



**NWG Network**

Tackling Child Sexual Exploitation

“If you Shine a Light you  
will probably find it”

Report of a Grass Roots  
Survey of Health  
Professionals with Regard  
to their Experiences in  
Dealing with Child Sexual  
Exploitation

Dr Paul Kirtley



March 2013

- 1.1 Introduction
- 1.2 Definition of CSE
- 1.3 Warning Signs and Symptoms of CSE
- 1.4 Factors associated with CSE
  
- 2.1 The Young people
- 2.2 Communications and Technology issues
- 2.3 Gangs
- 2.4 Trafficking
- 2.5 Boys & Young Men
- 2.6 Ethnic Minorities
- 2.7 Learning Disability & Learning Difficulties
  
- 3. Health Professionals
  - 3.1 School Nurses
  - 3.2 Accident & Emergency (A&E) Departments
  - 3.3 Sexual Health Services (SHS)
  - 3.4 Paramedics & Ambulance Services
  - 3.5 Midwives
  - 3.6 Primary Care
  
- 4.1 Mental Health Issues
- 4.2 Child & Adolescent Mental Health Services (CAMHS)
  
- 5.1 Co-working & sharing of Information within the Health Service
- 5.2 Co-working outside the health community
- 5.3 Information Sharing & Confidentiality
- 5.4 Third Sector Agencies
- 5.5 Named Nurses and Designated Safeguarding Nurses
  
- 6.1 Actions when CSE has been recognised
- 6.2 Fears and Concerns
- 6.3 Examples of Good working
- 6.4 Awareness of General Public and Areas to Target
- 6.5 Education & Awareness Training needs
  
- 7.1 Recommendations from the NWG
- 7.2 Actions for the NWG
  
- Appendix 1 Forum Terms of Reference
  
- Appendix 2 Abbreviations and Acronyms

INSET BOXES	PAGE NUMBER
BOX 1: WARNING SIGNS & INDICATORS OF CSE	7
BOX 2: FACTORS HEIGHTENING RISK OF CSE	8
BOX 3: TOOLS USED TO ENFORCE CSE	9
BOX 4: GEOGRAPHICAL AND OTHER AREAS OF CONCERN WITHIN A COMMUNITY	11
BOX 5: MENTAL HEALTH PROBLEMS ENCOUNTERED	23
BOX 6: WORKING WITH PARENTS	28
BOX 7: MYTH BUSTING	31
BOX 8: OTHER AREAS TO TARGET FOR AWARENESS	35
BOX 9: HEALTH PROFESSIONALS TO TARGET FOR AWARENESS TRAINING FOR CSE	38
BOX 10: ORGANISATIONS TO DISSEMINATE AND SHARE INFORMATION WITH	40
BOX 11: USEFUL PUBLICATIONS, GROUPS ETC.	40

## 1.1 Introduction

The report is based on an accumulation of views, comments and experiences from a wide range of health and associated voluntary workers who have been involved in responding to Child Sexual Exploitation (CSE) or personal experiences of Serious Case Reviews relating to child sexual abuse.

The contributors came from many areas of the country, and included representatives from rural areas, inner city, industrial towns and tourist destinations. These terms and those below, describing actual job titles, have been kept deliberately vague as the attendees were promised anonymity.

Professional representatives included:

- Assistant Director of Public Health Nursing
- Specialist Safeguarding Health Practitioner for Sexual Exploitation
- Safeguarding Nurse from several areas of the NHS:
  - Sexual Health Services (SHS)
  - Ambulance Trust
  - Adults & Children
- Designated Nurse for Commissioning Trust
- Consultant Paediatrician
- Public Health Manager
- Deputy Director Sexual Health Network
- Consultant Child and Adolescent Psychiatrist
- Named Doctor for Provider Trust
- Public Health Representatives
- General Practitioner
- Named Nurse for Hospital Trust
- School Nurse
- Sexual Health Services Nurses
- Programme Lead for STI Screening

Voluntary Sector Representatives included:

- Representatives from National Children's Charity Team
- Service Manager voluntary organisation Non- Governmental Organisation (NGO)
- Specialist Team Member NGO
- Director NGO

Some of the contributors came to a full-day Forum held in Derby on 9<sup>th</sup> October and others, who were unable to attend, were subsequently interviewed either personally or in small groups by Dr Kirtley. The Terms of Reference of the Forum are attached. (Appendix 1)

The purpose of the Forum and the subsequent discussions was to provide an environment in which the health workers could be open and honest without fear of any repercussions. This enabled them to talk about what went well and what didn't go well, where the barriers were and what they would do differently in a similar situation so that we can all learn from their experiences.

This was a 'grass-roots' survey and everything written in the report is based on the personal comments made by the contributors either personally to Dr. Kirtley or at the Forum. The report reflects their knowledge, their experiences, their thoughts and their opinions. We have deliberately not used any other sources. By its very nature the report, therefore, cannot be nor does it pretend to be wholly inclusive and there may be gaps in what has been covered. The participants do, however, provide a wealth of safeguarding experience in Healthcare.

There are many experienced and knowledgeable Health Professionals but they are limited to their geographical or immediate clinical areas of expertise. There does not appear to be many individuals who could be called overall "experts" in CSE within the NHS. But all those spoken to were experts within their own locality and their own field of work.

The discussions were wide-ranging and actually brought up more questions than answers, but we felt in a position at the end of the exercise to make recommendations and decide on the next steps.

There are areas of best practice but the quality of service is variable and the term "post-code lottery" was often used. Each local area needs to get best practice embedded in their system.

The frequency of identified CSE varies across the country. In some areas it appears to be a huge problem and in others such as Metropolitan London it is uncommon and not widely recognised. The NWG believes that this variation is unlikely to demonstrate that it does not exist in the areas of low incidence but that it has just not, from the evidence so far found, been brought to the attention of the authorities.

## 1.2 Definition of CSE

The National Working Group has developed the following definition, which is utilised in [UK government guidance and policy](#). The definition will be reviewed in the near future and the updated version will be available on the NWG website.

The sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing, and/or others performing on them, sexual activities.

In all cases those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources.

## 1.3 Warning Signs & Symptoms of CSE

*"A holistic view of a young person would allow all the indicators to be seen."*

Although signs and symptoms are already well-documented elsewhere and well known to most Safeguarding Nurses and Doctors experienced in CSE cases, there appeared to be a lack of knowledge amongst some front line health workers. There is a myriad of ways in which CSE can present.

It seems that CSE is not included in many Child Protection Training courses. These signs and symptoms should be known and immediately available to all those who work in the Health Service and allied professions. They should be part of everybody's Child Protection Training so that awareness and professional curiosity are stimulated.

Health workers are ideally placed to recognise CSE and in fact in several serious cases they have been the first people to be aware of CSE and to report their concerns. However, one Specialist Safeguarding Health Practitioner reported that in over 200 referrals to her this year only 2% had come from a health professional. This could indicate that a lot of health workers are either not aware or are reluctant to refer.

### WARNING SIGNS & INDICATORS OF CSE

- Self harm
- Low self esteem
- Rapid change in appearance
- Sexualised behaviour
- Disruptive or challenging behaviour at school
- 'Revolving door' with A&E or police
- Bullying as a victim or a perpetrator
- Repeat STI testing
- Pelvic-inflammatory disease
- Repeat pregnancy
- Repeat alcohol abuse
- Drugs & solvent abuse
- Physical injuries
- Late presentation of untreated injuries or illnesses
- Running away/missing from home
- Repeated absence from school
- Mental health problems
- Suicidal ideation
- Unexplained injuries

BOX 1

Signs that a young person is being exploited include rapid changes in appearance and behaviour. Before and after photographs show huge differences and can be difficult to believe that it is the same person. Some Safeguarding Nurses routinely take a photograph at the first assessment and perhaps this should always be done as a comparative record.

