple agencies to target protection and recovery activities slightly differently, than if the child

¹⁵ Beckett, H et al (2013), *"It's wrong... but you get used to it"* A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England, University of Bedfordshire



“A lot of girls when they’re young and vulnerable and haven’t got a mind of their own, they see these guys driving the big cars and they wanna be part of that so they’ll basically do whatever it takes to get in with that crowd.”¹⁵

were a victim of familial sexual abuse. Child sexual exploitation usually takes place outside the family home (the child can be missing and/or trafficked), and victims are unlikely to disclose either from shame and fear or from a belief that they are in a loving relationship.

Exploitation without physical contact includes when perpetrators:

- groom children via social networking sites and children are persuaded or forced to post indecent images online:

*'[The] shame of anyone discovering his/her uninhibited use of language and activities online, including being made the subject of abusive images.'*¹⁶

- use children's friends' lists to target new children
- bully their victims through text messaging
- share victims' numbers with other abusers
- view extreme or violent pornography and discuss it during sexual assaults
- film and distribute incidents of rape
- distribute Blackberry pin numbers for lists of girls labelled as 'easy'.¹²

Types of sexual exploitation

Types of sexual exploitation can be understood using Barnardo's models¹⁰ together with the CSEGG Inquiry's findings about peer exploitation.^{12,13} In all the types, increasingly the sexual activity is filmed and used to blackmail and humiliate the victim:

1. *Inappropriate relationships*: usually involving a sole perpetrator who has inappropriate power or control over a child (physical, emotional, financial) and uses this to sexually exploit them. One indicator may be a significant age gap. The child believes they are in a loving relationship.

2. *'Boyfriend' model of exploitation*: in the boyfriend model, the perpetrator befriends and grooms a child into a 'relationship' and then coerces or forces them to have sex with friends or associates. The child believes they are in a loving relationship.
3. *Peer exploitation model*: a child is invited (often by same sex friends) or forced by peers or associates to engage in sexual activity with several or all of the children present at the time. There is no pretence of a special or intimate relationship with any of the perpetrators.
4. *Organised/networked sexual exploitation*: children (often connected) are passed through networks, possibly over geographical distances between towns and cities where they may be forced / coerced into sexual activity with multiple men. Often this occurs at 'sex parties' organised by perpetrators for the purposes of giving victims drugs and alcohol before sexually abusing them. The children who are involved may be used as agents to recruit others into the network.¹⁷ Some of this activity is serious organised crime and can involve the organised 'buying and selling' of children by perpetrators.

Most sexual exploitation occurs within inappropriate intimate partner relationships, and these can be in person or online. There is a growing awareness of sexual exploitation which is defined in model three – involving groups of peers or associates. For this reason, the Office of the Children's Commissioner focused on exploitation in groups and gangs as part of its recent two-year inquiry.^{12,13}

Prevalence and profile

Sexual violence or abuse against children represents a major public health and social welfare problem within UK society. It is difficult to obtain a reliable estimate of the prevalence of child sexual abuse. Research by the National Society for Prevention of Cruelty against Children (NSPCC) put it in the range of 5 to 16 per cent of children under 16 years old. That is between

¹⁶ Taskforce on the Health Aspects of Violence Against Women and Children, Consultation with Children (2011)

¹⁷ Trowell J, Kolvin I, Weeramanthri T, Berelowitz M, Sadowski H, Glaser D and Leitch I (2002), Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. *British Journal of Psychiatry*, 180, 234-247

650,000 and 2 million children.^{18, 19} To the best of our knowledge, sexual violence or abuse against children is greatly under identified and reported. Research conducted by the NSPCC suggests that only a small proportion of victims disclose this abuse. More than one in three children (34 per cent) who experienced abuse by an adult did not tell anyone else about it, and four out of five children (83 per cent) who experienced contact sexual abuse from a peer did not tell anyone else about it.¹⁹

Reliable estimates of the prevalence of child sexual exploitation are also difficult to find. Child sexual exploitation is hidden, rarely recognised or identified. Victims of child sexual exploitation say that shame and believing the threats made by the perpetrator/s of harm to them or their family silence them. Victims are also afraid that they will not be believed, and there is justification for this. Many who have spoken out about being sexually exploited or abused have not been believed because professionals, the public, and perhaps even those close to them often do not see them as being exploited (see 'Exploring Consent' below).¹⁶ Experts agree that child sexual exploitation is more prevalent than the number of reported cases suggests.

The CSEGG Inquiry estimated that at least 16,500 children were at risk of child sexual exploitation during the period from April 2010 to March 2011.¹² Whilst 2,409 children were confirmed as victims of sexual exploitation in gangs and groups during the period from August 2010 to October 2011, there is no confirmation of the numbers of children sexually exploited by individuals.

'Imagine that within three medium sized secondary schools every pupil was being subjected to sexual violence on a routine basis over months, and sometimes years, by multiple perpetrators; or that within 20 medium sized secondary schools every child was displaying behaviours which indicated they were at significant risk of being sexually exploited,

Imagine that within three medium sized secondary schools every pupil was being subjected to sexual violence on a routine basis over months, and sometimes years, by multiple perpetrators; or that within 20 medium sized secondary schools every child was displaying behaviours which indicated they were at significant risk of being sexually exploited, and only a small number of staff acted on these warning signs.

The equivalent of this is true.¹²

¹⁸ Cawson, P et al (2000), Child Maltreatment in the United Kingdom: A Study of the Prevalence of Child Abuse and Neglect. NSPCC

¹⁹ Radford L et al (2011), Child abuse and neglect in the UK today. NSPCC

and only a small number of staff acted on these warning signs. The equivalent of this is true.¹²

Gender

The majority of child victims of sexual exploitation are girls, but boys are also sexually exploited. Of the 2,409 children identified via the CSEGG Inquiry's call for evidence, 72 per cent were girls and 9 per cent were boys, where gender was disclosed.^{12, 13} The average age of children experiencing sexual exploitation is 15 years old. However, there is a growing cohort of 10 to 14 year old victims.

Pre-existing vulnerability

The vast majority of sexually exploited children are already vulnerable. Factors which can increase a child's vulnerability to sexual exploitation include disrupted family life and domestic violence, a history of physical or sexual abuse, disadvantage, poor mental health, problematic parenting, parental drug or alcohol misuse and parental mental health problems, and more recently, exploitation of learning disability.²⁰

Missing

In particular, children who go missing frequently and those who live in care are over represented among sexual exploitation victims. A University of Bedfordshire study found that over half of all children using child sexual exploitation services on one day in 2011 were known to have gone missing (a quarter more than 10 times) and 22 per cent were in care.²¹ Of the sexually exploited children who were interviewed during the CSEGG Inquiry, 70 per cent had gone missing from home and 65 per cent were not attending school.

²⁰ Scott S and Skidmore P (2006), Reducing the risk: Barnardo's support for sexually exploited young people. A two-year evaluation. Barnardo's

²¹ University of Bedfordshire (2011), What's Going On to Safeguard Children and Young People from Sexual Exploitation? How local partnerships respond to child sexual exploitation

Impact on health and wellbeing

Victims of child sexual exploitation can experience severe consequences on their physical and mental health.

Sexually exploited children have a range of vulnerabilities with many physical and mental health implications. Some vulnerabilities contribute to the exploitation whilst others arise from it. Many of the health needs are shared with other marginal groups, but they are exacerbated by the sexual nature of the abuse and their adolescent life stage.

Assumptions about 'normal' aspects of adolescent behaviour, such as risk taking and a focus on the present, potentially at the expense of longer term consequences of actions, may reduce practitioners' ability to recognise and respond to the needs of a sexually exploited child.

Physical Health

All the children interviewed for the CSEGG Inquiry reported experiencing physical violence.^{12, 13} 48 per cent of them had injuries that required them to visit an accident and emergency department. In the Inquiry's call for evidence submissions:

- 41 per cent identified children having drug and alcohol problems as a result of sexual exploitation
- 32 per cent identified children self-harming as a result of sexual exploitation
- 27 per cent raised broader concerns about victims' mental health following sexual exploitation
- 39 per cent identified a negative impact on children's sexual health.

Professionals reinforced this concern during site visits and evidence hearings, reporting pregnancy, miscarriages, terminations, sexually transmitted infections including chlamydia, herpes and gonorrhoea, and other consequences. One verbal report was made of a child contracting HIV/Aids.

Mental Health

There is reliable evidence to show that being a victim of sexual violence or abuse is a risk factor for the development of mental health problems and disorders. Findings from three studies indicated that about half the children who had been sexually abused experienced depression, post traumatic stress disorder (PTSD) or disturbed behaviour, or a combination of these,^{22,23} and 40 to 70 per cent of those diagnosed with a borderline personality disorder reported having been sexually abused when younger.²⁴

In another important study, girls who needed treatment as a result of having experienced contact sexual abuse had high rates of disorder and co-morbidity (using DSM-III-R criteria) prior to treatment:¹⁷

- 73 per cent suffered post-traumatic stress disorder (PTSD)
- 57 per cent suffered major depression
- 37 per cent suffered generalised anxiety disorder
- 58 per cent suffered separation anxiety disorder.

The CSEGG Inquiry reported that 85 per cent of the sexually exploited children who were interviewed had either self harmed or attempted suicide as a result of sexual exploitation.^{12,13} During site visits, evidence hearings and interviews with children, the following issues were identified:

- emerging personality disorder
- borderline personality disorder
- emerging psychosis

²² Monck E and New M (1996), Sexually abused children and adolescents and young perpetrators of sexual abuse who were treated in voluntary community facilities. In Jones DPH and Ramchandani P (1989), Child Sexual Abuse – Informing Practice from Research

²³ Sharland E, Seal H, Croucher M, Aldgate J and Jones D (1996), Professional Intervention in Child Sexual Abuse. In Jones DPH and Ramchandani P (1989), Child Sexual Abuse – Informing Practice from Research

²⁴ Zanarini M C, Childhood experiences associated with the development of borderline personality disorder. *Psychiatric Clinics of North America*, 2000; 23(1): 89-101

- depression
- self-harming
- thoughts of suicide
- drug and alcohol abuse
- severe low self-esteem
- self-neglect.

Information on the range of health impacts as a result of child sexual exploitation can be found at:

http://www.barnardos.org.uk/what_we_do/policy_research_unit/research_and_publications.htm.

Improving the evidence base

The research evidence on the links between child sexual exploitation and health is more limited than we might hope:

*'This is a very difficult group to research; the few studies that do exist... tend to be in depth, participatory and qualitative, based on non-probability sampling methods (typically used when the members of a population are difficult to locate). These studies provide rich data and important insights, but are not designed to give estimates of prevalence or provide representative data on patterns of health needs.'*²⁵

Prevalence and profile

We have some evidence and estimates of the prevalence of sexual abuse from NSPCC research^{18,19} and the CSEGG Inquiry¹² has produced some sexual exploitation prevalence estimates. These estimates are not likely to be very accurate.

Impact on health and wellbeing

We have good information on supporting recovery from sexual abuse¹⁷ and evidence also from the NSPCC, about the need for more therapeutic services

²⁵ Association for Young People's Health, University of Bedfordshire, National Working Group (2013), Be Healthy Project

for sexually abused/exploited children.²⁶ We have testimonies from victims of sexual abuse which have helped us to understand the emotional, psychological and physical impact of the abuse and some of this is applicable to sexual exploitation.¹⁶ We can also draw on the different fields of research into the health consequences for an individual child of experiencing one or more of the elements which can be found in child sexual exploitation. These include the impact of witnessing and experiencing physical violence, addiction to drugs or alcohol, the isolation and chaos of disrupted family and social relationships and routines, living with threats, humiliation and pervasive control.

It remains that better evidence specifically related to child sexual exploitation is needed. It would include, for example, the different age and developmental stage of the victims – adolescence, and the impact of the different models of exploitation on victims. These two factors, amongst others, influence the shape of the care pathway and the configuration of the multi-agency response at each intervention point.

We need to continue to listen and learn from victims and use their experiences, together with professional expertise, to inform the support that is provided and the way in which services are commissioned and delivered and acute response to longer term recovery services.

In the meantime wherever possible, organisations involved in tackling child sexual exploitation should collect data to support the case for a better response from health services.

Recommendations

- 1. The Department of Health should commission work on where the gaps are in the existing evidence base on child sexual exploitation, what the priorities to address them should be and how best to address them (potentially through system wide actions and focused work, such as, research) with a clear understanding of who leads on each strand.**
- 2. The Department of Health should request NICE guidance on how to identify and treat children who have been sexually abused which should also cover children who have been sexually exploited.**

²⁶ Allnock et al (2009), Sexual abuse and therapeutic services for children and young people, The gap between provision and need. NSPCC

Responding Well – Identification and assessment



Identification and assessment

*'All agencies need to improve their recognition of this abuse and exploitation, intervening with safeguarding activity at an early stage. The need for a commitment to multi-agency work to tackle this issue encompasses all front line services.'*²⁷

Raising awareness through education and training and encouraging staff to be more curious about child sexual exploitation is a vital part of transforming the culture of health services.

