

# Key messages from research on child sexual exploitation: Commissioning health care services

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This briefing paper is for commissioners of health services. It brings together key messages from research on child sexual exploitation (CSE) and should be read in conjunction with guidance for professionals. [\[Links to English guidance\]](#) and [\[Welsh guidance\]](#).

## Key messages

- Child sexual exploitation can happen to young people from all backgrounds. Whilst young women are the majority of victims, boys and young men are also exploited.
- Sexually exploited young people will access a broad range of healthcare in different settings, including sexual health, Accident and Emergency (A&E), walk-in centres, GPs, Child and Adolescent Mental Health Services (CAMHS) and services for self-harm and drug and alcohol use.
- Sexually exploited young people and those at risk should have easy access to services along health care pathways at the point of need.
- Commissioners can undertake an audit of available services to check whether such points exist and to ensure that they are sufficient to meet demand
- Local assessments of scale, evidence gathered for Joint Needs Assessments and problem profiles developed by the police will offer Commissioners a picture of the level of support that needs to be provided.
- Commissioners can put in place measures that will encourage health professionals to view the young person holistically and to see beyond the presenting clinical issue
- Commissioners can play a crucial role in ensuring that required standards are being met by making adequate resources available and championing good practice.
- Investment in specialist services can yield financial benefits.
- Health care professionals can contribute to multi-agency work to protect young people, identify patterns in abuse and disrupt perpetrators. Commissioners can play a role in assisting health staff balance maintaining confidentiality and safeguarding through this mechanism.
- Commissioners of health services can play a wide-ranging role in prevention and early intervention: from promoting early identification of CSE through universal services to targeted opportunities.

## Child Sexual Exploitation

‘Child sexual exploitation is a form of child sexual abuse where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator.’  
[\(New England definition 2017\)](#)

There is no one way that CSE is perpetrated (Child Exploitation and Online Protection Centre, 2011; Berelowitz et al. 2012; Gohir, 2013; Research in Practice and University of Greenwich, 2015). Grooming is common in some forms of CSE, but it is not always present (Beckett, 2011; Melrose, 2013). Online and offline exploitation can overlap (Fox and Kalkan, 2016). That children and young people may appear to co-operate cannot be taken as consent: they are legally minors

and subject to many forms of coercion and control. These abuses of power are similar to those which are recognised in domestic violence and they may lead to children and young people being unable to recognise what is happening to them as abuse.

Whilst all of the research evidence to date shows that girls and young women are the majority of victims, boys and young men are also exploited. The average age at which concerns are first identified is at 12 to 15 years, although recent studies show increasing rates of referrals for 8 to 11 year olds, particularly in relation to online exploitation (Department for Education, 2017). Less is known about the exploitation of those from Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) communities (Ward and Patel, 2006; Gohir, 2013; Coy, 2016a; Sharp, 2013; Fox, 2016).

There is no 'typical' victim. That said, some young people may be more vulnerable than others, and a range of indicators have been highlighted to which professionals should be alert. These include: prior abuse in the family; deprivation; homelessness; misuse of substances; disability; being in care; running away/going missing; gang-association (Beckett et al. 2013; Brown et al. 2016; Coy, 2009; Franklin, Raws and Smeaton, 2015; Harris and Robinson, 2007; Klatt et al. 2014; Jago et al. 2011; Smeaton, 2013). It is not known whether these also apply to young people where exploitation begins or wholly occurs online, although some factors appear to be involved in both contexts (Whittle et al. 2013). Indicators are not evidence that sexual exploitation has taken place. All they suggest is that practitioners need to use professional curiosity and judgement to explore what is going on with each young person.