*"Young people should routinely be questioned regarding domestic violence."*

*"We need to be asking young people about CSE, it needs to be embedded into everyone's practice- there needs to be specific questions asked to ensure young people know exactly what they are being asked-specific questions relating to CSE used in health assessment tools."*

*"Health workers need to be aware of related presentations such as drug problems".*

## 1.4 Factors Associated with CSE

As with signs and symptoms only those experienced with CSE cases were fully aware of factors that would make a young person more susceptible to becoming a victim of CSE. Indeed, some Safeguarding Nurses were not aware of all the factors or perceived that one area of concern was vastly more important than others. These thoughts were probably weighted by their own personal experiences. For example, in one area a young person in a care home was the uppermost factor while in another area with a large number of CSE cases only 5% of the young people were in care.

### FACTORS HEIGHTENING RISK OF CSE

- Children in care (looked after Children, adopted children)
- Early child protection concerns
- Previous sexual abuse
- Family bereavement
- Family alcohol
- Alcohol abuse
- Substance misuse
- Out of mainstream school
- Absent from home/homelessness
- Domestic violence
- History of abuse
- Dysfunctional family home
- Male domination
- Poverty
- Learning disabilities
- Learning difficulties- additional educational needs
- Gang association
- Social isolation
- Peers who are sexually exploited

**BOX 2**

In one city there had been a case that had involved 25 young women. Nine of those abused had a history of alcohol abuse and nine had a history of drug misuse. Whether the drug use comes first or whether they are introduced to them through CSE is unclear. With regard to domestic violence, 5 were known to have been subjected to this but there was no evidence that questions had been routinely asked about domestic violence. Early child protection concern is also a known factor. Of the 25 young women, 12 had experienced physical abuse, 12 sexual abuse, one emotional abuse and one where



neglect was explicitly noted. The highest incidence was in school non-attendance, which had been reported in 19 cases.

One of the most common points that all health workers should be aware of is that it is often the case that the girls and boys do not think that they are being exploited. They feel that what is happening to them is normal and the way things are.

Young people do not seem to recognise the dangers. Often a reaction to an immediate problem such as falling out with parents at home can cause the young person to run to the abusers in the first place. The grooming process usually starts with kindness, friendship and gifts.

There is no “one size fits all” with regard to sexual exploitation and factors seem to vary around the country. In one area drugs, especially cocaine, ecstasy and MCAT (mephedrone) is a huge problem, whilst in others it did not seem so important. This may be a reflection of whether the exploitation is a result of groups or gangs. The former tend to control their victims by rewards such as drugs and the latter by fear.

#### TOOLS USED TO ENFORCE CSE

- Presents: especially in grooming phase
- Drugs: either supply or paying off drug debt
- Fear
- Alcohol
- Food treats
- Rewards e.g. mobile phone top-ups
- Black magic
- Blackmail
- Paying off debt
- Physical violence
- Mental manipulation
- False promises of love and/or affection
- False promises of opportunities i.e modelling, photography, acting

**It should be recognised that there is always power imbalance and the perpetrators have control over their victims.**

**BOX 3**

## 2.1 The Young People

*"We do not view young people properly"*

In one city where there had been a Serious Case Review investigations had shown that there were over 200 girls possibly exploited between the ages of 11-18. 130 were identified as victims of sexual exploitation but of these less than 20 were willing to go to court. When this was discussed at the Forum concerns were expressed as it was felt that many of those girls were lost in the process. Some of these could have been victims but they were never followed through.

The initial Forum also felt that society had let all of these girls down over many years and that the situation had to improve.

Experience has shown that taking a girl and the family away from a town in an attempt to remove from the CSE situation does not seem to work. The girls often return of their own volition allowing the process to continue.

Grooming is not always achieved by initial kindness and gifts. Examples were given of older girls bringing younger girls in and the girls having their eyes taped open and forced to watch violent sexual activities with the threat that if they are not obedient the same will happen to them.

It should be recognised that girls who are being exploited often use nicknames for themselves and their acquaintances. This is a protection, as they do not want to use their real name. When working with these girls then the continued use of nicknames is important.

There is little encouragement across the Health Community to go out and meet young people in their own environments and at suitable times. However, at least one region with multi-agency teams does work in the evenings and they will drive around hot spots and party areas. (See 6.3 Examples of Good Working)

There also appears to be very little training available with regard to routinely enquiring. But above all and as mentioned in other parts of the report - professional curiosity is paramount.

*"Young people will only tell if they have been asked, the importance of asking the questions must be emphasised"* Health service staff need to ask the question of young people and in the right way. Questions such as "have you ever taken part in a sexual activity that you didn't want to?" What is the right question in each situation? Northumbria has a model of "How to Ask" as do some other areas and perhaps a national model based on these is a way forward. Further comment on this can be found in the section 6.5 Training Needs at the end of the document.

## GEOGRAPHICAL AND OTHER AREAS OF CONCERN WITHIN A COMMUNITY

(Known as “honey-pots”: either where young people congregate or where they can easily be accessed).

- Shopping centres
- Arcades
- Cafes
- Areas with no parental supervision e.g. fairground, circus, roller ball, cinema complexes
- Take-away food outlets
- Sheesha (Hookah) bars
- Alcohol outlets including corner shops with liquor licences: effective use of licensing officers can disrupt
- Taxi drivers
- “Mascots” –(men dressed up as friendly animals).

BOX 4

## 2.2 Communications and Technology Issues

Mobile phones and modern technology was reported by almost every contributor as something that makes the whole process of sexual abuse easier for the offenders and as a means to control the victims by threats and coercion. Facebook and Blackberry messaging is known to be accessed to identify young people who may be suitable for grooming. The geographical location of photographs taken on an android phone, I-pad etc. are at risk as software can be freely downloaded that can give the co-ordinates of where the digital image was taken to within a matter of yards.

*“If the exploitation is to be stopped then the victim’s Facebook needs to be de-activated, the android phone needs to be got rid of and the girl given a pay as you go mobile phone”-*  
Safeguarding Nurse.

There is no standardisation of systems across the health service or even within a Trust with regard to whether mobile phones are allowed to be taken into clinics. Some perpetrators insist that their victims carry their mobiles switched on and connected so that they can listen to what is said in the clinic. Some SHS clinics take the phones off patients attending and some do not. This is something that all health clinics need to consider.

Also when attending a health clinic, the young people often attend with a friend or supposed relative. The reason why that person is often there is to be aware of what has been said. At every clinic attendance it is important that at some stage of the consultation an opportunity is made to talk to that young person on their own.

## 2.3 Gangs

*“Gang culture with girl on girl violence complicates the issue”.*

There is a difference between gangs and groups involved in CSE. As listed in Box 3, various tools are used to enforce CSE and groups tend to use “reward” in some shape or form to maintain control. Gangs do not need to bother with the expense of rewards as they control by fear.

Gangs can vary in size. The minority may have more than 50 members, most have 15-20 individuals and some a handful. Girls see themselves as part of the gang and not as being exploited and can be responsible for bringing new girls in or being violent with other girls. There is a danger that they are seen just as perpetrators and not as victims.

Young people may willingly join gangs for protection or a sense of belonging. However, gang culture can pressure the girls into sexual activity, which can be violent, especially if between gangs. Nearly all girls who are involved in gangs report that they have been raped and passed around. Girls can subsequently become instigators of sexual and other violence and the behaviour becomes normalised within their neighbourhood.