Children at risk or experiencing sexual exploitation access a broad range of healthcare in many settings, pointing to the need to support all health staff with:

- **raising awareness of the indicators of abuse**
- **structured identification and assessment of risk**
- **exploring consent**
- **the impact of diversity**
- **multi-agency risk assessment**

Some presentations will be directly and some indirectly related to the abuse that a child has experienced, or is experiencing, and children will also continue to require routine services such as the following:

- accident and emergency
- sexual health
- primary care
- drug and alcohol services
- mental health
- maternity and terminations of pregnancy services.

The Government's *Tackling Child Exploitation Action Plan*³ and supplementary guidance on safeguarding

children from child sexual exploitation²⁸ both emphasise the importance of raising awareness to:

- support children so they understand that they are being abused
- support professionals to identify victims so that they know what to look out for and what they can do if they find it.

Raising awareness of the indicators of abuse

Raising awareness of the indicators of abuse is a critical first step so that staff know what to look out for and adopt a more holistic and curious approach to children presenting with a range of problems.

*'Identifying young people at risk relies on practitioners' awareness of the issue, their proactive work to identify indicators of risk, their preparedness to work with situations where sexual exploitation is indicated rather than definitely known to be occurring....'*²⁹

The CSEGG Inquiry published a list of warning signs that a child may be at risk of sexual exploitation and also a list of indicators that a child is being abused (see Annex C).^{12, 13} The CSEGG Inquiry found most victims exhibited three or more of these indicators. In its interim report, the Inquiry recommended that the indicators should be sent to all organisations and professionals with an interest in tackling child sexual exploitation.

Structured identification and assessment of risk

There are a range of risk assessment tools, one of which will form part of each Local Safeguarding Children Board's procedure for safeguarding children at risk from sexual exploitation. These are useful for frontline practitioners both as a risk identification checklist (RIC) and also to support a more

²⁷ Child Exploitation and Online Protection Agency (2011), Making Every Child Matter ... Everywhere: Thematic Assessment, (CEOP)

²⁸ Department for Education (2009), Safeguarding Children and Young People from Sexual Exploitation: Supplementary Guidance

²⁹ Scott and Harper (2006) in Rigby P and Murie S (2013), Sexual Exploitation of Vulnerable Young People Looked After and Accommodated in Glasgow

comprehensive assessment of the harm a child may be at risk from or already experiencing.

In a number of local areas across the country, health service agencies have gone further in awareness raising to ensure that health care professionals – and other staff who might come into contact with sexually exploited children such as receptionists – are alert to recognising indicators of sexual exploitation in their day-to-day practice.

Case study: Southwark Protocol

Southwark is one of a number of areas across the country which has published indicators in their protocols for responding to child sexual exploitation. The Southwark Protocol for Children at Risk of Child Exploitation includes the following *health* indicators:

- physical symptoms (bruising suggestive of either physical or sexual assault)
- chronic fatigue
- sexually transmitted infections
- pregnancy and/or seeking a termination
- evidence of drug, alcohol or substance misuse
- sexually risky behaviour.

Case study: Identification through sexual health services

There are a number of protocols in use within sexual health services, including the British Association for Sexual Health and HIV (BASHH) profoma which is the standard for most GUM clinics and one developed by Brook.³⁰ In addition to this, the Department of Health has recently commissioned a new piece of work from BASHH to build on existing good practice and develop a new tool for identifying child sexual exploitation in sexual health setting. This is due to be launched in March 2014, and its development will include engagement with young people to allow their views to inform and shape the final product.

³⁰ Brook online Sexual Behaviours Traffic Light Tool for all professionals working with young people

Case study: Identification through accident and emergency services

The King's College Hospital Accident and Emergency's approach to identifying children at risk, or experiencing child sexual exploitation may be a useful one for other accident and emergency (A&E) departments to consider. Here the approach has been to firmly place child sexual exploitation within safeguarding processes, including providing training. Staff complete a sexual health safeguarding assessment for all under 18 year olds who attend the A&E department. The assessment form can be found at Annex D.

Structured assessment tools are designed to encourage practitioners to focus on the risk factors supported by research, but they also require practitioners to use their professional judgement³¹. To do this well, staff need training. Two concerns which recent studies have flagged are health and other professionals' understanding of children's consent to sexual activity and the influence of diversity on professional thinking.

Exploring consent

Where implemented properly, existing safeguarding procedures should protect children who are vulnerable. However, there is emerging evidence that professionals typically view children as consenting to sexual activity and therefore take no further action. This is referred to in high profile child sexual exploitation cases, and the CSEGG Inquiry commissioned research into children's understanding of consent to sex: *"Sex without consent, I suppose that is rape": How young people in England understand sexual consent.*³²

One child commented on the rape of a girl by her boyfriend and two of his friends as follows:

"It's like he forced her to do it but then she still carried on. It was like she wanted to but she didn't want to."

³¹ Calder M.C. ed, Contemporary Risk Assessment in Safeguarding children, 2008

³² Coy M et al (2013), "Sex without consent, I suppose that is rape": How young people in England understand sexual consent, Child and Woman Abuse Studies Unit, London Metropolitan University

*She didn't know what to do. She didn't want him to think she was frigid... I think she was convinced that that was the only way that he would still like her. [She did consent] because he asked if she liked it and she said yeah. Even though in her head she didn't, she should have said no."*³²

Whilst another said of the same scenario:

*"There were three of them so even if she'd wanted to fight back, she couldn't could she. So she couldn't exactly say no..."*³²

If professionals are not taking appropriate action because children are seen as consenting to sexual activity, then this is a matter of serious concern. The law is clear – the age of consent to sex is 16 years old.^{6,7} Any sexual activity involving children under 16 years old is unlawful, and in particular, those under 13 years old are deemed not to have the legal capacity to consent to sex. For children over 16 years old, professionals need to explore potential power imbalances in the relationship (due to fear of violence, age difference, the provision of gifts, alcohol or drugs etc) because a child cannot freely give their consent in these circumstances.

Essential to taking appropriate action is providing training and supporting health professionals to:

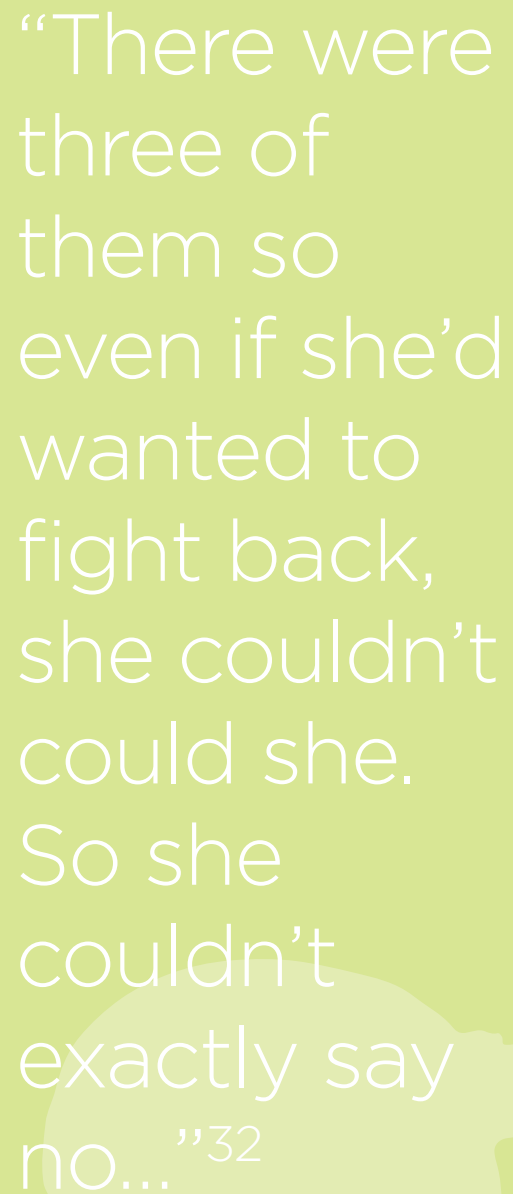
- recognise indicators of potential or actual abuse
- ask the necessary questions
- make a realistic assessment of risk.

Clarifying the care pathway gives staff confidence to act. Health professionals should feel equipped to help children who are sexually exploited in a safe and appropriate manner and to refer to children's social care, the police, and services providing support in the community.

The impact of diversity

Children with other protected characteristics³³ need to be considered when developing the response to sexual exploitation, including gender issues:

³³ Equality and Human Rights Commission (2012). The essential guide to the public sector equality duty England (and non-devolved public authorities in Scotland and Wales). Revised (third) edition



“There were three of them so even if she'd wanted to fight back, she couldn't could she. So she couldn't exactly say no...”³²

*"I had to speak to a man. I don't want men to be there."*¹³

Disability, sexual orientation, culture and ethnicity are also issues:

*'Frontline professionals are not aware of any additional pressures these girls feel such as cultural, emotional etc. Some females who leave home are too afraid to return home due to the stigma attached to them of already leaving.'*³⁴

Research is limited. However, a recent report by the Muslim Women's Network UK, *Unheard Voices - Sexual exploitation of Asian girls and young women*, gives an insight into the experience of Asian girls.³⁴ The exploitation of these girls can be even more difficult to expose than the exploitation of other ethnic groups because they are unlikely to seek help or report their abuse due to shame and dishonour.

Health services staff need to be aware of the needs of children with other protected characteristics and apply professional curiosity to safeguard all children.

*'When Asian girls are presenting with indicators at their GPs or other health clinics, are these not picked up because of their ethnic background? Are they even being asked if they have underlying issues?'*³⁴

A summary of the key findings of the report can be found at <http://mwnuk.co.uk/resourcesDetail.php?id=97>.

Multi-agency risk assessment

The challenge for frontline practitioners is that even if they are aware of the warning signs and indicators which assist identification of sexual exploitation, this, in some cases, may not be enough:

*'It's that collective understanding of the incidents in relation to individual children...the police have got 12 incidents, social care have got three incidents and I've got one incident, collectively that pattern is a lot more serious than one agency currently understands.'*²¹

³⁴ Muslim Women's Network UK. *Unheard Voices - Sexual exploitation of Asian girls and young women*, 2013

The CSEGG Inquiry recognised this in its interim report and recommended that the Department of Health should issue guidance to all health agencies to ensure effective information sharing so that victims of child sexual exploitation, and children at risk of child sexual exploitation, are identified (see 'Information Sharing' below).¹²

NHS England's *Accountability and Assurance Framework* emphasises the role of designated doctors and nurses in safeguarding, as multi-agency clinical experts and strategic leaders.³⁵ They will provide advice and support to the Clinical Commissioning Group, the NHS Commissioning Board, the local authority, the Local Safeguarding Children Board, the Health and Wellbeing Board and other health professionals in provider organisations.

Recommendation

3. NHS England and their area team safeguarding leads should work with Clinical Commissioning Groups (CCGs), Health Provider Trusts, General Practitioners and local authority public health commissioners and their partners, to ensure that:

- Designated doctors and nurses for safeguarding support their area teams and CCGs' work on child sexual exploitation.
- Local multi-agency teams combating child sexual exploitation are fully represented from all relevant NHS agencies, including professionals from primary and secondary, physical and mental health care.

³⁵ NHS Commissioning Board. *Safeguarding Vulnerable People in the Reformed NHS. Accountability and Assurance Framework*, 2013

Responding Well – A ‘child-centred’ focus



A 'child-centred' focus

*'Please treat children and young people as people, not a diagnosis. It makes you feel like an object that can be treated however people like. And I think it makes them feel OK to treat you like an object when you're a label. But you're not. You're a person who's been treated badly and they need to ask what's happened to make you feel so sad and desperate.'*¹⁶

Health services staff need not only to be competent in recognising that a child may be at risk or already being abused through sexual exploitation, they also need to be confident to engage the child appropriately.

Our view is that health service staff can contribute substantially to protecting more children from sexual exploitation if they are committed to:

- **taking a child-centred focus**
- **taking professional responsibility**
- **building trust**
- **working with families**
- **being a lead professional, advocate or key worker**

The statutory guidance *Working Together to Safeguard Children 2013* is clear that failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children.³⁶ *Working Together* lists what children have said that they need:

- *vigilance*: to have adults notice when things are troubling them
- *understanding and action*: to understand what is happening; to be heard and understood; and to have that understanding acted upon
- *stability*: to be able to develop an ongoing stable relationship of trust with those helping them
- *respect*: to be treated with the expectation that they are competent rather than not

- *information and engagement*: to be informed about and involved in procedures, decisions, concerns and plans
- *explanation*: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- *support*: to be provided with support in their own right as well as a member of their family
- *advocacy*: to be provided with advocacy to assist them in putting forward their views.