## Supporting health care needs

Sexually exploited young people may access a broad range of healthcare in a variety of different settings, for needs that include:

- sexual health (Kirtley, 2013; Nelson, 2016) e.g. sexually transmitted infections; testing for urinary tract infections; (emergency) contraception; pregnancy tests; terminations; heavy bleeding; and abdominal pains (Berelowitz et al 2012; Department of Health, 2014; Jay, 2014; Myers and Carmi, 2016).
- physical injuries, including those incurred through self-harm and injury (Berelowitz et al. 2012; Kirtley, 2013; Marshall, 2014).
- drug and alcohol misuse (Berelowitz et al 2012; Child Exploitation and Online Protection Centre, 2011; Coy, 2009; Department of Health, 2014; Jay, 2014; McClelland, 2011).
- psychological impacts, including anxiety, depression, flashbacks, post-traumatic stress and psychosis (Royal College of Psychiatrists, 2012; Marshall, 2014).

Healthcare staff in all settings should assume that sexual exploitation is happening in their area (Beckett and Schubotz, 2014; Berelowitz et al. 2012; Hughes and Thomas, 2016; see also Office for Standards in Education, Children's Services and Skills 2016) and plan accordingly. Plans to address sexual exploitation should recognise that known CSE cases are likely to be an under-estimation of the problem given under-reporting and under-identification of the issue (Public Health England, 2017).

## Assessing need and planning approaches

Young people who are sexually exploited require easy access to health services at all points along care pathways. Commissioners can undertake an audit of available services to check whether such points exist and to ensure that they are sufficient to meet demand. For instance, inquiries into sexual exploitation have reported difficulties for young people in accessing Child and Adolescent Mental Health Services (CAMHS), identifying barriers such as insufficient resources, strict access criteria and long wait times for assessment and treatment (Allnock et al. 2015; Martin et al. 2014; Goddard et al., 2015).

Local assessments of scale, evidence gathered for Joint Needs Assessments and problem profiles developed by the police will offer Commissioners a picture of the level of support that needs to be provided. The practice-based knowledge of agencies working directly with sexually exploited young people (including Rape Crisis Centres and Sexual Assault Referral Centres) is a further valuable resource. Commissioners can also invite young people with experience of CSE services into conversations about whether and how current provision is meeting their needs (Office for Standards in Education, Children's Services and Skills, 2016; Webb and Holmes, 2015).

If there are not enough resources locally to provide support then commissioners can consider jointly commissioning them across geographical areas (Allnock et al. 2015). One possibility is an integrated approach, combining joint commissioning arrangements between the police, social care and education. The advantage of this is that health services can be organised to respond to young people efficiently and address their multiple needs (Nelson, 2016). Collaboration through the pooling of budgets will enhance planning and can result in clearer referral pathways (Research in Practice, 2015). When health professionals are working closely with the police, for example, young people may have better access to pre-trial therapy as well as access to therapeutic services during court cases and in the aftermath (Beckett and Warrington, 2015).

## Ensuring the needs of victims are met

Traditional approaches to child protection are stretched by the complex dynamics of sexual exploitation and the range of needs that sexually exploited young people have (Pearce, 2014). Young people may not think of themselves as victims and may believe that they are in love (Pearce, 2009). Sexual exploitation is a process, and enabling young people to find a way out can be similar to supporting victims of domestic violence: focussing on strengths, assessing risk and widening space for action – a process of 'sustained safeguarding' (Pearce, 2009). Intensive support provides young people with the sense of security they need and acts as a counterbalance to the 'pull' of exploiters (Coy, 2009; Gilligan, 2016; Shuker, 2013).

Commissioners can put in place measures that will encourage health professionals to view the young person holistically and to see beyond the presenting clinical issue (Research in Practice, 2015). All members of health care staff have a role to play in identifying signs of sexual exploitation. Therefore a key activity is to review the availability of specialist training to frontline practitioners and ensure that it is delivered on a regular, ongoing basis. Local strategic approaches to child safeguarding and local specialist services that work with sexually exploited young people are often an excellent resource from which to commission training, because of their experience and expertise.