It should be recognised that within gangland culture both boys and girls are sexually exploited both within their own gang and by neighbouring gangs as a revenge, power or punishment issue.

The fear that gangs can engender is not confined to the victims. The effects of gangs can run through whole communities and even though the parents of victims can be aware of what is going on, they feel powerless or too frightened to do anything. (See section 2.6 Ethnic Minorities).

Those health workers who work in areas where gang culture exists believe that different tactics need to be utilised to deal with the problem compared with areas where group CSE exists.

What is a gang?

The broad definition of child sexual exploitation in gangs and groups as described in the Office of the Children's Commissioner Report "I thought I was the only one. The only one in the world" Nov 2013 is this:

- . 1) **gang** – mainly comprising men and boys aged 13 – 25 years old, who take part in many forms of criminal activity, such as knife crime or robbery, who can engage in violence against other gangs, and who have identifiable markers such as territory, a name, sometimes clothing etc. While children can be sexually exploited by a gang, this is not the reason why a gang is formed.
- . 2) **group** - By contrast, child sexual exploitation by a group involves people who come together in person or online for the purpose of setting up, coordinating and/or taking part in the sexual exploitation of children in either an organised or opportunistic way.

## 2.4 Trafficking

Trafficking is the recruitment, harbouring and movement of children, women and men for the purpose of exploitation. People can be trafficked from overseas into the UK and from within the UK itself as defined in Section 58 of the Sexual Offences Act 2003. This means that a girl taken from her place of residence to a house/hotel or to the other side of the country in order that she can be sexually exploited and abused is actually being trafficked.

This report does not wish to deal with trafficking as this area has its own groups that are also developing toolkits and guidelines with regard to awareness training and how to respond to concerns. However, most of the key indicators for trafficking are also the key indicators for CSE and health workers need to be aware of this if they have concerns.

Those experienced in trafficking have learnt that you cannot just treat victims as sexually abused. If their situation is not understood sorted and de-constructed then they will be more at risk of being re-victimised. Children and young people who are being sexually exploited are often trafficked within the UK too. This means that they are subjected to some of control measures very similar to migrant adult women, men and children trafficked victims. Unless we recognise these unique symptoms it is difficult to successfully develop the effective responses required to reduce the significant impact that will have been experienced by the victims.

Developing systems that allow the whole picture to be seen means earlier identification, more effective responses and less reliance on services for their lifetime.

## 2.5 Boys and Young Men (B&YM)

It is widely recognised that sexual exploitation of young men is a huge problem, that it is under-recognised and that we do not know the real extent of the problem. There is still a lack of recognition among some groups that B&YM are vulnerable to or victims of sexual exploitation and there remains a lack of knowledge about the long term effects of sexual abuse on the victims.

The actual incidence of occurrence is unknown, but it is certainly greater than we presently know, and the numbers seem sure to rise. One area reported that of the last 90 cases of CSE being looked into, 10 of them were boys and another that of her recently reported cases 16 were girls and 10 were boys.

*“B&YM are deemed perpetrators- either perpetrators of criminal behaviour or perpetrators of grooming/recruiting- it is often not the case. The reality is that they are the victims in the first place.”*

B&YM seem to have their individual needs met e.g. alcohol or substance misuse issues but will not be offered the same holistic package that is available to girls when it comes to CSE. Because of real or perceived criminal behaviour they are then placed in secure units. One specific example given was of two boys who had been actually exploited, then became perpetrators, but were not seen as victims and consequently sent to prison.

It was generally felt that what has been missed by professionals around girls in the past is now being missed in boys. Even when a young person is recognised and helped there are insufficient services available, this can be demonstrated by one scheme having one boy's worker for 6 police divisions.

There are multiple challenges in protecting young male sex workers, although limited help can be provided by the Third Sector and Charitable Organisations.

## 2.6 Ethnic Minorities

CSE exists within many different ethnic minorities and is not confined to one culture. It probably exists in all areas of a community and

*“If you Shine a Light you will probably find it”*

Because of recently highly publicised court cases there has been an increasing opinion that CSE is prevalent amongst groups of Asian men exploiting young white girls. Although this does occur to some extent, all cultures are involved and girls from all backgrounds are just as likely to be victims. This is one of the myths that needs challenging as it means that health workers and the general public, because their thoughts are already channelled on specific communities, may not be able to focus on what is really going on in the wider client group. CSE is prevalent in all communities including travelling communities, individuals from a wide range of BME backgrounds, as well as individuals from European and Western countries. Many think it is *“certainly not a racial issue”* and that *“it’s a criminality issue not a racial issue”*.

It was noted that in many areas the migrant communities have little engagement with sexual health services.

Some areas have found working with Mosques to be of great benefit and CSE is something the Imams will not tolerate. The amount of input seems to vary across the country, in some areas it is being done by front-line workers, but in others it is done at a strategic level. Parents and Imams have subsequently talked about CSE in groups and although some have found it difficult to understand CSE the clear message has been that young adult men should act to control their own behaviour and families should not ignore the behaviour of their young men.

In a school where the majority of pupils are mostly of ethnic minorities a boy’s group has been formed in the school to change attitudes towards women. There is also a parent programme within the school. A positive result from this was that one parent suspected sexual exploitation and on returning home very late put her daughter’s underwear into a freezer bag in the freezer to be used as DNA evidence.

In some communities families may be aware that relatives are being sexually exploited. Unfortunately, they are too frightened to do anything about it because of the gang culture that exists in their locality. Others may attempt to discipline the girls, imprison them, shave their heads, arrange forced marriages or remove them from the UK in order to “protect” them. Female Genital mutilation is still practised, as is “breast ironing” by some mothers in order to protect daughters from sexual harassment at puberty.

## 2.7 Learning Disability & Learning Difficulties

Many contributors commented that there is a lot of work that needs to be done in this area. There was special concern with regard to Autism (especially in girls), Asperger's Syndrome, Down's Syndrome and those with a Learning Disability who are in care.

The following points were made:

- Learning Disability is one of the main factors heightening the risk of CSE
- Those with a Learning Disability may have a disordered attachment to the grooming process, examples of girls with Down's Syndrome were cited
- Learning Disability victims can become the offenders but they do not have the capacity to understand
- Young people on the Autism Spectrum, particularly girls, are often pre-occupied with relationships and it is difficult for them to understand grooming
- It was felt that agencies do not always pick up on Learning Difficulties

We need to learn how we can educate these children and young people in the dangers of sexual exploitation. It is important that the educational methods used for this client group need to be adapted to their level of understanding and delivered in a way that they can absorb the information given and subsequently put that information into practice. This does not appear to be something that is being done at the present time.

## 3.1 School Nurses

*"Young people are often aware of the problem of CSE"*

Throughout the discussions, nearly all the contributors felt that *"the importance of School Nurses must be emphasised"* and that *"the key is early intervention in schools"*. In one area the school nurse was the first to recognise CSE in a young girl and her action of reporting proved to be the key in a group of abusers being identified, reported and convicted.

It is also important that the relevant Safeguarding Nurses should liaise with the Pastoral Head at the school as well as the School Nurses.

There is still a need to raise awareness in schools and some secondary schools, although they have allocated School Nurses, they are not available on site. As CSE can manifest at school with "behaviour changes" or "change in eating habits" these could be more easily missed if the nurse is not on site. It also means that if the pupils are not familiar with the



nurse they are less likely to approach her and trust her with their fears. A repeated comment was that school-nursing provision is not standardised even at a local level.