A child-centred focus

Keeping a 'child-centred' focus requires services to engage with children and finding out what works for them both collectively and for each child who is at risk, or already experiencing child sexual exploitation.

*'They talked about me like I wasn't even there.'*¹⁶

The CSEGG Inquiry found children at risk or already victims of sexual exploitation are often simply ignored or discounted as 'putting themselves at risk'. The Inquiry uncovered a significant difference between children and children's views of their needs and what would help them, and professionals understanding of what would help.¹²

The Violence Against Women and Children Health Taskforce commissioned a study in 2009-10¹⁶ asking for views from children about their experience of seeking or receiving help from the NHS after suffering sexual violence or abuse. The children listed four factors which they felt helped most in their recovery:

- feeling they were believed: *"Young people want a non-judgmental service."*
- counselling – but not *"Counsellors asking questions, then just letting you sit there in loads of awkward silence for ages."*
- support groups
- support for carers and siblings.

³⁶ Department for Education (2013) *Working Together to Safeguard Children*

Taking professional responsibility

The CSEGG Inquiry reported numerous cases where time was lost and a child continued to suffer harm because too much responsibility was placed on the victim to make an upfront, full disclosure about the sexual exploitation. A child might not recognise their situation as abusive:

*"I thought it was normal. I thought I was having fun. They opened my eyes to what was happening."*¹³

And two of many other reasons for not disclosing are shame:

*"Obviously if it happened to a [boy] they'd be too embarrassed to say this happened to me... it's not worth it, they'd just keep it to themselves."*¹⁵

And fear – one head teacher reported:

*"One of my year 10 students was recently gang-raped by some gang members. I talked to her and her mother. They are obviously very frightened and the mother insists that it was consensual. The girl won't come to counselling because she is afraid of being seen to talk to anyone in authority about it."*³⁷

Some children fear the response to a disclosure to a health professional:


*"A young person doesn't want to feel like a victim – make them feel normal and reassure them that they're not the only one."*¹⁵

Building trust

*"If there are serious concerns but no disclosure, [or disclosure but the young person is blocking out the abuse as a way of coping]... Befriending is needed in the first couple of sessions, explaining about child sexual exploitation and safety strategies. If they won't engage, we keep trying."*²¹

Research stresses the importance of building trust as the first stage in any intervention in order for there to be sufficient information from the child and openness

³⁷ Pitts J, *Reluctant Gangsters: Youth Gangs in Waltham Forest*, 2007



"I thought it was normal. I thought I was having fun. They opened my eyes to what was happening."¹³

from their family to understand the problems that need to be addressed.

Cook and Fleming (2007) found that, while time constraints can be challenging and informed judgement is needed about the level of risk, 'in order to help build trust and encourage a child to return to the clinic, it is possible that some sensitive questions might be left to be asked at a follow-up visit (or visits).'

*"Services shouldn't force you to talk about stuff if you're not ready."*²¹

The local care pathway should provide referring-on options to services (e.g. in the voluntary sector) which can offer a child the time it takes to build a relationship and trust. This very often includes the provision of persistent outreach work as engagement with this can be enormously difficult for children at risk or experiencing sexual exploitation.

*"You always feel people think "is that all?" - they're waiting for something more and actually it's quite a lot to even start to develop a relationship with young people who are so damaged and so disaffected."*²¹

Engagement is often accomplished through outreach services working on other issues, such as substance misuse.

Case study: Association of Young People's Health - Be Healthy²⁵

The University of Bedfordshire worked with the Association of Young People's Health on the Be Healthy project, training and supporting young people to become 'health advocates' and raise awareness about the health impact of child sexual exploitation. This is what young people said about what services should be doing to help:

"It's good if services can help young people feel like they have a choice about whether or not to attend. Reminding young people that they don't have to use a service is a really helpful message when they first attend."

"If confidentiality does get broken and we haven't been properly prepared or informed about this, here's what we'd like to see happen:

- *make sure we know how to complain and that we know it is our right to do so*
- *whoever broke confidentiality without preparing or informing us should apologise. We do understand that mistakes can sometimes happen*
- *if possible, offer us the chance to work with another worker."*

What children do not like:

"Workers showing that they feel sorry for you. Giving you 'the look', and you don't know what to say next."

But:

"You don't want workers to look or act like robots - sometimes you think that [workers] have got all their pre-prepared answers and they're just waiting to use them."

Or:

"Sometimes it feels like [workers] are talking to you as if you're below their level and they make you know that they have authority over you."

"It's really difficult when your social workers are always changing. It means that you have to explain yourself again and again. Then you get replacements when your social workers are on holiday and you have to explain yourself again."

Working with families

According to a survey commissioned by Parents Against Sexual Exploitation (PACE) and the Virtual College Safeguarding Children e-Academy, parents are aware of child sexual exploitation.³⁸ However just over half of professionals think that parents do not fully understand what it is.

This professional concern is supported by the fact that 40 per cent of parents stated that they would not be confident in recognising the difference

³⁸ PACE/Virtual College Safeguarding Children e-Academy (2013), Are parents in the picture? Professional and parental perspectives of child sexual exploitation, YouGov survey

between indicators of child sexual exploitation and normal challenging adolescent behaviour.

Whilst research supports the fact that the majority of children who are sexually exploited come from a chaotic or dysfunctional home, not all do.

“Sometimes it feels like social workers are interrogating you and your family – especially when they come into your house and are asking your parents loads of questions and you feel like your parents are being blamed. It’s hard for a parent to admit that their child is at risk and you feel defensive for them.”²⁵

Being a victim of sexual exploitation will have a traumatic and negative impact on a child’s family, parents and siblings. Health and other staff working with children at risk or experiencing sexual exploitation can help the child by working supportively with their parents and family and referring them for support in their own right. This will enable them to help a child through disclosure, the criminal justice system, possible intimidation and therapy.

Lead professional, advocate or key worker

Coordination of care plans for individual children can be by a lead professional, advocate/key worker or social worker. Advocacy or support through counselling should be offered, ideally at a venue where the child feels most able to engage, which may not be a health centre (school or other statutory facility). Practitioners need to be innovative, proactive and persistent because the lives of these children are often very chaotic, and expecting them to attend an NHS appointment at a set time and date or risk losing the service is unlikely to be an effective way of supporting them:

“Unless you’ve got a normal routine, these things like mental health appointments and education and careers ain’t going to happen.”²¹

It can be key to successful support for a child if services identify a particular adult (e.g. parent, carer, relative) that the victim trusts and engage with them at the outset, maintaining contact where possible.²¹ Supportive outreach by an advocate or key worker can enable children to recognise the risk or reality of sexual exploitation and build resilience.^{39, 40} Studies of resilience have found that ‘being there’ for children can enable a caring and supportive adult to counter previous exposure to risk and help children to develop protective behaviours’.⁴¹



Case study: Guildford Rape and sexual abuse support centre

The Guildford Rape and sexual abuse support centre (RASASC) offers advocacy services by Independent Sexual Violence Advisors (ISVAs), plus youth counselling, self-help groups and (in 2014) drop in sessions for children and young people (as well as adults).

Local services can refer sexually exploited children to RASASC, and children can self refer. RASASC offers the time, space and safety for victims to start on the road to recovery, aiming to avoid such typical impacts from sexual abuse or exploitation of depression, low self-esteem, relationship problems, self-harming, eating disorders, drug abuse and alcoholism.

RASASC has more than 20 experienced counsellors who are registered with the British Association of Counsellors and Psychotherapists, BACP or UKCP.

³⁹ Pearce J. (2009), Young People and Sexual Exploitation: ‘It’s not hidden, you just aren’t looking’

⁴⁰ Luthar, S.S. (ed.) (2003), Resilience and vulnerability: Adaptation in the context of childhood adversities

⁴¹ Coleman J. and Hagel A. (eds.) (2007), Adolescence, risk and resilience - against the odds. Wiley Series in understanding adolescence

Emma

A 13 year old girl, Emma, reported to police that she had been raped. She participated in an Achieving Best Evidence (ABE) interview with the police and had a medical examination at the SARC (Sexual Assault Referral Centre).⁴² All relevant agencies were informed and engaged – children’s social care, her GP, her school etc. Despite having this support, Emma was completely confused about what to do and had started withdrawing from relationships with her friends and family, as well as her teachers and other adults who may have been able help her. She was becoming physically and emotionally isolated. The consequences of this could be self-harm, possible suicide attempts and probably prescribed anti-depressants.

The RASASC advisor contacted Emma and her family and offered a chance to talk, ask questions, receive information and think through what felt helpful to them, individually and together. Quite often, victims will not want help immediately. Emma said she wanted help and then she changed her mind. RASASC’s offer of help remains open at any point in the future. Victims sometimes struggle with too many different agencies trying to help within a limited time frame.

Emma came for help within the month. She received individual counselling and was soon able to consider choices such as joining a self-help group to meet others who have been through similar situations, or perhaps local courses on self-esteem, confidence, art therapy, anger management, health and wellbeing. RASASC in Guildford offers one to one off road cycling sessions with a helpline volunteer to empower the victim to break out of isolation, to speak to others who have survived, to build confidence and self-esteem.

⁴² The Crime prosecution Service (2011), Achieving Best Evidence in Criminal Proceedings, Government Guidance on good practice in interviewing victims and witnesses

Responding Well – Intervention and interruption



Intervention and interruption

*'Safeguarding those at risk of sexual exploitation is rarely a matter of responding to a formal complaint or clear single indicator of abuse. A conceptual shift needs to be made as child sexual exploitation requires a very different, proactive, way of working.'*²¹

Local health agencies should offer easily accessible health services at all points along the care pathway (acute and recovery) and share information to assist prevention, early intervention and interruption of child sexual exploitation.

The NHS is a key partner in the multi-agency response to child sexual exploitation. Our expectation is that staff understand/know how to access:

- **health professionals' responsibilities**
- **the roles and responsibilities of all relevant agencies**
- **the multi-agency care pathway**
- **co-located services and multi-agency safeguarding hubs**
- **alternative forms of partnership**
- **the needs of Looked After Children**
- **specialist child sexual exploitation services**
- **and know how they can support the interruption and apprehension of perpetrators**

The Government guidance *Working Together to Safeguard Children* is clear that 'Safeguarding children is everyone's responsibility'.³⁵ It describes health professionals as being in a strong position to identify safeguarding concerns regarding individual children and to understand risk factors, communicate effectively with children and families, to liaise with other agencies, assess needs and capacity, respond to those needs and contribute to multi-agency assessments and reviews.

Health professionals' responsibilities

The role of the health professional may include:

- identifying warning signs of risk or indicators of child sexual exploitation
- being open to the possibility of disclosure but acting to safeguard the child whether or not there is a disclosure
- carrying out a holistic risk assessment
- taking advice from internal safeguarding advisors
- sharing information with, and making a referral, as appropriate, to other agencies including the police and children's social care
- referring a child for immediate treatment for physical and/or psychological health, and provision of longer term recovery treatment
- where victims may have learning disabilities or language/communication difficulties, assessing the level of disability/difficulty and then agreeing and implementing the best method of supporting the child.

To fulfil these responsibilities, all health staff should have access to appropriate single agency safeguarding training, learning opportunities as well as the multi-agency training offered by Local Safeguarding Children Boards.

The *Intercollegiate Safeguarding Training Competencies*⁴³ (currently being updated) provides a framework for this. It identifies the competences required for all health care staff, and explicitly includes competence in responding to child sexual exploitation. Levels 1-3 relate to different staff groups, while level 4, 5 and 6 are related to specific roles. It also provides guidance on education and training, highlighting flexible learning opportunities to enable acquisition and maintenance of knowledge and skills.

⁴³ Royal College of Paediatrics and Child Health (2010), *Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document*

Agencies' roles and responsibilities

Diagram 1 provides an overview of a child's potential needs, in the domains of the child's developmental needs, the parents' or caregivers' capacity to respond appropriately and the wider family and environmental factors on parenting capacity and the child.⁴⁴

Staff in all the agencies may have opportunities to identify child sexual exploitation and to help the child with recovery. In order to support health and other agency responses, it is important for the following to be in place:

- knowledge of local services and referral mechanisms i.e. the local child sexual exploitation care pathway
- adequate service provision at all the points along the care pathway commissioned to meet population need.

The local multi-agency care pathway

It is important that health staff are confident about a local child sexual abuse and exploitation care pathway. That is, a recognised referral route with clear decision making points, which provides staff supporting a child who is a victim, or who is at risk of, sexual exploitation, with a means of easy and timely access to the services needed for acute and recovery support.