Commissioners can also play a crucial role in ensuring that required standards are being met by making adequate resources available and championing good practice. Additional resourcing

in safeguarding leadership across primary care, community health and the hospital sector has been found to effectively support the development of frontline professional confidence and expertise (Office for Standards in Education, Children's Services and Skills, 2016). Relationship-based work on sexual exploitation has a high emotional impact, so resources are also required to ensure health professionals have regular supervision.

Another important consideration for Commissioners is whether specialist child sexual exploitation services are included within referral pathways. Specialist teams in the voluntary or statutory sector are consistently identified as being able to work with young people for longer (Gilligan, 2016; Pearce, 2014). They are also able to undertake proactive outreach work, including daily phone calls and text messages, door-stepping and other ways of maintaining contact, even where this support is initially, or repeatedly, rejected (Coy, 2016b; Oxford Brookes University, 2015; Warrington, 2013).

This highlights how contracts for specialist services need to be of sufficient length that they can build trusting relationships with young people. While commissioning long term services may appear costly, re-referrals and ongoing crises are more so (Webb and Holmes, 2015). Investment in specialist services can yield financial benefits with one cost-benefit analysis showing a potential saving of £12 for every £1 invested (Barnardo's, 2011).

## Multi-agency working

At a strategic level, work to address the sexual exploitation of young people needs to connect with other forms of child sexual abuse (CSA). This is because many young people who are sexually exploited have histories of other forms of sexual abuse (Coy, 2009; Hickle, 2016) which may amplify current health concerns. Connections also need to be made with local approaches to violence against women and girls (Brayley and Cockbain, 2014; Coy, 2016b) as well as issues such as going missing, youth offending and substance misuse. Multi-agency working is therefore important and Commissioners can encourage this.

Inquiries into CSE have reported reluctance to share information, due to the important focus on confidentiality and building trust with children and young people (Barnardo's 2012; Berelowitz et al. 2015; Champion, 2014; Dodsworth and Larsson, 2014; Pearce, 2014). One of the consequences of failing to link information is that intelligence may not be shared in ways that would enable health services to contribute to the identification and disruption of perpetrators (Jago et al. 2011) including where the perpetrator is implicated in more than one case. However, sharing information in multi-agency contexts is not an intervention in and of itself; it must be linked to protective and/or preventative action. Commissioners can play a role in assisting health staff to balance maintaining confidentiality and safeguarding (Department of Health, 2014).

Whilst all the research evidence to date shows that the majority of offenders are men, sexual exploitation can also involve peers in complex ways – as facilitators, abusers or bystanders (Firmin, 2011; Beckett et al. 2013). Other useful intelligence that can be recorded and shared by health care professionals may include locations where sexual exploitation takes place e.g. house parties.

## Prevention and early intervention

Prevention and early intervention work is another important element of strategic approaches to sexual exploitation. Commissioners of health services can play a wide-ranging role; from promoting early identification of CSE through universal services such as school nursing and

health visiting through to targeted opportunities such as liaising with local authority partners such as licensing to disrupt perpetrators (Public Health England, 2017).

Another role is to lead public health campaigns that involve young people, families/carers and professionals. Raising awareness can increase knowledge and confidence about how to keep young people safe (D'Arcy et al. 2015; Bovarnick and Scott, 2016). These will be more effective if the messages and materials are 'sense checked' with young people who have been sexually exploited. Programmes and/or materials aimed at young men about sexual consent, sexualisation of young women's bodies and standards of masculinity are also important prevention initiatives (End Violence Against Women Coalition, 2011). Commissioners of health services can also promote young people's health in schools and colleges, supporting them in the delivery of Sex and Relationships Education (Public Health England, 2017). Yet another approach may be to train and support young people who have experienced exploitation to become peer 'health advocates' and raise awareness about the health impact of CSE (Hagell, 2013).

## **Key messages from research on child sexual exploitation – also available**

- Staff working in health settings
- Police
- Strategic commissioning of police services
- Social workers
- Strategic commissioning of children's services
- Professionals in school settings
- Multi-agency working

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