CSE can be associated with past inconsistencies in Health screening, particularly year 6-7, when some children get missed completely. These children need following through even more carefully as they move through senior school.

Many young people are at college and not at school. Some Safeguarding Nurses were concerned as to the role of College Nurses- they are not aware as to who they are, who employs them and their actual involvement? It should also be noted that not all Colleges have an attached Health Professional.

There were concerns expressed regarding the change of School Nurses from PCT employment to Local Authorities and that it may affect what they do. Many schools, having gone to Academy Status, are no longer under Local Authority control. There are fears that, due to financial restrictions, School Nurses will not be seen as a priority.

It was pointed out that School Nurses need face-to face contact and need to do holistic assessment. As problems identified do not stop during school holidays, they need to work all year round, not just term-time as in the past. Apparently this is now the case for all new appointments.

Several Safeguarding Nurses who were not School Nurses pointed out that the huge workload that they are under.

One area mentioned that worried S/G Nurses and School Nurses was that of "home educators". Although this involves very small numbers, the Local Authority only has to keep a list. There is no monitoring. It was felt that there should at least be some checks on these children.

It was suggested that specific CSE training should be given to School Staff and School Nurses should use this in order to raise awareness in schools. (Other bespoke training such as Chlamydia training for girls is also available from a variety of organisations).

## 3.2 Accident & Emergency Departments (A&E)

One Named Nurse for a Hospital Trust felt that A&E is the riskiest place in the hospital but there was a lack of awareness around CSE in that department. An experienced A&E Charge Nurse had said, *“when it comes to sexual exploitation, we do not know what we are doing”*. For example, the Self-Harm Pathway did not link with sexual exploitation and therefore cases were being missed.

A&E staff feel that they are just too busy to look fully into cases and *“opportunities are missed when teenagers want to talk.”* Most health workers say that they would like to spend more time and question young people but time constraints limit what they can do. Other workers said that this was not a problem. This probably reflects different areas of work, as the most pressurised seem to be A&E and Midwives.

This lack of time means that the frequency of other attendances, admissions or even dates of birth are not always checked. It is apparent that young people will lie about their patient details so that a 15-year-old girl can pass through the system as a 19 year old under a false name. **Perhaps the supermarket rule should apply, whereby if the young person is under 25 then proof of age and identity is required.** This could be difficult to enforce in an A&E setting as treatment could not be refused if identification was not forthcoming, however, further thought is needed in this area.

Hospital workers felt that each department worked within a silo so that the GUM clinic, Paediatrics, A&E, Gynaecology and Maternity did not know what each other was doing. There was also a feeling that the system is resource led and not needs led.

Comments were also made with regard to responsibility and that all staff need to know that *“they are responsible to do something if they acquire a bit of information and not expect someone else to deal with it.”* This would mean that if a junior nurse tells a senior nurse something and is not happy with what has been done then the junior nurse herself should report her concerns to the Safeguarding Nurse.

In one hospital trust visited, if A&E staff have concerns then they refer to the Safeguarding Nurse and the system seems to work well.

In another inner city hospital it was reported that a successful “Alert Scheme” has been set up within the A&E, which flags up particular vulnerable young people if they present in the department and reports the concerns to the safeguarding Nurse.

A hospital Safeguarding Nurse felt that we need to decide on *“What key message do we have for young people?”* and that health workers need to take the opportunity of when they are in hospital care. She also said *“opportunities are missed when teenagers want to talk”*.

### 3.3 Sexual Health Services (SHS)

Sexual health services are one of the most important areas within the health community for being able to recognise CSE. However some SHS workers feel that some of the larger multi-agency groups set up to tackle CSE and organised by Local Authorities have a blinkered view of what SHS has to offer. From the conversations that were held it would seem that SHSs have a considerable amount to contribute to recognition of CSE as well as to training to a wider audience.

One region has the same computer system across all the SHS clinics. This is important as often the victims will be taken to different clinics for treatment by their handlers. One region has over 1000 different sites for screening and performs 8000 Chlamydia tests per month. If an individual young person has a certain number of regular screens in a given timescale then this is chased up.

A neighbouring area reported that they have huge numbers of Sexually Transmitted Infections (STIs) especially Chlamydia. Contact tracing has shown that victims are being taken to different clinics and has identified from partner tracing several cases of 13 year old girls who are sexually active with adults. **It is therefore important that SHS can share the same database.**

One Young Persons SHS has already held a successful conference with the focus – “to identify how sexual health services can contribute to the wider CSE agenda”. More regions should follow their lead. That area now has a CSE Task & Finish Group with a well-developed work-plan complete with actions and progress.

In most areas if a girl under the age of 13 requests contraception then there is a “presumption” that the Clinician will refer to Social Services as a safeguarding issue. In one northern town this has been changed to a mandatory referral. Is this something that should be done nationwide? Certainly there should be further discussion amongst the relevant bodies.

SHS have been aware for some time that adult sex workers in their 20s often were victims of CSE from their early teens.

It was thought amongst those working within SHS that there exists a big difference between Young People’s Sexual Health services (YPSHS) and the Adult Services. This is partly due to confidentiality issues but there is a feeling that there exists a gap in knowledge in Adult SHS with what is going on with CSE.

Comment was made that, although there is some excellent work going on, there is also a disconnect going on in other SHS around the country. It was felt that all should work to the same standards with regard to CSE.

Those working in SHS have great difficulty in sharing and acquiring information. Some PCTs have multi-agency groups that share information, but these were not common. Whether these groups will survive the transition in the Health Service remains to be seen.

**It was recommended by several SHS staff that every Sexual Health Clinic has a named person for CSE.**

### 3.4 Paramedics & Ambulance Services

Ambulance personnel are often in the position of responding to CSE victims in the first instance and can be let into houses and establishments where entry has been refused to Doctors, Midwives, Health Visitors, Social Services etc.

They can also be aware of irregularities in the history of a particular case as 'Call Centres' often get different stories from those given to the paramedics who arrive on the scene. For example, the initial call is often panicky and there may be background noise with lots of people, or a man giving orders in the background. When the crew arrive on scene everything is more controlled, often a different story and all people in the background have gone. However, attending staff are sometimes met at the gate or front door and do not always enter properties to observe what is occurring and who is present.

*"Communications sometimes have more or different information than paramedics".*

The Ambulance Services have a lot of information that is not shared. They seem very happy to share this information as there is no problem with confidentiality as CSE is seen as a safeguarding issue. As with A&E services they also have frequent callers and individuals and addresses that are well known to the service.

External agencies, such as the Police, only usually enquire about single events for their intelligence. There are very few occasions when historical data is asked for regarding previous 999 calls, and yet a huge accurate database exists.

Ambulance crews may see a child or young person who is not conveyed to the hospital as either not immediately necessary or a family member or friend say they will take to hospital. That person's registered General Practitioner may be electronically informed on the next working day, but there is no follow up with A&E and there is no feedback.

The Ambulance Services monitor non-conveyance rates and frequent callers and report to the relevant PCTs on a monthly basis, but there is often no further discussion or feedback with regard to these. They also have information such as timed and documented evidence of someone being at a specific address, but this is rarely asked for by other services.

The Ambulance Services at present know little about the families that they are attending, other than the information stored in its own systems, and yet this information could be vital. A new computer system, to start in 2015, has been announced recently by the Department of Health. This will enable A&E departments to be linked nationally to flag up Child Protection and Domestic Violence issues. It would seem desirable for the Ambulance Services also to be linked to this system and that the new system should include CSE concerns.