A local multi-agency care pathway would need to enable staff to apply the local safeguarding children framework for all levels of need, from preventative (e.g. common assessment framework or equivalent), through children in need to protective service provision (section 47 child protection procedures). A good care pathway will also link to the local Sexual Assault Service, where there is one, which will assist a holistic approach to reproductive and sexual health screening and treatment, as well as assessment for

physical and mental health services, safeguarding services and police protection and investigation.^{45, 46}

Department of Health Public Health Nursing Policy has a programme for developing practice tools and professional pathways. They have established a small task group to develop a multi-agency child sexual exploitation policy and care pathway which will be published in spring 2014.

Co-located services and multi-agency safeguarding hubs

Barnardo's have referred to the 'gold standard' co-located multi-agency teams offering direct support to victims.⁴⁷ Co-location of health professionals alongside other statutory agencies is regarded by many as key to significantly improving the local responses to child abuse, child sexual exploitation and the abuse of vulnerable adults.

Multi-agency safeguarding hubs (MASHs) can provide a single referral point and initial response and risk assessment for children and adults for whom there are safeguarding concerns. MASHs usually consist of co-located practitioners from children's (and adults) social care, police, health and education.

Additional partners could be probation, youth justice, housing and voluntary sector agencies, such as a domestic abuse service. Co-location facilitates early information sharing, and as health can often be in possession of key information, it is vital that representatives are involved so that the most effective response are developed.

⁴⁴ Department of Health (2000), The Framework for the Assessment of Children in Need and their Families

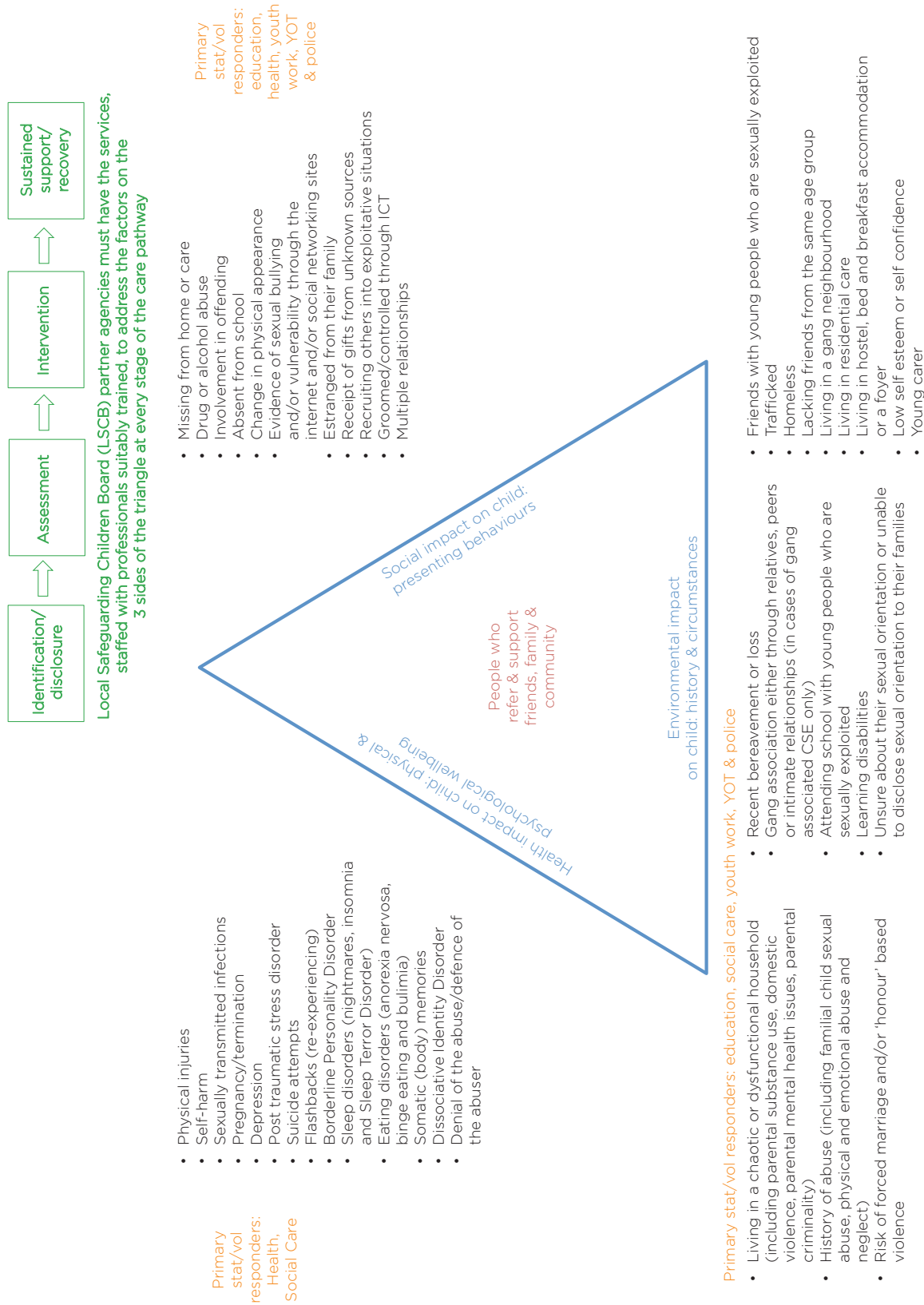
⁴⁵ Department of Health, NHS Commissioning Board (2012), Public health functions to be exercised by the NHS Commissioning Board Service specification No.30, Sexual assault services

⁴⁶ Department of Health, NHS England (2013), Public health functions to be exercised by NHS England. Service specification No.30, Sexual assault services

⁴⁷ Paskell C with the Local Government Association (2012), Tackling Child Sexual Exploitation: Helping local authorities to develop effective responses

Diagram 1: Child sexual exploitation care pathway and response based on the Assessment Framework

Sources signs of risk and vulnerability: CSEGG Report and others



Early findings from a Home Office-funded study of models of multi-agency information sharing around safeguarding children and vulnerable people shows that professionals are enabled to make timely and robust decisions where accurate information is shared.⁴⁸ The Home Office is planning, with the Department of Health, publication of a final report early in 2014.

Alternative forms of partnership

Health and other practitioners can safeguard children from child sexual exploitation effectively without co-location or a MASH. What is essential is that they work together with protocols for information sharing and care planning which enables effective early intervention and committed multi-agency strategic support.

There are a number of local safeguarding children board areas which have established a monthly Multi-Agency Sexual Exploitation (MASE) meeting to review new cases and activity against previously reported cases of child sexual exploitation. Membership for the MASE meetings includes nominated child sexual exploitation leads from each of the statutory partners, including the youth offending team, and local specialist child sexual exploitation voluntary sector agencies. MASE meetings can provide an overview of cases and a way of cross-referencing children who are known to several agencies for different reasons e.g. a child who is at risk from substance misuse, self-harm and sexual exploitation. They can also be 'cross borough' for children who are placed out of borough.

This can be supported by 'young people's panels' providing an overview of cases and a way of cross referencing children who are known to several agencies for different reasons e.g. a child who is at risk from substance misuse, self-harm and sexual exploitation.

Case study: Bristol BASE Project, sexual exploitation and health

Bristol BASE Project (Barnardo's against sexual exploitation) works with children who are at risk of sexual exploitation or who are being sexually exploited. Staff offer help with immediate practical difficulties and then support children longer term to get their lives back on track. Since starting in 1995, BASE has been evaluated as a good partnership working service which is effective in reducing the level of risk in children's lives.

Shanika

Shanika was 16 years when she was referred to BASE. She had moved in with a 41 year old male called Phil as a safe haven away from her parents' alcoholism and violence. Two months after moving in Shanika had stopped attending college or seeing any of her family or friends. Phil was a heroin addict and used his drug use to control Shanika telling her that if she left the house he would use heroin and it would be her fault. Soon he began forcing her to use heroin with him and in time he moved Shanika into a property belonging to his violent associate which was used as a 'crack house'. Shanika was sexually exploited by Phil as a means of funding his drug use.

Shanika had a history of self-injury and suicidal thoughts but, due to her non-engagement with health services, had not been assessed or accessed any support. Previous referrals to counselling had not been successful as Shanika often felt unable to leave the house or travel independently to the sessions and was not supported by family members.

Multi-agency working

The BASE keyworker used assertive outreach to engage Shanika tailoring sessions to the severity of Shanika's mental health problems, getting her to eat and giving her lifts. The keyworker interrupted her isolation with regular social interaction. Shanika was supported to engage with the onsite sexual health nurse for contraceptive advice, HIV screening and Hep B vaccination. The keyworker also got Shanika to see the GP who referred her to CAMHS. Her

⁴⁸ Home Office (2013), Multi-Agency Working and Information Sharing Project. Early Findings

keyworker attended with her until she could cope on her own, and on occasions the CAMHS psychiatrist came to see her at BASE.

A third key multi-agency intervention Shanika received was for her drug use. She would not have managed to maintain a relationship with multiple workers and would have felt overwhelmed. So the keyworker received advice from the specialist drugs worker seconded to BASE from the local authority service. This approach also recognised the intrinsic link between Shanika's substance misuse and her experience of sexual exploitation. Working on both together rather than fragmented work allowed for much greater insight and joined up safety approaches.

In summary

In common with the majority of sexually exploited children, Shanika's complex needs stopped her accessing health services in a traditional way.

She was able to leave Phil and live independently because she was provided with an integrated sexual exploitation service which recognised the elements of her sexual exploitation, and it was able to respond to all of them in one place.

This took time and needed persistent keyworker support:

- contraception allowed her the time to make this decision without managing an unplanned pregnancy
- drugs work meant that she had a safe plan in place for the cessation of heroin use
- her mental health was managed and contained allowing her to leave the property alone, and
- she had received extensive specialist sexual exploitation work and support to recognise, plan and leave the abuser.

Had Shanika not been able to receive these services together, she is clear that she would still be living in the crack house and entrenched in sexual exploitation.

The needs of Looked After Children

When a child's needs are judged to be best met by taking her or him out of their current circumstances and placing them in foster or residential care, health practitioners have a responsibility to ensure that the child continues to receive the health services they need in their new setting. A study by the University of Bedfordshire into child sexual exploitation showed that 22 per cent of all young people using child sexual exploitation services on one day in 2011 were in care.²¹ This means that the role of health professionals caring for looked after children have a crucial role in identifying children at risk, or experiencing sexual exploitation and responding appropriately to safeguard them.

Case study: Ealing Hospital Trust

The Ealing Hospital service for looked after children is provided by a dedicated health team who work to promote the emotional, physical and social health of looked after children and young people in Brent. The team works in partnership with children's social care to provide a comprehensive package of care. The core team consists of a consultant paediatrician, a designated nurse, a community children's doctor and an administrator. Consultant community paediatricians provide medical advice to Brent fostering and adoption panels.

Case study: Ealing Children's Social Care Department

Ealing has a Vulnerable Adolescents Panel chaired by the Director of Children's Services. Several agencies sit on the panel, which meets every six weeks to discuss its most complex cases. The panel agrees actions to be taken in each case and monitors and reviews progress until the desired outcomes are achieved. The fact that the Director of Children's Services chairs the panel ensures that there is accountability, commitment and strategic leadership in the safeguarding of young people within the local authority. The establishment of a multi-agency forum has been included as a necessity for tackling child sexual exploitation precisely because some sexually exploited children and young people face dangers from multiple sources.

Specialist child sexual exploitation services

The CSEGG Inquiry reported that 69 per cent of local areas have a specialist child sexual exploitation service, however some were only able to offer short term or time limited support.^{12,13} The complex nature of child sexual exploitation and the need for persistent outreach and advocacy to engage victims and change the trajectory of their lives, supports the case for more investment in local specialist services, including a local or regional witness service.

Therapy for child witnesses

Government guidance is available both for the provision of therapy for child witnesses and vulnerable or intimidated adult witnesses prior to a criminal trial, the latter is useful for children whose case are heard after their 18th birthday. The guidance is aimed at practitioners in the criminal justice system, NHS, children's social care and the voluntary sector. It assists decision making about the provision of therapeutic help for child witnesses prior to a criminal trial.⁴⁹ The guidance makes it clear that the best interests of the child are paramount when deciding whether, and in what form, therapeutic help is given. The London Child Protection Procedures also provide guidance on pre-trial therapy.⁵⁰

Interrupting perpetrators

Health staff are in a position to support the interruption and apprehension of both adult and child perpetrators of sexual exploitation. Perpetrators may come to notice when they use health services or through information from a victim, including cases where the victim is also implicated in perpetration of child sexual exploitation.