The Ambulance Services are well aware of Safeguarding issues and this is included in training to all communications and front-line staff. The effectiveness of this training can be demonstrated with one Ambulance Trust reporting over 500 Safeguarding issues every month, this equates to about 1% of all call-outs.

However CSE and its awareness is not part of the present training but there is a willingness to incorporate CSE training into the existing systems and the NWG will be happy to offer its advice. CSE training is important as one S/G nurse reported that a paramedic had said to her *"I knew something was not right but where do we go?"*

It should be noted that the National Ambulance Safeguarding Group meetings take place regularly to share good practice, benchmarking etc.

It appears that no one asks the Ambulance Service to case conferences, strategy meetings etc. It is almost as if other agencies and Health Services forget that the Ambulance Service are very much part of the Health Service. This finding has been confirmed by NWG staff who have been to very few multi agency meetings that have included the Paramedics and Ambulance Services; and yet often they are in the position of responding to these victims in the first instance. Again this demonstrates that there has to be closer working relationships amongst the various Health Service bodies.

### 3.5 Midwives and Gynaecology

CSE victims sometimes want to get pregnant as then they would have somebody to love, something that is lacking in their lives. Other victims want to get pregnant as they think it is a way out of their situation. This seems to be rarely the case.

In one area, of all the young girls known to Safeguarding Nurses to have been victims of sexual exploitation and had babies, all cases but one had had their baby removed from them. When the Midwives had been informed they were nearly always surprised and unaware of all the circumstances.

Several safeguarding nurses reported that they thought “*Midwives are the weakest link*” and that they do not ask the right questions, even of young girls with several pregnancies. It was thought that the Midwives concentrate on the successful outcome of the pregnancy being a healthy baby and mother without looking at all the factors around the pregnancy.

There were also comments about it being a struggle to get Midwives to conferences with regard to sexual exploitation, as they do not see it as part of their remit. This may not be for lack of will from the Midwives but could be that as there is a shortage of Midwives nationally, and that the Management are reluctant to let their staff go for a day’s conference because of lack of cover.

Other Safeguarding Nurses reported that Gynaecology departments do not appear to associate requests for termination of pregnancy, problems with early pregnancy, Pelvic Inflammatory Disease etc with the girls being victims of CSE.

## 3.6 Primary Care

None of the patients of the General Practitioners who contributed had been involved in Serious Case Reviews or CSE cases. Their knowledge of CSE was, therefore, based on what they had read or heard about generally in the press. They, however, confirmed that CSE training did not appear in their mandatory Child Protection Training Courses but felt that it should be included.

General Practitioners, Practice Nurses etc. consult with children and young people every day and as front-line health workers they need to be aware of the possibility of their patients being victims of CSE. Primary Care is ideally placed to be able to identify the signs and symptoms of this form of abuse and it is evident that training on CSE should be available.

## 4.1 Mental Health Issues

*“Victims often have intrusive thoughts and flashbacks”.*

*“Young people suffering from Post Traumatic Stress (PTS) may be treating their own symptoms by using drugs and alcohol”*

It is thought that the rate of mental health issues amongst sexually exploited victims is in the region of 40% and that victims of CSE are 17 times more likely to become psychotic than other young people.

### **MENTAL HEALTH PROBLEMS ENCOUNTERED**

- Self-harming
- Suicide and suicide attempts
- Self blame (big problem even with successes)
- Multiple personality disorders
- Dissociation
- Psychosis
- Depression
- Sleep disorders
- Eating disorders
- Post-traumatic stress disorder
- Drug problem effects
- Alcohol abuse

Many of the mental health problems will persist into adulthood.

**BOX 5**

## 4.2 Child & Adolescent Mental Health Services (CAMHS)

There were variable reports about CAMHS services. In some areas the CAMHS team were fantastic and in other areas other health workers were disappointed in the service. Another reported that the service was poor as CAMHS was only interested in mental health reasons, not emerging personality disorders, which could be an indicator of sexual exploitation. CAMHS tend to see a patient with a targeted issue and therefore don't look for CSE. She felt that CAMHS were not asking the right questions and young people were falling through the service. This view was repeated on other occasions by other health workers.

One Safeguarding Nurse referred all cases to the CAMHS team and she could always get an appointment within 10 days.

A number of Safeguarding Nurses recommended the Solihull approach (a holistic assessment of behavioural disorders), also suggested was the IAPT (Improving Access to Psychological Therapies) model.

<http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=334>

<http://www.iapt.nhs.uk/cyp-iapt/>

Several areas reported that their local CAMHS service had a policy for non-attendees of "2 or 3 strikes and out". For a girl who is being exploited and controlled it may be impossible for her to attend an appointment at a given time. Although it is understandable from an administrative point of view this does mean that vulnerable young people are lost from the system and it was felt that there should be a back-up system to follow these cases up. CAMHS was not the only agency that did not follow up Did Not Attend (DNA) patients.

One Voluntary Sector Organisation has a monthly consultation session with CAMHS to explore how the voluntary sector can best support individual children.



## 5.1 Co-Working & Sharing of Information Within The Health Service

It is generally accepted that Health Services do not talk to Police Services who do not talk to Social Services. However the message here was that 'health' does not "talk" to 'health'. The Health Service is compartmentalised and there is little or no communication between the strands. It appears that all sorts of health areas don't "talk" to one another.

This area was one where most frustrations occurred. It was highlighted that not all systems of recording children's records "talk" to each other and there is no universal case recording method. Computer systems are often not compatible between GP Practices and School Nurses or even within a single Hospital Trust.

In one region Health Visitors and School Nurses use System 1 and can actively share information, but more than half the GPs are on an EMIS system and there is no compatibility. Even if there were compatible computer systems there is no co-ordination and no one responsible for co-ordination between the services.

Health Visitors and School Nurses are having increased difficulties with no longer being attached to GP practices and working in teams. Systems of talking and sharing information with GP practices have not been developed.

It was identified that it would be useful if there were greater links between the drug & alcohol services, youth offending workers, CAMHS, substance misuse etc. It was also commonly felt that these were fringe services and treated as such by other NHS and non-NHS services. It should be pointed out that these areas can make an enormous contribution to CSE work and indeed in one large city they appear to be the driving force when it comes to CSE and are therefore forcing the agenda forward.

## 5.3 Information Sharing and Confidentiality

*“How can we overcome the issue of confidentiality? “*

*“There are still issues of safeguarding overriding confidentiality”.*

The medical world’s determination to stick to patient confidentiality was repeatedly mentioned as a frustration for those working with CSE cases.

There seems to be widespread misunderstanding that although a young person may consent to sex, they cannot consent to abuse or to being exploited. Under the Sexual Offences Act 2003 “a girl under 16 is not responsible for aiding and abetting a sexual offence against her”.

It is widely recognised that young people are Gillick/Fraser assessed around the issue of sexual consent, although there appears to be misunderstanding around Gillick/Fraser competency. Clearly any sexual activity with a child 12 or under cannot be classed as consent and is a rape.

It was also noted that under our present legislation the issue of consent at 13 years upwards is often debated and interpreted differently between different workers.

Some health workers appear to forget that when dealing with CSE then this is a Child Protection Issue and that this overrides issues of confidentiality. Child Protection guidance in the UK defines a child up to the age of the 18<sup>th</sup> birthday. The definition of Child Sexual Exploitation refers to under the age of 18.

*“Health workers are not good at sharing information when there is a need to do so”.*

Other health workers who are nervous about “breaking confidentiality” said that they are happy to share medical information with consent. But these young people are in constant danger of further rape and abuse and may be afraid to give consent. Perhaps the health professions need to re-think their duty of care, especially when it is a child protection issue.

When dealing with those over the age of 18 then health professionals need to think about the consequences of sticking to the confidentiality path and not sharing the information.

There is no evidence that breaking confidence loses the trust of the young person and is often subsequently welcomed if the communication is done correctly.

For those health workers who feel that they need consent in a given situation then experienced workers report that the young person will give consent if asked in the correct way.

Comments from health workers regarding this area were:

- Gillick/Fraser Competence is overused and used in the wrong situations.
- There is confusion amongst health workers regarding the terms
- The terms are used as *“shorthand for lazy professional practice”*. Competence and situations should always be assessed and decisions made on that assessment
- *“Young people are only competent in what they are competent in”*. This leads on to a further question – How many people are competent to assess their own exploitation?
- *“You need professional curiosity and then understand the analysis of that consent”*.

There are still some workers in the health and social services who think that the young people are “making a choice” and therefore do not wish to get involved.

*“Young people may compartmentalize the agencies and not share the same information with each agency that they are engaging with, therefore the emphasis is on the agencies to share information between themselves and not be reliant on the young person.”*

The general feeling at the Forum was that the enabled health professionals need to share information whilst maintaining confidentiality and that the strength of inter-professional relationships and the sharing of information is vital. Too often relevant information is not passed on because of a rigid adherence to confidentiality; this allows the exploitation to continue. Sexual exploitation, in someone 18 years old or younger is a child protection issue and the welfare of the child supersedes issues of confidentiality.

In some areas the Safeguarding Nurse will send a brief summary and action plan plus they make School Health aware, do a CAMHS referral and offer 1:1 support. Information is sent to the GP, School Nurse, teenage health services and GUM services. They also inform the relevant S/G Nurse. **Experience has shown that information sharing has not been a problem for the young people with whom they have been working.**

## 5.4 Third Sector Agencies

During the forum and subsequent interviews it became increasingly apparent that the Voluntary Sector plays a huge role in helping to deal with the effects of CSE, both in identifying and subsequently helping the young people. Different areas have different voluntary agencies but they are all extremely valuable if not vital.

There are concerns regarding future funding of the third sector. Some are national bodies and others are small local groups reliant on grants from other agencies such as Primary Care Trusts (PCT). Funding streams must not be lost as health service commissioning moves to Clinical Commissioning Groups (CCG).

When discussing CSE issues at either the informal or formal level then Third Sector Organisations should be invited to the table and be fully involved in all the discussions.

Quite often the Third Sector Organisations have engagement with parents. If parents are known not to be involved in the case then parents should also be involved in all child protection issues and ongoing work where safe to do so. Families often get fragmented as a result of CSE to one of the family, adding resources to the family unit and involving the Third sector may be the best way of protecting the child.

### WORKING WITH PARENTS:

Teams have found that parents of victims work really well them. Key messages for parents are:

- Get rid of android phones and get simple pay as you go phone
- De-activate Facebook etc.
- Agree reasonable time to be home (9:30 on school nights)
- If suspect their child may be victim then collect evidence- underwear, £10 notes into plastic bag, dated and timed and put in freezer

**BOX 6**

## 5.5 Named Nurses and Designated Safeguarding Nurses

Safeguarding Nurses (S/G Nurses) and Designated Nurses appear to be key in managing the links between the numerous health streams, the police, social services and the third sector. There are Named Nurses in all areas of the Health service e.g. acute hospital, youth offending, looked after children, ambulance service, GUM clinic etc. It is important that they meet regularly in order to support each other and to share ideas. Concern was expressed that the ongoing efficiency savings in the NHS will affect the number of S/G Nurses.

In some areas every young person referred gets a full nursing assessment, this does not seem to occur everywhere. The assessment includes:

- History
- Family history
- Social service contact with
- Whether in care system
- Who lives at home
- Birth father and step-father names
- Anything traumatic ever happened (sensitivity risk) including any experience of bereavement, previous sexual abuse etc.
- General health
- A&E attendances
- Vision
- Hearing
- Asthma/allergy
- Mental health- uses assessment tool
- Ever harmed
- Vaccinations
- When started sex
- Menarche
- Pelvic inflammatory disease (based on GUM questionnaire)
- History of pregnancy/Termination of Pregnancy
- Contraception
- Substance use
- Height & weight
- Photograph taken
- Nickname (use nickname as protection as do not want to use real name)

One Nurse, where a victim gets to 18 and there are still concerns, will discuss this with Vulnerable Person's co-ordinator at the local Police Station so that they are aware.

During the interviews the Nurses gave many comments and personal thoughts on CSE. These do not fit neatly into any one category but are too important to leave out as they demonstrate additional thoughts, frustrations and ideas:

- *“Sexual Health Services have been shouting about CSE for some time but been ignored”.* (In some areas the YPSHS have taken a lead on CSE).
- *“Each local area needs to get best practice embedded in its system”.*
- *“CAMHS, substance misuse, SHS offenders services, the 3<sup>rd</sup> sector services and other health teams need to meet together”.* This could be during multi-agency training but there needs to be other formal situations’.
- *“The Multiagency Safeguarding Hubs (MASH) have made a great difference and those involved in the group have a heightened awareness of CSE. Other members of the NHS are not there yet”.*
- One small complaint that could be easily corrected was mentioned. It is useful if a Safeguarding Nurse can go with a young person to a clinic (e.g. CAMHS, Genito-urinary etc). The nurse’s contract does not allow them to transport that young person to the clinic, they have to rely on another member of the multi-agency team to transport the young person and then they can meet them at the clinic and accompany them at the consultation. This seems an inefficient use of manpower and is annoying to the Safeguarding Nurses.
- Transfer from children to adult services often seems problematic and needs careful consideration on how it is managed and which services the young person is passed to.
- Some gaps in services in one area were recognised by S/G Nurses. They are:
  - Work in schools- who does it?
  - Post-termination counselling
  - Targeted work with Black and Minority Ethnic communities.

## 6.1 Actions When CSE Has Been Recognised

It was widely suggested that each area should have one ‘Point of Contact’ to whom all CSE and vulnerable adolescent referrals are made and that only that the Safeguarding Nurses at that point of contact should do the risk assessment. It was strongly felt that not just anybody can do a risk assessment and it should not be done in isolation.

One person being responsible also means that local knowledge can be developed and trends and links identified. It also has the advantage if every health service worker knows who to report a CSE concern.

Already mentioned in this document, it seems that health professionals are often not invited to strategy meetings with Social Services and Police. The overwhelming opinion is that a health representative should always be invited to a strategy meeting.

Often a CSE case is recognised and a risk assessment is done. Often the young people are categorised as at 'high risk' of CSE but all the signs and symptoms would indicate that they are CSE victims that are being harmed at present and are continuing to be harmed. The young person's life is already unbearable and the only thing left to them, and hence the main risk, may be suicide. High risk implies that it is preventable when in fact it is already taking place. It was suggested that perhaps there should be a new category of *"Being Significantly Harmed at the Present Time"*.

Some health workers felt that *"risk assessments are often done to protect the trust or the health workers and not for the benefit of the young person."*

Other points raised were:

- If seizing phone from victim, then experienced S/G Nurses recommend that they should be able to give them a pay as you go phone.
- Some S/G nurses have funding to buy victims change of clothing, toiletries etc. When assessing CSE then *"always speak to the parents"* but it goes without saying that this would not apply when it is dangerous to do so.

The Forum thought that there should be more consistency across the country with regard to the forms that are used and that The Derby Information Report Form or similar should be widely adopted. Also that all health workers should work to guidelines and 'Open Door Guidance' as used in Sheffield was suggested as a possible format.