⁴⁹ The Crown Prosecution Service, Department of Health and Home Office (2001), Provision of therapy for child witnesses prior to a criminal trial and Provision of therapy for vulnerable and intimidated adult victims prior to a criminal trial

⁵⁰ London Safeguarding Children Board (2013), London Child Protection Procedures

In addition, through professional curiosity and careful and accurate recording and sharing of information health practitioners are in a good position to assist the local police by contributing to multi-agency intelligence leading to the identification and apprehension of perpetrators.

Children who are perpetrators

Children who are perpetrators should themselves receive a safeguarding response, that is, a strategy meeting or similar between children's social care, the police and other relevant agencies. The CSEGG Inquiry was repeatedly informed of children who had been exploited and who were being groomed to draw in other children.^{12,13} Both girls and boys were used to groom and sexually exploit girls before passing them on to older men. A child used in this way should receive a safeguarding response as both a victim and as a perpetrator.

Recommendations

4. All child safeguarding education and training should contain a comprehensive section on sexual exploitation, recognising that it has profound health consequences, so that health professionals are supported to respond appropriately to victims.

Bodies responsible for this include:

- **the individual medical colleges in their training roles**
- **the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the Health and Care Professions Council in their roles for setting education standard**
- **Health Education England (HEE)**

- NHS England and their area team safeguarding leads; Clinical Commissioning Groups (CCGs) with their designated health professionals; NHS Trusts and providers with their named health professionals, in their capability development work through local safeguarding children boards.
5. The Department of Health should ensure that relevant e-learning material is available for all staff to have basic child sexual exploitation training to enable them to take preventative action, identify, understand and make safe exploited children; engage with multi-agency partners appropriately and provide recovery services as needed.
 6. Local health commissioners would wish to promote a joined-up response with partner agencies through care and referral pathways for health treatment and recovery services for children who have been sexually exploited, and where appropriate, engage non-statutory agencies in delivering or co-delivering these services.

Responding Well – Strategic cooperation



Strategic cooperation

“You’ve got so many different people looking at different aspects of it and actually there’s normally just one or two major things that are causing everything else, and they need to be more focused on the root of the problem [...] you might just want one person to help you – you might not want 20 odd people trying to come and help you.”²¹

We expect the NHS to play its part in contributing to the multi-agency approach to tackling child sexual exploitation. Effective multi-agency service delivery requires a partnership working framework driven by strategic cooperation.

Child sexual exploitation can only be tackled successfully when senior managers and safeguarding professionals cooperate to provide direction through:

- **the Joint Health and Wellbeing Strategy**
- **the Local Safeguarding Children Board**
- **good strategic partnership working.**

Joint Health and Wellbeing Strategy

Joint strategic needs assessments (JSNAs) are the means by which local leaders work together to understand and agree the needs of all local people, with the Joint health and wellbeing strategy (JHWS) setting the priorities for collective action. Clinical commissioning groups (CCGs) and local authorities jointly lead the local health and care system, through health and wellbeing boards and in collaboration with their communities. Joint working between councillors, Directors of Public Health and clinicians is therefore key to improving the health and wellbeing of local populations.

The Joint Health and Wellbeing Strategy should be informed by evidence and strategy in relation both to tackling violence, from the community safety partnership and to safeguarding children, from the local safeguarding children board.

Local Safeguarding Children Boards

Local Safeguarding Children Boards (LSCBs) play a key part in promoting a good response to child sexual exploitation. Their remit is to ensure the effectiveness of local single agency responses and coordinate local multi-agency activity to safeguard children and promote their welfare. This includes raising awareness, monitoring and evaluating the effectiveness of what is done and helping to plan services to safeguard children.

LSCBs are guided by *Working Together to Safeguard Children*²⁵ and by the Supplementary guidance, *Safeguarding Children and Young People from Sexual Exploitation*.²⁸ *Working Together* is clear that ‘Safeguarding children is everyone’s responsibility’, it lists the accountabilities for NHS England, clinical commissioning groups and individual providers of services.

Many LSCBs now have child sexual exploitation sub-groups with a local child sexual exploitation strategy linking schools, health services, children’s social care, the voluntary sector services and the police (and other services such as, housing, youth justice and the courts). LSCBs are also in a position to encourage local and regional information sharing and action for children who are missing from care or home and trafficked children, who may also be suffering sexual exploitation.

LSCBs each publish an annual report on the effectiveness of single and multi-agency safeguarding of children and the promotion of their welfare in the local area – based on the performance and outcomes for local services. This, together with their ongoing influence, can be an incentive to health, as well as the other local partners, to improve their response to child sexual exploitation and the outcomes.

Good strategic partnership working

In practical terms, partnership working means that health professionals contribute proactively to the multi-agency response at every stage of the commissioning cycle and delivery of services along the care pathway for children who are sexually exploited:

- gathering information at a population level (through the JSNA)
- contributing to a local response strategy (through the JHWS)
- jointly commissioning services, including local voluntary sector specialist child sexual exploitation services wherever possible
- identifying individual children and sharing information
- providing acute and recovery health services, often as part of a multi-agency care package.

Sexually exploited children and those at risk should have easy access to health services, not just for sexual health, but also for their physical and mental health, reflecting the broad range of potential health problems they may have.

Case study: Partnership working on child sexual exploitation through the Greater Manchester sexual health network

Sexual health services play a key role in identifying young people at risk of, or experiencing, child sexual exploitation. The Directors of Public Health in the ten local authority areas in Greater Manchester (GM) fund the Greater Manchester Sexual Health Network, which is hosted by the Greater Manchester Public Health Network.

The Sexual Health Network works with commissioners and providers of sexual health services to encourage collaborative working and strong partnerships to tackle priority areas of work, increase quality of services and ensure cost effective services are delivered to meet the needs of local populations.

In October 2012, the Greater Manchester Sexual Health Network organised a workshop on child sexual exploitation for sexual health commissioners and providers to raise awareness, share good practice and identify further actions required.

Eighty sexual health commissioners and health practitioners attended the event including staff from contraception services, specialist GU clinics, integrated sexual health services, young people's sexual health services and termination services.

Following the workshop, the Sexual Health Network established a child sexual exploitation task and finish group for sexual health services to:

- increase awareness of child sexual exploitation amongst all staff working in GM sexual health services and all commissioners of sexual health services
- map out current child sexual exploitation policies and procedures in sexual health services
- standardise GM risk assessment tools, pathways, training and guidance on child sexual exploitation
- improve information sharing within organisations, between health organisations and between health and other multi-agency partners
- consider the health and wellbeing of all staff working within this field – psychological support for staff for debriefing / very specialist supervision.

The child sexual exploitation task and finish group includes sexual health commissioners and sexual health service representatives from across GM local authority areas and from different sexual health disciplines.

To ensure providers identify risk of child sexual exploitation and act upon it, GM commissioners have prepared a paragraph on identifying child sexual exploitation and referral mechanisms that should be followed for inclusion in all contracts with sexual health providers.

Child sexual exploitation is now a standing item on the Greater Manchester Sexual Health Network Board, Sexual Health Commissioners Group and other priority action groups.

The Greater Manchester Sexual Health Network is a member of the strategic GM Phoenix Steering Group, working closely with Greater Manchester Police and local authorities and also works with GM Designated Nurses for Safeguarding to agree minimum health input requirements into specialist multi-agency child sexual exploitation teams.

The Network is planning standardised GM wide child sexual exploitation training for all sexual health service professionals (including reception and administrative staff).

Case study: Northumberland Safeguarding Children Board

The local safeguarding children board oversees virtual teams operating to respond to child sexual exploitation across their police force area. Referrals are received from multi-agency co-located safeguarding hubs, following which either a multi-agency child sexual exploitation meeting or strategy discussion will be arranged.

The meeting is used to coordinate a partnership response to the referral including: an assessment of the case; decision making about investigations; actions to meet the safeguarding and health needs of the child.

Virtual requests (requests from 'virtual partnerships') from all partners are made for information pertaining to the cases. This information is shared at the earliest opportunity. Information from the meeting is circulated across the virtual partnership, with different agencies assigned to taking forward actions.

Case study: Sheffield child sexual exploitation Genito Urinary Medicine (GUM) teams

Development

The Sheffield 'wrap around' child sexual exploitation GUM service has integrated four services into its teams – GUM, community paediatricians, children's social care and the police. The challenge in developing the teams was that each service had a different agenda and culture:

- GUM: 'hide behind a cloak of confidentiality, don't take child protection seriously'
- community paediatricians: 'don't know anything about teenagers and normal sexual behaviour'
- social workers: 'have no awareness about confidentiality, it doesn't exist in their service, which has already failed the young person, they can't do anything'
- police: 'they blunderbuss in, arresting boys for consensual sexual activity, they are only concerned with crime targets'.

The teams produced, piloted and implemented a set of procedures which they could all agree on and worked to embed the work in the cultures of their respective organisations.

Investment in the Sheffield service was twofold: firstly there has been the commitment and work needed to build an integrated service; secondly the service procedures require staff to complete the five-minute assessment, followed by the child or young person seeing an extra worker and receiving a follow up visit.

Results

The 'wrap around' service has increased the identification of children at risk, or experiencing sexual exploitation in Sheffield, and referrals, usually with consent, have greatly assisted safeguarding interventions for the children. The national roll out has enabled GUM services across the country to use a quick screening tool that requires less than five minutes to be used; and using the Sheffield procedure, GUM services are able to maintain a confidential service for clients in the most part.

The integrated child sexual exploitation GUM service has improved the effectiveness of other services in supporting sexually abused and exploited children (though this has not been formally measured, and is therefore an assumption).

Training the paediatricians in testing has meant that there are fewer examinations for the child or young person and fewer hospital visits (increased quality and efficacy). For the police, if referral is with the consent of the young person they are more likely to provide statements, improving quality of crime management. For social care they are better able to help the child or young person and protect others from harm.

Recommendations

- 7. To support appropriate local prioritisation, commissioning and local 'health scrutiny', health and wellbeing boards should ensure that the local joint strategic needs assessment (JSNA) and the joint health and wellbeing strategy, reflect the impact of different forms of violence and abuse, including child sexual exploitation; the JSNA being informed by evidence from a range of local sources, including the local safeguarding children board and the community safety partnership.**

Leadership in the New Health and Care System



The NHS Leadership Academy describes a model of leadership called shared or distributed, leadership. It is especially appropriate where tasks are complex and highly interdependent – as in healthcare. According to the model even though not everyone is necessarily a leader, everyone can contribute to the leadership process.⁵¹

We want to enable the NHS, to focus on responding to child sexual exploitation in the most effective way possible. This requires staff at every level to understand the new health and care system and deliver their services confidently within it.

This requires staff to be accountable for their role and responsibilities in:

- **NHS England**
- **Public Health England**
- **Clinical Commissioning Groups**
- **Local Authorities and Directors of Public Health**
- **Inspectorates**

In order to tackle an issue as complex as child sexual exploitation, it is vital to have well informed, committed and strategic leadership at a national and local level. The CSEGG Inquiry confirmed that ‘child sexual exploitation is tackled effectively – from prevention to protection, enforcement, securing justice and long-term recovery – when there is clear and committed leadership that imports unambiguous messages stressing the importance of doing this work¹³.

This leadership needs to be within organisations and across partnerships. Leadership means ensuring that appropriate training is delivered to a high standard. It also means that there is a responsibility for ensuring that the response to child sexual exploitation is embedded as part of broader safeguarding responsibilities in the system.

NHS England⁵²

Safeguarding responsibilities

The central and regional teams of NHS England are responsible for leading policy on safeguarding and overall assurance of the NHS safeguarding system, whilst the area teams are responsible for day to day support, leadership, quality and assurance.

The annual review process appears to offer an important opportunity to ensure that NHS organisations are including tackling child sexual exploitation effectively in their overall approach to safeguarding. NHS England has delegated responsibility for commissioning sexual assault health services, which it does in collaboration with other commissioners in the care pathway.

NHS England’s Accountability and Assurance Framework states that:

‘We expect to see the NHS, working together with schools and children’s social services, supporting and safeguarding vulnerable, looked after and adopted children, through a more joined up approach to addressing their needs.’⁵³

Public Health England

Public Health England (PHE) has outlined its priorities for 2013-14.⁵⁴ One of these is:

‘Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme.’

PHE has a responsibility for leadership across the public health system and could support staff in these workstreams to improve the health response to child sexual exploitation.

⁵¹ The NHS Leadership Academy (2013), Health Care Leadership Model

⁵² NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000

⁵³ The Mandate from the Government to the NHS Commissioning Board (NHS CB) for April 2013 to March 2015 (2012)

⁵⁴ Public Health England (2013), Our Priorities for 2013/14

Public Health Outcomes Framework

All local authorities will be measured on progress towards delivering across all 50 Indicators of the *Public Health Outcomes Framework*.⁵⁵ This makes the Framework a useful starting point for a conversation with local Directors of Public Health (DPHs). There are a number of potential relevant indicators, including:

- hospital admissions caused by unintentional and deliberate injuries in children
- violent crime (including sexual violence)
- emotional wellbeing of looked after children
- under 18 conception rate.

Health Education England (HEE) ensures that the health and public health workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and drive improvements.

Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs) are responsible for commissioning children's healthcare treatment services for physical and mental health – child and adolescent mental health services (CAMHS) and other therapeutic recovery services. They are therefore in a key position not only to identify and to stop child sexual abuse and exploitation in their day-to-day work, but also to significantly improve the local multi-agency response. They can support awareness raising campaigns, promote appropriate information sharing, contribute to multi-agency interventions and commission the statutory and voluntary services needed for children to recover well.

Clinical commissioning groups are also responsible for identifying child sexual abuse and exploitation and sharing information about it as part of their contribution to a strategic assessment of crime and disorder, anti social behaviour, and drug and alcohol misuse, for the community safety partnership area/s

in which they are located.⁵⁶ Their contribution extends to assisting with the development of local strategies that effectively deal with these issues where they are identified.

Local Authorities and Directors of Public Health

Local authorities' responsibility for improving the health of their local populations include delivering and commissioning public health services for children aged 5-19 (including Healthy Child Programme (HCP) 5-19) and school health, public mental health services, sexual health services and public health aspects of promotion of community safety, violence prevention and response.

Directors of Public Health (DsPH) are the statutory chief public health officer of their local authority and the principal adviser on all health matters to elected members and officers. They have a key role in local authority public health commissioning and will need to work closely with the local safeguarding children board and the community safety partnership, as well as the members of the health and wellbeing board.

⁵⁵ Department of Health. *Public Health Outcomes Framework 2013 to 2016 and technical updates*

⁵⁶ Health and Social Care Act 2012. Schedule 5, Paragraph 84: 1 April 2013, clinical commissioning groups (CCGs) became 'responsible authorities' on community safety partnerships (CSPs)

Case study: School nursing⁵⁷

School nurses will implement the Healthy Child Programme for school age children. They are responsible for 'early help' e.g. through care packages for children with additional health needs, for emotional and mental health problems and sexual health advice. They will provide longer term support for vulnerable children, and they will form part of the high intensity multi-agency services for children for whom there are child protection or safeguarding concerns.

Children say:⁵⁸

- What makes a good school nurse is: "*Someone you know and can trust*"
- School nurses need to be visible and well known to pupils.
- School nurses need to use technology such as texting and emailing
- School nurses need to offer *early* help to support young people
- School nursing services need to offer choice to young people in order to ensure that services are accessible and confidential.

School nurses who can offer the above are in a key position to identify child sexual exploitation. Not only do pupils see them as someone they can approach and trust with their fears, but also the nurse can observe child sexual exploitation indicators such as behaviour changes, symptoms of depression, changes in eating habits etc. On site school nurses are well placed to notice changes and intervene where appropriate.

In addition to their role in frontline practice, school nurses can make a vital contribution to the Joint strategic needs assessment (JSNA), and future planning and commissioning of services for children, and local authority public health should support them in providing this contribution.

The Department of Health is developing a child sexual exploitation pathway, with evidence, challenges and good practice to support school nurses and schools to improve their response to child sexual exploitation.

Health and Wellbeing Boards (see 'Commissioning' below)

Inspectorates

The Care Quality Commission (CQC)'s targeted child protection inspection regime will, it claims 'focus on the child's journey through the maze' of GP surgeries, health visiting, school nurses, hospital emergency departments, maternity units and mental health.⁵⁹

They will consider how well local health services are working together and how 'safe, effective, caring, well led and responsive to children's needs' services are. The CQC will look for whether hospitals and other acute care settings have alert systems in place to identify and track children who are at risk of harm.

The Ofsted single inspection framework will examine the effectiveness of single and multi-agency working in services for children needing help and protection, services for looked after children (including local authority fostering and adoption services) and care leavers.⁶⁰ The inspection will also review local safeguarding children boards – both the Board's activities and individual partners' contributions. Ofsted has identified as a focus for these inspections, the effectiveness of the multi-agency response to reduce the harm or risk of harm to children who are sexually exploited, trafficked and/or missing from home, care or full time school education.

Ofsted, CQC and the other inspectorates are committed to introducing multi-agency inspections of local arrangements for child protection and looked after children in 2015.

⁵⁷ Getting it right for children, young people and families: Maximising the contribution of the school nursing team: Vision and Call to Action. Department of Health Best Practice Guidance (2012)

⁵⁸ *School Nurses Survey Results*, DH/National Children's Bureau (2011); *Our school nurse. Young people's views on the role of the school nurse*, DH/British Youth Council (2011) and '*Someone you know and can trust*', DH/North West Regional Youth Work Unit (2011)

⁵⁹ Care Quality Commission (2013), Care Quality Commission (CQC) announces launch of targeted child protection inspections

⁶⁰ Ofsted (2013), Framework and evaluation schedule for the inspection of services for children in need of help and protection, children looked after and care leavers (single inspection framework) and reviews of Local Safeguarding Children Boards. Ref: 130216

Recommendations

8. The Department of Health, the Royal College of Nursing and other nursing professional bodies should promote the role of school nurses in recognising, addressing and coordinating the response to child sexual exploitation.
9. Public Health England should seek to tackle child sexual exploitation through Directors of Public Health and their central role in the local health and care system.
10. The NHS Safeguarding Leads at national, regional and local level should work to promote a better health response for victims of child sexual exploitation. This could include use of the annual assurance process.
11. The Care Quality Commission (CQC) and Ofsted inspections should scrutinise the health contribution to the local response to child sexual abuse and exploitation.

Commissioning



*'The importance and value of a mixed economy should not be underestimated. Statutory and non-statutory service provision for children who have experienced sexual violence or abuse will be required.'*¹⁶

We want the right services to be commissioned so that all children who are sexually exploited have access to services where they can disclose or be identified as victims and receive acute and recovery services which address their needs.

Good local commissioning for child sexual exploitation services requires people at all levels to be confident about the roles and contribution of:

- **NHS and local authority public health**
- **Health and wellbeing boards**
- **Sexual assault services**
- **Commissioning specialist support**

It is important that local commissioners of health services are well informed about the needs of child sexual exploitation victims, as this will help to encourage the commissioning and provision of a range of health services which respond appropriately to victims.

NHS and local authority public health

We have already confirmed the central role of JHWSs etc and the role of NHS England, CCGs, PHE and DsPH. They can play a key role locally to:

- adequately map the local population need in relation to child sexual exploitation (as part of the JSNA)
- agree and promote a local child sexual exploitation care pathway (supported by the JSHWS)
- commission services for responding effectively
- monitor service delivery and outcomes well

“It’s too risky not to help these young people. You need to be willing to spend money now because if not, you will end up spending more money later on anyway.”²⁵

- have a system for gathering views and feedback from children about what child sexual exploitation services are needed and are effective.

“It’s too risky not to help these young people. You need to be willing to spend money now because if not, you will end up spending more money later on anyway.”²⁵

Local authority ‘health scrutiny’ holds all commissioners and providers of publicly funded healthcare and social care to account for their activities arising from the JSNA, JSHWS and their section 17 responsibilities in reducing crime, disorder and the fear of crime, including anti-social behaviour and substance misuse.⁶¹

Health and wellbeing boards

Health and wellbeing boards (HWBs) are responsible for linking the NHS, public health and social care with a wide range of partners. As acknowledged by the recent Health Select Committee report,² HWBs provide the platform for ensuring commissioned services meet the needs of their local populations.

The HWB can ensure that the JSNA includes evidence on violence and abuse directed at women and children. The HWB can use the JHWS to support the commissioning of effective preventative, acute and recovery services.

According to the Government Guidance for safeguarding children from sexual exploitation members of local safeguarding children boards should assume that sexual exploitation occurs within their area unless there is clear evidence to the contrary.²⁸ The hidden nature of child sexual abuse and exploitation means that engaging with voluntary or specialist groups at a local level may be the key to developing intelligence and understanding of the problem. Barnardo’s noted that awareness raising increased the identification of victims and children at risk, also that whenever they open a sexual exploitation service, more victims are identified.⁴⁷ The local safeguarding children board (and the community safety partnership) should help ensure that child sexual exploitation is appropriately prioritised by the HWB.

⁶¹ Section 17 of the Crime and Disorder Act 1998, as amended by the Police and Justice Act 2006

Oxfordshire’s Joint Health and Wellbeing Strategy

In Oxford they have set up a Children’s Partnership Board which provides information and intelligence to the Health and Wellbeing Board and has a remit to keep all Oxfordshire’s children safe, raise achievement for all and narrow the gap for disadvantaged and vulnerable groups. The Children’s Partnership Board and the Health and Wellbeing Board link in very closely to the Oxfordshire Safeguarding Children Board.

The JHWS prioritises better recognition and prevention of child sexual exploitation emphasising the need for agencies to work together to prevent this type of crime happening. The Strategy makes links, for example, with the fact that going missing is a key indicator that a child might be at very serious risk of physical and sexual abuse and sexual exploitation. It reports that the number of looked after children reported missing from Oxfordshire care homes was reduced between 2011 and 2012 from 155 to 63 episodes.

Sexual Assault Services

Sexual assault services (SAS) integrate the health care, forensic medical, safeguarding and to other statutory and voluntary sector response. The health services aspects of SAS are responsibility of the Secretary of State, delegated to be commissioned by NHS England. The operational model for how NHS England secures the best possible outcomes for victims of sexual violence, co-commissioning with police forces and other partners in a care pathway, such as local authorities was set out in 2013.⁶² Currently, sexual assault referral centres (SARCs) are the typical model of integrated health and forensic medical provision in England, offering an open access one stop service to help victims of rape or sexual assault, irrespective of age.⁴⁵ SARCs currently exist in most parts of the country and the challenge is to offer consistent services wherever located.⁴⁶ They can provide access to a range of services of benefit to victims of child sexual exploitation.

⁶² NHS England (2013), Securing Excellence in commissioning sexual assault services for people who experience sexual violence.

In planning for a SARC to form part of a local child sexual exploitation care pathway, commissioners must address the need for the SARC:

- to have trained staff for children,
- to be integrated into a local safeguarding procedures including paediatric and child abuse and sexual exploitation care pathways to provide support and treatment
- be linked to wider networks that strategically consider tackling local violence, such as police and crime commissioners, community safety partnerships and specialist sexual violence children services in the voluntary sector which are able to work with children to gain their trust pre/post disclosure.

Models of sexual assault services in other countries have been documented which show a wider scope for self-referrals and/or integration with the wider health system.⁶³ However there are limitations to SARCs as a gateway for sexually exploited children. For instance, approximately 84 per cent of referrals to SARCs in England are through local police, which may be a hindrance for victims who do not wish to follow a criminal justice pathway, even though on access, SARCs give choice to victims to receive healthcare only or involve the police.⁶⁴ Only 12 per cent of cases are self-referrals.

Ambitions in the forthcoming year require the provision of Sexual Assault Services to address severe shortcomings in provision of paediatric child sexual assault and NHS England is also increasing investment in this area.

Child and young people's pathways involving SARCS can be found in the *Public health functions to be exercised by NHS England service specification no 30: Sexual assault services*.^{36, 45, 46}

⁶³ Jungpa Park J, Department of Health (2011), Sexual Violence Services: International Overview.

⁶⁴ Crilly T, Combes G, Davidson, D Joyner, O and Doidge S. Feasibility of Transferring Budget and Commissioning Responsibility for Forensic Sexual Offences Examination Work from the Police to the NHS. University of Birmingham, 2011

Case study: Sexual Assault Referral Centre

St Mary's Sexual Assault Referral Centre provides a co-ordinated response to women, men and children who have experienced sexual assault/abuse and provides services to over 1,200 people a year.

In the year ending March 2013 the Centre saw 507 children representing 42 per cent of all cases. 44 per cent of those children were aged 13 and under.

In December 2012 St Mary's Sexual Assault Referral Centre appointed a Young Person's Advocate supported by funding from the Home Office Violence against Women and Girls (Girls and Gangs initiative).

The aim of the advocate is to:

- improve services for young people suffering rape, sexual abuse and / or exploitation in the cities of Manchester and Salford
- support young people who have been affected by sexual abuse/exploitation to access services
- develop preventative and support services for young people who are at risk of sexual abuse/exploitation
- develop services to meet the needs of those young people affected by sexual abuse and/or exploitation by groups and gangs.

The St Mary's SARC advocate works as a member of the SARC team supported by forensic physicians, paediatrician, crisis workers, Independent Sexual Violence Advisors (ISVA), child advocates and therapists including a young person's therapist.