It was also suggested that the Health Service could possibly use an evidence-based model similar to that developed by Coordinated Action Against Domestic Abuse (CAADA) that measures level of risk for domestic violence victims. Further work would be required on this and a National Forum could also be used to develop these.

#### MYTH BUSTING

There are several misconceptions that the public have, and these are often reinforced by the press. This is probably not helpful in raising awareness of CSE.

Facts that need to be known are that:

- Girls and women can be both the groomers and the offenders.
- White Caucasians are just as likely to be the offenders as other racial groups.
- Individuals offend as well as groups of men.
- Boys are often victims of sexual exploitation.

BOX 7

## 6.2 Fears & Concerns

Possible lack of funding has already been mentioned for Third Sector Agencies but is also a concern amongst Safeguarding Nurses.

The NHS is once more in the process of change. In the past, the PCTs (Primary Care Trusts) have commissioned the services associated with CSE but PCTs are disappearing. From this year the higher tier local authorities will have the Public Health remit and be responsible for commissioning, for example, Sexual Health Services for Young People. The new Clinical Commissioning Groups (CCG) will commission termination services. Concerns were expressed that the new bodies will not appreciate the work that these areas do with regard to CSE. Only one S/G nurse reported that the emerging CCG in her locality was aware of CSE, in all the others it would appear that CSE is not on the radar.

Similar concerns were expressed by School Nurses and these were covered in the section on School Nurses.

It is important that CSE is included in the service specifications of SHS, abortions and school nurses etc. when the services are retendered under the new regimes.

The potential effects of a reduction in funding for mainstream health services and voluntary sector cutbacks was a repeated concern. These effects are already beginning to bite as in one area the NSPCC representative had been removed from the Safeguarding Board because of lack of funding. In another area there had been a loss of youth service workers and a loss of Connexions.

Concerns were expressed that in some areas CSE is not seen as a priority. This tends to be in the areas where there are no known cases. In areas where there had been cases, and especially high profile cases, there was much more awareness of the issues and there was more activity in all services.



## 6.3 Examples of Good Working

There were many examples of good working by the contributors but these tend to be very local and are certainly not universal. We have deliberately been vague on the whereabouts or titles of these examples to preserve the anonymity of all the contributors. One of the actions of the NWG is to develop a National Forum for CSE and the aim is that this Forum will gather and disseminate examples of good working complete with references, contact numbers etc. Examples of Good Working included:

- A Director of Public Health set up a CSE investigation as a major incident with a three-tier command in line with the Police Colour Command system. Gold covering strategy, Silver covering welfare and Bronze covering practitioners . At the initial Forum this was recommended as a method of working in the future.
- The multi-agency team work evenings and drive around hot spots and party areas and they walk the parks. As a result have found young women with mental health problems who have been exploited. They have also picked up on other safeguarding issues e.g. a vulnerable 16 year old boy was taken home from a house party. His Eastern European parents were out at work and they found a 5-year-old boy looking after a 10 month old sister.
- Some areas have really good partnership working between health, the police and social services. If a referral is made then a risk assessment matrix is done immediately. If Section 2 needs completing, then the police will readily fill the form in when requested by the Safeguarding Nurse. Also, an experienced Social Worker will visit the perpetrators home to assess the risk to other children. The whole system is seamless and should not be limited to certain local authority areas. Co-location appears to be important so that the Safeguarding Nurse has access to the police system.
- One Voluntary Sector Organisation has a monthly consultation session with the CAMHS Service to explore how the voluntary sector can best support individual children.
- In order to raise awareness amongst GPs, one area has sent a letter to every local GP together with a referral form and a Police Officer's card.
- Some cities/areas have a very active Missing, Sexually Exploited & Trafficked Group (MSET) who if they have any concerns will respond. The group includes representatives from the health community and meets monthly.
- In one inner city there is a successful "Alert Scheme" in the A&E, which flags up particular vulnerable young people if they present in the department and reports the concerns to the safeguarding Nurse.
- One region has developed the same computer system across all the SHS clinics. This is important as often the victims will be taken to different clinics for treatment by their handlers.
- One Young Persons SHS has held a successful conference with the focus – "to identify how sexual health services can contribute to the wider CSE agenda".

That area now has a CSE Task & Finish Group with a well-developed work-plan complete with actions and progress.

- The staff of one working partnership has a monthly consultation with the CAMHS team and the Community.
- The Community Paediatrician and/or the Safeguarding Nurse attend CSE case conferences.
- One area has completed a Literature Search on sexual health services' approach to CSE. This includes good practice on guidelines/frameworks for screening for possible CSE, guidance on referrals to other agencies etc. This survey has pointed out that there is no established screening method in common usage across multiple SHS.
- A Nursing School has a modular training course in CSE included in Nurse Training.

## 6.4 Awareness of General Public and Areas to Target

*"We need to make the most of every opportunity".*

All the contributors believed that in addition to the education needs of health service workers there needs to be more awareness among the general public. There were also certain areas (geographical and work-based) that should be targeted (see Box 4)

The recent Jimmy Saville case was evolving during the first weeks of the project and this certainly has increased public awareness of sexual abuse, and more importantly a willingness to report that abuse. However, do the general public know how widespread sexual abuse and child sexual exploitation actually is? Do they know that it may be happening in their neighbourhood? With the numbers of men taking part in sexual activity related to child sexual exploitation, there are reasonable odds that we all know someone who is involved to some degree. But who are they?

Awareness training for the general public is therefore vital and we need to use every opportunity available to spread the knowledge. Ideas from the contributors included:

- Need to get into schools and change attitudes to girls
- A screen saver can be put on school intranet system-aimed at year 7-11. "Is there anyone you are worried about and who will you tell?"
- The film "Dangerous Lover Boy" should be seen by all young people
- A housing association has education and support for domestic abuse for its tenants. In certain locations it would be worth getting housing associations involved.

- Awareness needs to target parents.
- A film production company has some short films on CSE written by young people. (Peer production though could possibly be more effective).
- Local and National Campaigns
- Posters on backs of toilet doors

### **OTHER AREAS TO TARGET FOR AWARENESS**

(as suggested by Safeguarding Nurses)

- Young People
- Teachers
- Parents
- Libraries
- Hotels
- Door staff of clubs
- Hot spots
  - Take-aways
  - Taxi ranks
  - Alcohol outlets
  - Sheesha (Hookah) bars
  - Shopping Centre
- Park rangers

BOX 8

## 6.5 Education & Awareness Training Needs

*“Education of health workers vital as they are the first to recognise symptoms”*

Mandatory training in many areas and sectors of the Health service is just about child protection issues and Sexual Exploitation is not covered. In other areas all child protection training at every level includes sexual exploitation and there are moves to have a regional approach on training. There is no consistency across the health community.

All the contributors felt that CSE training is absolutely vital and should be mandatory CSE as part of Safeguarding Training. CSE awareness and reporting should be part of “the duty of care” of every health professional.

Simple tips to health professionals such as if a girl goes to pharmacy for emergency contraception then the pharmacy staff needs to ensure identification, check age and be aware if there is someone waiting outside. Tips such as these need to be included in training and could make a huge difference in arousing suspicions.

It was felt that training needs to include:

- How do you identify?
- What do you do with the information
- Are systems clear? If not, where do you go?

Comments were made that training must include record keeping. Should the situation result in a court case then the health worker will rely on contemporaneous written evidence and this needs to be able to stand up in court.

Most contributors commented that they believed that child protection and CSE training should be multi-agency. This would broaden the sharing and allow more opportunity to learn from the experience of others. However, some thought that basic training could remain at single agency level but agreed higher training should be multi-agency.

It was felt that education should have engagement at practitioner and senior management level and that training should include:

- Recognition
- Identification
- What to do with it?
- What stops you doing it?

Also, when looking at developing a toolkit then we need to know what it is that Primary Care, A&E etc. require and must include signs and symptoms to raise awareness.

The basic toolkit should be as concise as possible and limited to one side A4 so it is easily available. However, this would only have the key points on it. The larger version should be computer based with drop down menus compatible to GP and hospital systems.

It is likely that there will be basic generic toolkit for all health workers but then it can be tweaked for the different specialities e.g. Sexual Health Services.

The Forum also thought that a flowchart should be developed as there needs to be a clear written pathway for health practitioners to follow when concerned about a young person and to include what happens next.

*"If a tool is developed and nurses use it then some nurses see this as 'job done'. They need to be aware to ask the same questions again at subsequent visits, not just the once, as they may change their story."*

***"Young people will only tell if they have been asked. The importance of asking the questions must be emphasised."*** Health service staff need to ask the question of young people and in the right way. For example, do not ask, "what school do you go to"? as they will lie or give the school they should be attending. It will not give the clue as to whether they may not be attending school as often as they should. Therefore ask questions worded differently, such as "and how do you enjoy school?"

Northumbria has a model of "How to Ask" as do some other areas and perhaps a national model based on these is a way forward.

There also appears to be very little training available with regard to routinely enquiring and how to ask the question. It was felt that skills training is required by more front-line health workers.

Throughout the exercise the most common theme was the need to raise the level of awareness at all levels of health workers but more importantly is the need to engage professional curiosity. Several Safeguarding Nurses commented on the need to follow one's gut feelings. Often they had found that if a nurse had uncomfortable feelings about something, they are often right. They realised this was not very scientific but is part of the "art of medicine". It should be encouraged.

And finally, staff that have been involved with a number of CSE cases can feel burnt-out. The Health service needs to look after these valuable staff members and give them full support. There is a publication called "The International Order of Migrants, Caring of Witnesses Manual" that talks about staff 'burn-out'. The National Working Group can give further details.

**HEALTH PROFESSIONALS TO TARGET FOR  
AWARENESS TRAINING FOR CSE**

- Safeguarding Nurses
- A&E Staff
- Midwives
- Genito-urinary Clinics
- Sexual Health Services
- Gynaecology Services
- Private Sexual Health Services
- Ambulance/Paramedics
- GPs
- School Nurses
- Health Visitors
- Pharmacists
- Dentists
- Walk-in Centres
- The 'gatekeepers' (Reception Staff, Porters etc.)
- NHS Direct/111 Staff

**BOX 9**

## 7.1 Recommendations from the NWG

1. CSE and Trafficking awareness training should be included in every Child Protection Training course.
2. Bespoke training should be available for health professionals tailored to the area of work e.g. SHS, A&E, Midwives etc.
3. The NHS needs to ensure that staff who are working with CSE are fully supported by management and dedicated resources.
4. Health workers need to recognise the importance of sharing information to better protect Children and Young People.
5. A basic toolkit for health workers should be developed in order that health workers can be aware of and can recognise warning signs. The computer version should have relevant drop-downs.
6. A National Health Forum to be established to pull this toolkit together and also develop guidelines. (It was recognised that a regular National Health Forum would also be beneficial to Health Practitioners).
7. A flow-chart to be developed that is a clear written pathway for health practitioners to follow when concerned about a young person and to include what happens next

## 7.2 Actions for the NWG

1. A National Health Forum to be established to meet quarterly, first meeting aimed for June 2013.
2. A basic toolkit for health workers should be developed in order that health workers can be aware of and can recognise warning signs. The computer version should have relevant drop-downs.
3. A flow-chart to be developed that is a clear written pathway for health practitioners to follow when concerned about a young person and to include what happens next.

ORGANISATIONS TO DISSEMINATE AND SHARE INFORMATION WITH INCLUDE:

- Department of Health
- Royal College of Paediatrics & Child Health
- Royal College of Nursing
- Royal College of GPs
- Royal College of Psychiatrists
- Directors of Public Health
- British Medical Association
- National Working Group (NWG) Network
- NHS Working Group
- British Association for Sexual Health and HIV
- National Sexual Health Commissioning Forum
- Medical & Nursing journals
- Non-NHS sexual health providers.

**BOX 10**

USEFUL PUBLICATIONS, GROUPS ETC.

- “The International Order of Migrants, Caring of Witnesses Manual”
- BASHH Guidelines ( UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault 2011 produced by the British Association for Sexual Health and HIV
- Open Door Guidance (Sheffield)
- Section 58 Sexual Offences Act 2003 on Internal Trafficking
- Derby Information Report Form (available from NWG)
- ‘Responding to Violence Against Women and Children – The Role of the NHS
- Taskforce on the Health Aspects of Violence Against Women and Children’ - Report from the Child Sexual Abuse Sub-group
- ‘What Can I Do- Protecting Your Child From Sexual Abuse - NSPCC
- ‘Consultation with Children’- Taskforce on the Health Aspects of
- Sexual Violence Against Women and Children
- ‘Child Sexual Abuse and Embodiment’- Heather R. Hlavka
- ‘Sexual Abuse and Psychiatric Disorder in England: Results from the 2007 Adult Psychiatric
- Morbidity Survey’-S. Jonas et al.

**BOX 11**



# Health CSE SCR Forum Terms of Reference

This forum has been established on behalf of NWG Network (NWG)

### Aim

Share and learn from good (and poor) practice nationally to improve the health response to children and young people at risk of or involved in Child Sexual Exploitation

### Objectives

- Produce a report/paper of learning from SCRs
- Share the report/paper with professionals through:
  - Royal College of GPs
  - Royal College of nursing
  - RCPCH Royal College of Paediatrics and Child Health
  - Health task and finish group
  - NWG
  - Medical journals
  - National Sexual Health Commissioning Forum
  - BASH
- Share and find solutions to common frustrations and barriers
- Influence national policy and practice
- Look at developing a health toolkit for professionals
- Ensure minority groups are represented in discussions and findings

### Membership

This forum will include health professionals from across the country that have been involved in responding to CSE in their local area and may have experience of being involved in a Serious Case Review relating to Child Sexual Exploitation.

### Chairing arrangements

Paul Kirtley – Retired GP - Derbyshire

### Ground rules

- Respect for others views and opinions
- Participants will be given the opportunity for regular open discussions, exploring relevant, key issues
- Recognise and respect different levels of knowledge
- Be sensitive to the needs and opinions of others
- Challenge views and language appropriately
- Use appropriate language
- Consider interpretation of language
- Share ideas openly
- Ensure confidentiality amongst the group but not be restricted in sharing information
- Be honest regarding mistakes

No victims were interviewed for this survey. Any disclosures made will go through normal child protection procedures. The standard NWG ethic are available on our website.



## Appendix 2 Acronyms and Abbreviations

A&E	Accident and Emergency Department
B&YM	Boys & Young Men
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CSE	Child Sexual Exploitation
GP	General Practitioner
GUM	Genito-Urinary Medicine
HV	Health Visitor
IAPT	Improved Access to Psychological Therapies
LA	Local Authority
MCAT	Mephedrone
NGO	Non- Governmental Organisation
NHS	National Health Service
NWG	NWG Network
PCT	Primary Care Trust
PTS	Post Traumatic Stress
SHS	Sexual Health Services
STI	Sexually Transmitted Infection
YPSHS	Young Peoples Sexual Health Services