The advocate has developed networks with other agencies involved in the safeguarding of young people including the Protect team, a dedicated child sexual exploitation (child sexual exploitation) unit, bringing together police, health and social care workers to recognise and respond to the needs of exploited children. According to the advocate:

"This is challenging but rewarding work. It is a real privilege to meet young people, build a trusting relationship and for them to allow you into their

world. I am moved by the courage of the young people I work with and their experiences."

Working with one young person, the advocate was able to challenge professionals to ensure the girl's safety and that the potential for sexual exploitation was disrupted.

In the following examples two young people were being groomed and experiencing child sexual exploitation. One said:

"It was the first time I felt listened to and acknowledged and that the SARC and my contact with you [the advocate] was the one place that I feel safe."

Another said: *"You helped me a lot knowing that you won't be shocked or upset by what I say. I know that it was nothing that I did that was wrong."*

Commissioning specialist support

'Universal services can certainly do more to identify those children at risk. However, research by Barnardo's over a number of years has found that it is only through specialist services that we can fully ensure that the needs of sexually exploited children are met.

*We do not expect every local authority to have such a service, but where there is a clear need, authorities should be prepared to pool resources with other agencies and, where possible, across geographical boundaries to provide an appropriate response.'*¹⁰

It is important that victims are able to access some voluntary sector specialist support when required. It can be difficult to ensure that every local area has dedicated specialist services. However, within a good commissioning structure a voluntary sector specialist service can be a very effective and cost effective way of safeguarding and supporting sexually abused and exploited children.

Research by Pro Bono Economics for Barnardo's in 2011 found that there is a potential saving of £12 for every £1 spent by Barnardo's on providing the

intervention.⁶⁵ These savings are shared by multiple agencies and government departments.

The University of Bedfordshire study found that participants from voluntary sector specialist projects are particularly keen to be involved but as part of a commissioned multi-agency partnership:

*'As a voluntary organisation we would be happy to manage the risk in a proper partnership, where the safeguarding issue is identified, and we all work together to do something about it.'*²¹

An option for some areas is to commission specialist voluntary sector services through regional arrangements, such as those in place in North London.



Case study: Barnardo's Young Women's Project

The Barnardo's Young Women's Project provides a specialist sexual exploitation service for four neighbouring north London boroughs - Camden, Hackney, Haringey and Islington.

The Project also offers sexual health services, and a missing children service (for one of the boroughs). Children at risk, or experiencing sexual exploitation, are referred to the Project through children's social care, who convene a multi-agency planning meeting.

A Barnardo's worker attends the meeting and offers expert advice about the level of risk to the child.

The meeting agrees a multi-agency care plan and a Barnardo's keyworker is allocated for the child.

Voluntary sector specialist services have a track record in being able to respond effectively to the needs of victims. The National Audit Office identified the particular benefits of the voluntary sector as being:

- understanding the needs of local service users and communities

⁶⁵ Pro Bono Economics and Barnardo's (2011), Reducing the risk, cutting the cost: An assessment of the potential savings from Barnardo's interventions for young people who have been sexually exploited.

- closeness to the children needing a service
- ability to deliver outcomes that statutory services find hard to deliver on their own, and
- innovation in developing solutions.⁶⁶

Recommendations

The content of this chapter supports recommendation 7. This is found at the end of the 'Responding well - Intervention and interruption'.

⁶⁶ Girach M, Hardisty H and Massey A (2012), A Clinical Commissioner's Guide to the Voluntary Sector, ACEVO & NHS Alliance

Information Sharing



*'There is nothing within the Caldicott Report, the Data Protection Act 1998 or the Human Rights Act 1998, which should prevent the justifiable and lawful exchange of information for the protection of children or prevention of serious crime.'*⁶⁷

We want all health professionals to be confident in carrying out their duty to safeguard sexually exploited children (and vulnerable adults) by knowing when and how to share confidential information, even without consent.

In order to share information appropriately to safeguard children health staff need to be confident about:

- **what children say about confidentiality**
- **using professional discretion**
- **multi-agency risk assessment**
- **safeguarding and sexual health services**
- **the Caldicott2 Review support for safe information sharing**

What children say about confidentiality

Children are realistic about the need to share information and asked that information be shared between professionals working directly with them – from practitioner:


"Young people have said to me, 'I'm sick of telling my story to the YOT worker, the drugs worker, the sexual health worker, the social worker, you, the Connexions worker.'"²¹

*"It is better for services to be clear and open at the beginning about having to pass information on – so it isn't a shock."*²⁵

"If confidentiality does get broken and we haven't been properly prepared or informed about this, here's what we'd like to see happen:

⁶⁷ Lord Carlile (2002), Too Serious a Thing – The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales

“It is better for services to be clear and open at the beginning about having to pass information on – so it isn't a shock.”²⁵



- *make sure we know how to complain and that we know it is our right to do so*
- *whoever broke confidentiality without preparing or informing us should apologise. We do understand that mistakes can sometimes happen*
- *if possible offer us the chance to work with another worker.*²⁵

Using professional discretion

The sharing of health data is a challenging balancing act for health professionals, who need to maintain confidentiality wherever possible, whilst also complying with section 1 (1) of the Children Act 1989 – that the welfare of the child should be the paramount consideration.

Whether or not information should be shared comes down to the professional discretion of the healthcare team – it should not be an individual decision.

Sharing some health information can help to identify children at risk/victims and help to disrupt sexual exploitation: ‘There will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action – the information shared should be proportionate.’²⁸

Multi-agency risk assessment

We have already confirmed the challenge for frontline practitioners that in some cases sharing of information is needed before a judgment can be made about the level of risk a child is facing from sexual exploitation.

The initial issue may relate to a single concern, e.g. a change in physical appearance, self-harm or substance misuse, but through this assessment process, what at first may appear to be low risk can become significantly more serious as the wider circumstances of the child’s daily life are understood.²⁸

Local areas therefore need to have specific procedures in place to enable key professionals to

pool information and to undertake an assessment of risk.

Any provider of relevant health services could improve the sharing of information across agencies in order to tackle child sexual exploitation.

Safeguarding and sexual health services

Working Together to Safeguard Children is clear that:³⁵ ‘fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children;’ also that local multi-agency information sharing arrangements should be in place and no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe.

The legislative framework for sharing information includes sections 10 and 11 *Children Act 2004* which confer on agencies the duty respectively, to cooperate to improve wellbeing of children and to safeguard and promote the welfare of children.

Whilst sexual activity by children under 16 years is classified as an offence under the Sexual Offences Act 2003, teenagers, including under 13s, are entitled to receive confidential sexual health advice and contraception (in the context of Gillick competence and Fraser Guidelines).⁶⁸ Health service legislation prohibits the sharing of information on STIs and terminations except in very specific circumstances.

In practice, *‘It is essential that the nurse [or health professional] informs the young person that this information will only remain confidential if she feels that he or she does not require further investigation or safeguarding. The dangers and risks must be explained to the young person and why a certain course of action that may be contrary to their wishes, needs to be taken. It is essential that the child is helped to understand how and why decisions are*

⁶⁸ NSPCC (2012). Gillick Competency and Fraser Guidelines. NSPCC Factsheet

being made and that they are supported to cope with the action taken.⁶⁹

"I would rather that services are straight up at the beginning about confidentiality. Otherwise they tell you it's confidential and then you end up telling them stuff and then they pass it on and say 'oh we're worried about you and we had to tell someone' - and then you get more angry."²⁵

There is some consensus amongst service providers and health care professionals that sharing information, particularly around STIs and terminations, could deter children from seeking help.⁷⁰ This needs to be balanced with the fact that these children might be at considerable risk of harm. Research from the US found that girls who have had a termination are six times more likely to commit suicide in the six months after the termination than teenagers who have not had a termination.⁷¹

Caldicott2 Review⁷²

The second review conducted by Dame Caldicott on health and information sharing recognised that more work needs to be done to ensure that information is shared appropriately about children at risk of harm (including through child sexual exploitation). The Caldicott Report and Government response note that there are cultural challenges around information sharing that need to be addressed:

'Indeed, the duty to safeguard children or vulnerable adults may mean that confidential information should be shared, even without consent, because it is in the public interest to do so where there is a risk of significant harm to a child, either directly through abuse or neglect.'

The Caldicott2 Report recommends that:

'The Department of Health should work with the Department for Education to investigate jointly ways to improve the safe sharing of information between health and social care services and schools and other services relevant to children and young people, through the adoption of common standards and procedures for sharing information.' The Government response to this recommendation was that *'there would be clear benefits if a single, common approach to sharing information for children and young people could be adopted.'*

⁶⁹ Daniels and McAlinden (2012), The Sexual Offences (NI) Order 2008: implications for nurses, School of Nursing and Midwifery, Queen's University

⁷⁰ Bastable and Sheather, Mandatory reporting of all sexually active under-13s, BMJ 2005;331: 918-9 (2005)

⁷¹ Garfinkel B et al (1986), Stress, Depression and Suicide : A Study of Adolescents in Minnesota. Responding to High Risk Youth, University of Minnesota Extension Service

⁷² Department of Health (2013), Information: To share or not to share? Government response to Caldicott Review

Case study: child protection – information sharing

The Department of Health is sponsoring the development of the Child Protection – Information Sharing (CP-IS) project over a five year period.

To be taken forward by NHS England, CP-IS will help the NHS give a higher level of protection to children who present in unscheduled care settings, including emergency departments, walk in centres, minor injury units, GP out of hours services, ambulance services, maternity and paediatric wards.

A health professional registering a child in one of those settings will see an indicator flag on screen if that child is subject to a child protection plan or is looked after by a local authority. This information will be fed securely from local authority children's social care systems for all children in these categories up to the age of 18.

Prompt and easy access to such information will help health professionals to make an informed assessment of need and respond quickly if there is cause to do so.

CP-IS is a minimum requirement, although it has to be recognised that most children experiencing child sexual exploitation will not have a child protection plan though many such children are likely to be in the care of the local authority.

Whilst flagging is helpful, it is not a fail safe method of ensuring children are in appropriate relationships, so where there are concerns about a young person these should be explored even when there is no flag. Equally, not all children with a child protection plan will be in inappropriate relationships.

Recommendations

12. NHS organisations and staff should manage information in a way that is open and transparent to safeguard children who may be sexually exploited or at risk of exploitation. Staff should be clear that safeguarding considerations override the usual requirements for confidentiality and be confident to act accordingly, following the advice of the safeguarding professional. The child should be informed as appropriate and their consent to share information sought wherever possible.

13. The Department of Health and the Department for Education should work together to ensure the implementation of the response to Caldicott² and the document produced under the umbrella of the Code of Practice are relevant for victims of child sexual exploitation.

Recommendations



Responding well – Understanding and evidence

1. The Department of Health should commission work on where the gaps are in the existing evidence base on child sexual exploitation, what the priorities to address them should be and how best to address them (potentially through system wide actions and focused work, such as research, with a clear understanding of who leads on each strand.
2. The Department of Health should request NICE guidance on how to identify and treat children who have been sexually abused which should also cover children who have been sexually exploited.

Responding well – Identification and assessment

3. NHS England and their area team safeguarding leads should work with clinical commissioning groups (CCGs), health provider trusts, and general practitioners and local authority public health commissioning and their partners to ensure that:
 - designated doctors and nurses for safeguarding support their area teams and CCGs' work on child sexual exploitation;
 - local multi-agency teams combating child sexual exploitation are fully represented from all the relevant NHS agencies including professionals from primary and secondary, physical and mental health care.

Responding well – Intervention and interruption

4. All child safeguarding education and training should contain a comprehensive section on sexual exploitation, recognising that it has profound health consequences, so that health professionals are supported to respond appropriately to victims. Bodies responsible for this include:
 - the individual medical colleges in their training roles

- the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the Health and Care Professions Council in their roles for setting education standard;
 - Health Education England (HEE);
 - NHS England and their area team safeguarding leads; Clinical Commissioning Groups (CCGs) with their designated health professionals; NHS Trusts and providers with their named health professionals, in their capability development work on local safeguarding children boards.
5. The Department of Health should ensure that relevant e-learning material is available for all staff to have basic child sexual exploitation training to enable them to take preventative action, identify, understand and make safe exploited children; engage with multi-agency partners appropriately and provide recovery services as needed.
 6. Local health commissioners would wish to promote a joined-up response with partner agencies through care and referral pathways for health treatment and recovery services for children who have been sexually exploited, and where appropriate, engage non-statutory agencies in delivering or co-delivering these services.

Responding well – strategic cooperation

7. To support appropriate local prioritisation, commissioning and local 'health scrutiny', health and wellbeing boards should ensure that the local joint strategic needs assessment (JSNA) and the joint health and wellbeing strategy, reflect the impact of different forms of violence and abuse, including child sexual exploitation; the JSNA being informed by evidence from a range of local sources, including the local safeguarding children board and the community safety partnership.

Leadership and the New Health and Care System

8. The Department of Health, the Royal College of Nursing and other nursing professional bodies should promote the role of school nurses in recognising, addressing and coordinating the response to child sexual exploitation.
9. Public Health England should seek to tackle child sexual exploitation through Directors of Public Health and their central role in the local health and care system.
10. The NHS Safeguarding Leads at national, regional and local level should work to promote a better health response for victims of child sexual exploitation. This could include use of the annual assurance process.
11. The Care Quality Commission (CQC) and Ofsted inspections should scrutinise the health contribution to the local response to child sexual abuse and exploitation.

Information Sharing

12. NHS organisations and staff should manage information in a way that is open and transparent to safeguard children who may be sexually exploited or at risk of exploitation. Staff should be clear that safeguarding considerations override the usual requirements for confidentiality and be confident to act accordingly, following the advice of the safeguarding professional. The child should be informed as appropriate and their consent to share information sought wherever possible.
13. The Department of Health and the Department for Education should work together to ensure that the implementation of the response to Caldicott² and the document produced under the umbrella of the Code of Practice are relevant for victims of child sexual exploitation.

Conclusion



The profile of child sexual exploitation has been raised through a series of tragic and shocking cases which have exposed what was, until now, a relatively hidden form of abuse. It has provided the impetus for a *cross-Government Action Plan for Tackling Child Sexual Exploitation*,¹ and subsequently, the multi-sectoral work that the National group on Sexual Violence against Women and Children is taking forward, overseen by Home Office Ministers. We have also seen enormous changes in the NHS. In this context, the role of the Health Working Group report has been to support the safeguarding of children from sexual exploitation.

The Health Working Group on Child Sexual Exploitation recognises the wealth of good practice, expertise and training which is already in place around the country. The role that health services play in the lives of children means that they are in a position to make a significant contribution to identifying, making safe and supporting the recovery of children who may have been harmed through sexual exploitation.

The Working Group has been able to call upon extensive specialist knowledge in the areas of child sexual exploitation, multi-agency working and the health service at local, regional and national level. It has also had the advantage of having access to a range of high quality reports that have now been published. This breadth of expertise has informed a report which can be used by professionals at all levels to support an effective health response to child sexual exploitation.

We have recommended some important action to be taken on health and child sexual exploitation and would expect to see improvements through the development of care pathways, more co-ordinated multi-agency responses and the existence of appropriate accessible services.

Ultimately, the key measure of success will be the way in which children who have been abused experience health services. If we can improve the health and wellbeing of children who have experienced sexual exploitation, and ensure they go on to lead a full life and realise their potential, we will have achieved what we set out to do.

Annex A



Membership and Terms of Reference of the Health Working Group on Child Sexual Exploitation

Claire Phillips (Chair)	Deputy Director, Violence and Social Exclusion, Children, Maternity and Health Inequalities
Amanda Thomas	Medical Director, Leeds Community Healthcare NHS Trust and Officer for Child Protection Royal College of Paediatrics and Child Health
Androulla Michael	Violence, Social Exclusion, Military Health and Third Sector Programme
Ann Arscott	Association of Chief Police Officers
Carlene Firmin	Children's Commissioner's Office
Carron Fox	Barnardo's
Catherine Blishen	Platform 51
Catherine White	Clinical Director, St Mary's Sexual Assault Referral Centre, St Mary's Hospital Manchester
Christine Christie	Safeguarding Consultant
Danielle Harris	Association of Chief Police Officers
Dave Whatton	Chief Constable for Cheshire. National Policing Public Protection Lead
Debra Sohan	Violence and Social Exclusion Team, Department of Health
Emilia Wawrzukowicz	Consultant Paediatrician Designated Doctor Safeguarding Children Cambridgeshire and Peterborough Clinical Commissioning Group, representing Royal College of Paediatrics and Child Health
Emma Pawson	National Treatment Agency
Jane O'Brien	Head of Standards and Ethics, General Medical Council
Jodie Herbert	Child Exploitation and Online Protection Centre
Karen Rogstad	Consultant Physician in Genitourinary Medicine, Royal College of Physicians, member British Association for Sexual Health and HIV
Lucy Thorpe	Head of Policy Unit, Royal College of Psychiatrists
Martin Teff	Violence and Social Exclusion Team, Department of Health
Mary Selby	Royal College of General Practitioners
Moya Sutton	Safeguarding Lead, NHS England
Nick Libell	Royal College of Paediatrics and Child Health
Raymond McMorrow	Royal College of Nursing
Rebecca Salter	College of Emergency Medicine, National Working Group for Sexually Exploited Children and Young People
Rosanna O'Connor	National Treatment Agency
Simon Blake	National Director, Brook
Sheila Taylor	Director, National Working Group for Sexually Exploited Children and Young People
Susan Bewley	Professor of Obstetrics, Kings College London representing Royal College of Obstetricians and Gynaecologists
Tara Weeramanthri	Consultant Child & Adolescent Psychiatrist representing Royal College of Psychiatrists

Terms of Reference

1. The Health Working Group on Child Sexual Exploitation will look at the role of health services in identifying and supporting children who are victims of child sexual exploitation, and in preventing child sexual exploitation.
2. In particular, the Working Group will examine:
 - How to raise awareness of the *indicators* of abuse so that health care professionals are better able to identify children who may be sexually exploited;
 - How to ensure that health care professionals have the *tools* to 'ask the questions' sensitively, to gain the information that they need in these cases;
 - How to ensure that health care professionals feel equipped to *refer* children who are sexually exploited in a safe and appropriate manner to appropriate local services;
 - The role of commissioning in addressing the needs of children who have been sexually exploited.
3. The Working Group will take the opportunity to address similar issues around Female Genital Mutilation and-faith based abuse where appropriate.
4. Recommendations will take account of the transitional context of the health system and the 'new' partners which will be involved.
5. The Working Group will meet approximately three times and produce a report with recommendations by December 2012 (this was subsequently delayed to allow full consideration of other developments around time).

Annex B



Tackling Child Sexual Exploitation Action Plan – Department of Health (DH) Actions

- DH, as part of its work programme on violence against women and children, will work with its partners to see whether more can be done to **highlight the particular needs of children who have been sexually exploited**.
- DH has a programme of policy work in place to **improve the development of Sexual Assault Referral Centre (SARC) services** as they are positioned within the new NHS Commissioning and public health structures. It is also working to improve education and training to increase the pool of component forensic physicians available to victims.
- DH will liaise with those responsible for commissioning **Sexual Assault Referral Services** to draw attention to the special circumstances of children who have been sexually exploited.
- Department for Education and DH will continue to work with the National Working Group for Sexually Exploited Children and Young People on **'task and finish' groups within children's services and health** to consider: why agencies do not recognise or respond appropriately to child sexual exploitation and what might enable them to do so; the priority to be given to victims; what duty of care is once they have been recognised; and any other ways in which agencies can be encouraged to tackle the issues victims face.
- DH will also use networks and information portals for NHS staff, such as NHS Choices and the DH website, to **promote information** on tackling child sexual abuse.

DH will continue to work with stakeholders and key partners to identify where existing **training and guidance** for health professionals on child sexual abuse and other forms of violence against women and children can be expanded. The Department, in discussion with representatives of the relevant professional bodies, has reviewed the content on violence against women and children in relevant training curricula.

The Department is considering how more could be done to improve the content to reflect the particular needs of children who are being, or have been, sexually exploited; and, if so, will urge the professional regulators to approve amendments to curricula accordingly.

Annex C



Child sexual exploitation warning signs and indicators of abuse^{12, 13}

The following are typical vulnerabilities in children which increase the risk that they may be sexually exploited:

- living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, parental criminality)
- history of abuse (including familial child sexual abuse, risk of forced marriage, risk of 'honour' based violence, physical and emotional abuse and neglect)
- risk of forced marriage and/or 'honour' based violence
- recent bereavement or loss
- gang association either through relatives, peers or intimate relationships (in cases of gang associated child sexual exploitation only)
- attending school with young people who are sexually exploited
- learning disabilities
- unsure about their sexual orientation or unable to disclose sexual orientation to their families
- friends with young people who are sexually exploited
- homeless
- lacking friends from the same age group
- living in a gang neighbourhood
- living in residential care
- living in hostel, bed and breakfast accommodation or a foyer
- low self esteem or self confidence
- young carer.

Knowing the warning signs means that staff can be alert to the possibility that a child may be at risk of sexual exploitation.

Indicators of abuse

The following signs and behaviour are generally seen in children who are already being sexually exploited.

- missing from home or care
- physical injuries
- drug or alcohol misuse
- involvement in offending
- sexually transmitted infections, pregnancy and terminations
- absent from school
- change in physical appearance
- evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites
- estranged from their family
- receipt of gifts from unknown sources
- recruiting others into exploitative situations
- poor mental health
- self harm.

Knowing the indicators means that staff can be alert to the possibility that a child may be experiencing sexual exploitation.

Annex D



KYSS FORM

KING'S YOUTH SEX SAFEGUARDING FORM

Name:

No:

Date:

Age (circle) <13 (**involve Paediatrics**) 13 14 15 16 17 18

Confidentiality discussed

This is a confidential consultation. If we have concerns that you or someone else is at risk of serious harm then we may need to share information with others, but this is rare.

Parent/guardian/person with parental responsibility	Address & GP	School/College
Aware you are here? Y/N	Details checked with patient? Y/N	Details checked with patient? Y/N
Aware of sexual activity? Y/N		Are you attending? Y/N
Know of your partner? Y/N		

Questions to cover during consultation	
Who do you live with? Include siblings.	
Are you in contact with any other services? Name and contact details if possible. Eg, Social Worker/Mental Health Worker/Key Worker/Youth Worker?	
Contact with Family planning clinic/GUM services?	
Age at first sexual intercourse?	Number of lifetime partners?
Multiple partners at present?	
Current relationship: How long? Age of partner?	
Current/past alcohol/drug use? How much/how often /provided by partner? Does use affect sexual activity choices?	
Partner in position of trust? Power imbalance? Do you feel under pressure?	
Have you ever been made to have sex? (Non-consensual) Y/N	
Have you ever been paid, or given gifts for sex? Y/N	

Questions to reflect upon (not to be asked to patient)
Any evidence of grooming/bribery? Y/N
Does the young person deny/dismiss/minimise your concerns about them? Y/N

Fraser Guidelines. For under 16 s only
The young person understands the information given Y/N
Parental involvement explored with young person Y/N
The young person is likely to continue to have sex with or without treatment Y/N
Physical and or mental health is likely to suffer if they do not receive treatment Y/N
Young person's best interest to give advice or treatment without parental consent Y/N
Fraser competent Y/N

SEXUAL HEALTH SAFEGUARDING ASSESSMENT IN UNDER 18 YEAR OLDS

PATIENT FACTORS

1. Under 13yrs (**very high risk**)
2. Lacks maturity
3. Unusual level of secrecy for age
4. Withdrawn / anxious
5. Dismisses concerns
6. Presents alone or isolated
7. Previous STI
8. Previous pregnancy
9. History of self harm
10. Regular alcohol / drugs
11. Alcohol / drugs at time of sex
12. Violent / forced / pressurised relationship
13. Evidence of grooming
14. Poor school attendance
15. Lives away from parents
16. Problems at home
17. Social worker / Youth worker
18. Mental health problems
19. Looked after child
20. On a child protection plan
21. Learning disability

PARTNER FACTORS

1. Controlling/intimidating partner
2. Partner > 5 years older than patient
3. Partner not in school year
- less risk if patient is older
4. Partner drives or works
- less risk if patient is older
5. Imbalance of power or mental capacity
6. Partner is a family member
7. Partner is in a position of responsibility
8. Violent / forced / pressurised relationship
9. Partner supplies alcohol or drugs to patient
10. Partner known to police
11. Social worker / Youth worker
12. Mental health problems
13. Learning disability



If **YES** to any of the above points patient may be HIGH RISK for safeguarding

Discussed case with ED Consultant/SpR Paediatrics/Safeguarding team

(please circle) **Name of person/role:**

Do you still have safeguarding concerns? Y/N

If **YES**, please specify:

- Action plan:**
- (1) **Social Services referral** consented OR informed
- (2) **School Nurse referral**
- (3) **Youth Work referral**
- (4) Inform Police - important if <13 yrs

If **NO** to the above points, the patient is LOW RISK but may require further support/time:

- Youth work referral** consented mobile number checked
- Leaflet on sexual health services given Youth work card
- Safer sex and future contraception discussed

All notes to be placed in box for discussion at Child Review Meeting

Name of clinician:

Designation: