ACADEMY OF
MEDICAL ROYAL
COLLEGES

CHILD SEXUAL EXPLOITATION: IMPROVING RECOGNITION AND RESPONSE IN HEALTH SETTINGS

SEPTEMBER 2014

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FOREWORD

This valuable guidance arose from a meeting between the Department of Health, representatives from the Medical Royal Colleges, the NHS and the third sector to discuss the important role that health care professionals have in supporting children and young people who have been sexually exploited and to explore what more can be done in this area. This guidance is published at a time of widespread concern about the scale and extent of the problem following a series of shocking revelations emerging from Rotherham and elsewhere.

Stemming from the meeting, the Department of Health asked the Academy to examine what the Royal Colleges could contribute to tackling the problem, and any levers they could use to influence the NHS.

In particular, the Academy agreed to look at:

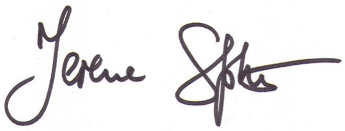
- How to raise awareness of the *indicators* of abuse so that health care professionals are able to identify children who may be sexually exploited.
- How to ensure that health care professionals have the *tools* to 'ask the questions' sensitively, to gain the information they need in these cases;
- How to ensure that health care professionals feel equipped to *refer* sexually exploited children in a safe and timely manner to the appropriate local services.

The Academy Council set up a Working Group in 2013 which was chaired by Dr Tara Weeramanthri from the Royal College of Psychiatrists and a Consultant Child & Adolescent Psychiatrist at the South London & Maudsley NHS Foundation Trust, London.

I am very grateful to Tara and all her group, ably supported by Carol Sheppard from the Academy Staff, for their hard work in producing this excellent report. We were particularly pleased to work with colleagues from beyond the Academy in Barnardo's, the Royal College of Nursing, the British Psychological Society, the University of Bedfordshire and Department of Health. Working with colleagues across professions and sectors increases the strength of this work.

The Working Group has made a series of recommendations for Colleges and Faculties which have all been endorsed by the Academy Council.

As a working paediatrician and Chair of the Academy of Medical Royal Colleges, I now hope that these recommendations will be taken forward so we can ensure that health professionals are equipped to undertake the vital task of supporting children and young people who have been sexually exploited.



Professor Terence Stephenson
Chair, Academy of Medical Royal Colleges

EXECUTIVE SUMMARY

CHILD SEXUAL EXPLOITATION: IMPROVING RECOGNITION AND RESPONSE IN HEALTH SETTINGS

Academy of Medical Royal Colleges Working Group on Child Sexual Exploitation

Child sexual exploitation (CSE) is a form of child sexual abuse. Children and young people affected by sexual exploitation can present with a range of physical and/or emotional problems to a wide range of health settings. It is therefore essential that doctors across all specialties as well as other health care professionals are aware of the range of presentations and that they know how to respond appropriately. The purpose of this report is to make recommendations to the medical Royal Colleges and Faculties to help:

- Raise professional awareness of the indicators of sexual exploitation in order to identify children and young people affected by sexual exploitation who are presenting to health settings
- Support health care professionals in communicating with and engaging young people in this situation so that they are encouraged to share information with professionals
- Ensure that health care professionals feel equipped to refer sexually exploited children in a safe and appropriate manner to local services for assistance.

The Academy of Medical Royal Colleges (the Academy) is the coordinating body for 21 medical Royal Colleges and faculties which represent over 220,000 doctors across all fields of medicine. The working group had representation from several medical Royal Colleges and Faculties and is grateful for the contributions it received from other health disciplines and groups.

Children and young people who are sexually exploited can present across a range of health settings in a variety of ways: poor self-care, injuries, sexually transmitted infections, contraception, pregnancy, termination, drug and alcohol problems, medically unexplained symptoms, mental health problems, self-harming behaviours, problem behaviours, problems in relationships. They may not recognise they are being sexually exploited as they may perceive the perpetrator as giving them something they need or want. This may change over time as the perpetrator's behaviour becomes more coercive, but, a fear of potential consequences may stop them from disclosing.

In improving response by health professionals, five key components were identified:

Training, awareness, recognition, response, supervision and support

All of these components are present in a central practice example described in the report of work currently going on in a busy Accident and Emergency department to identify and assist young people at risk of sexual exploitation. This demonstrates how these issues can be addressed in the everyday work programme of health settings. Examples of structured tools to support decision-making by health professionals are included in the report.

The working group report includes information on the following: definition of child sexual exploitation, prevalence, legal framework, messages from current guidance, indicators of child sexual exploitation, presentation across health settings and practice examples. It is hoped that the report will be of use in training and raising awareness.

The recommendations for medical Royal Colleges and Faculties cover the following areas:

- Curriculum development and training in relation to a). presentation of child sexual exploitation through a wide variety of health scenarios and b).t good communication and engagement skills with hard-to-reach young people
- The importance of information-sharing *'The duty to share information can be as important as the duty to protect patient confidentiality'* (Caldicott 2, principle 7)
- Knowledge of local safeguarding and referral and care pathways
- Support for multi-agency approaches to tackling child sexual exploitation
- Support for consideration of new partnerships with other sectors to increase capacity for outreach and holistic responses
- Support for provision of supervision and support to frontline staff
- For the public health community to work closely with local safeguarding children boards (LSCBs) in relation to

  a). improving awareness in parents, communities and schools of indicators of child sexual exploitation and of available help and

  b). building awareness and resilience in children and young people to prevent them being sexually exploited.

Note on terminology: Throughout the report the words 'child', 'children' and 'child sexual exploitation' refer to children and young people up to age 18 in accordance with the Children Act 1989.

1.0 INTRODUCTION: PURPOSE OF THIS DOCUMENT

Child sexual exploitation (CSE) is a form of child sexual abuse. Children and young people affected by sexual exploitation can present with a range of physical and/or emotional problems to a wide range of health settings. It is therefore essential that doctors across all specialties as well as other health care professionals are aware of the range of presentations and that they know how to respond appropriately. The purpose of this report is to make recommendations to the medical Royal Colleges and Faculties to help:

- Raise professional awareness of the indicators of sexual exploitation in order to identify children and young people affected by sexual exploitation who are presenting to health settings
- Support health care professionals in communicating with and engaging young people in this situation so that they are encouraged to share information with professionals
- Ensure that health care professionals feel equipped to refer sexually exploited children in a safe and appropriate manner to local services for assistance.

The Academy of Medical Royal Colleges (the Academy) is the coordinating body for 21 medical Royal Colleges and faculties which represent over 220,000 doctors across all fields of medicine. The working group had representation from several medical Royal Colleges and Faculties and is grateful for the contributions it received from other health disciplines and groups. The purpose of the Academy's CSE Working Group was to consider what specifically the medical Royal Colleges could do to improve awareness and recognition of and response to child sexual exploitation.

Note on terminology: Throughout the report the words 'child', 'children' and 'child sexual exploitation' refer to children and young people up to age 18 in accordance with the Children Act 1989.

2.0 BACKGROUND

This work takes place in the wider context of increasing public awareness of child sexual abuse and child sexual exploitation. There have been a number of high profile cases relating to child sexual exploitation that have been widely publicised. In 2010, Operation Retriever in Derby resulted in the arrest and conviction of a group of 13 defendants on 70 offences that related to the sexual exploitation of children and young people. Operation Kern subsequently resulted in the conviction of eleven individuals who had separately been involved in sexual exploitation. In May 2012, nine men from Rochdale and Oldham were convicted of offences that included: rape, sexual activity with a child; sexual assault, trafficking in persons for the purposes of prostitution/ trafficking within the UK for sexual exploitation.

In June 2013, seven men from Oxford were sentenced for offences related to child sexual exploitation that included: rape of a child under 13, trafficking in persons for the purposes of prostitution/trafficking within the UK for sexual exploitation, accusing or inciting child prostitution. In February 2014, four men in a child sex abuse ring from Peterborough were sentenced for offences that included: causing or inciting a child to engage in sexual activity, causing or inciting child prostitution or pornography; rape, sexual activity with a child, sexual touching / sexual activity with a child under 16. Very recently in August 2014, the Independent Inquiry into Child Sexual Exploitation in Rotherham by Professor Alexis Jay identified the shocking exploitation of at least 1400 children and young people between 1997 and 2013. The report raised many concerns about the treatment of victims and identified failures by the police, social care managers and officials in their response.

An ITV documentary in October 2012 ('Exposure, the other side of Jimmy Savile') led to Operation Yewtree. In January 2013, Giving Victims a Voice[1] , was published – a joint report between the Metropolitan Police and the NSPCC into sexual allegations against Jimmy Savile. That report noted that since Operation Yewtree began in October 2012 approximately 600 people had come forward to provide information to the investigative team. The total number of these relating to Savile was expected to be about 450, mainly alleging sexual abuse. Operation Yewtree has broadened its remit to include non-Savile related allegations.

The first hand testimony of victims in court and in the media and the learning from police operations and case reviews have raised awareness of the extent of and forms that child sexual exploitation can take. Reviews such as the Operation Kern Learning Review[2] carried out by Derby Safeguarding Children Board have given important insights into the impact of investigative and court processes on young people and their families and how professionals should approach and support children and families.

Given the consequences for physical and mental health for some children and young people who have been sexually exploited, this presents a major public health concern necessitating consideration of a more systematic approach to prevention and intervention.

3.0 DEFINITION: WHAT IS CHILD SEXUAL EXPLOITATION?

Child sexual exploitation is defined as follows:

'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 them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition, for example, being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain.

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. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.'

(Safeguarding Children & Young People from Sexual Exploitation, Department for Children, Schools and Families [DCSF], 2009)[3]

There are different ways in which sexual exploitation may take place such as:

- An inappropriate relationship often characterised by a significant age difference - the perpetrator exercises power over the young person through giving them something they need in exchange for sexual activity.
- The 'boyfriend' model - the young person is groomed to view the person as a boyfriend but is then forced into performing sexual behaviours for others.
- Peer-on-peer exploitation - the young person is drawn into sexual activities by their peers e.g. as part of the ritual of belonging to a gang

In contrast to other forms of sexual abuse, children and young people who are sexually exploited may not recognise that they are being abused as they perceive the perpetrator as giving them something they need or want. This may change over time as the perpetrator's behaviour becomes more coercive, but fear of consequences may stop them from disclosing. Both girls and boys can be sexually exploited (72% of cases identified in the Office of Children's Commissioner's Inquiry were girls, 9% were boys, and 19% were not gender specified).[4]

Perpetrators may be acting as individuals, or as part of a group targeting and sexually exploiting children and young people or as part of a gang. In the gang scenario, sexual exploitation is a by-product of the deviant values held by members, rather than the main purpose of the gang.

The following illustrative quotes are taken from *'Not a World Away'* Beckett, 2011[5]

Young woman
'I was 12, maybe a wee bit older, and I remember ….and my mummy run out of drink and she says to me, there was fellas in the house and she says to one of them to take me up the stairs and she got me to go with this man for a bottle of vodka for her'

Residential unit worker
'There was a guy running parties for sex. What was described to me was someone initially looking after you, taking you out, buying you clothes, looking after you, giving you lots of emotion and care. Then there were parties where other girls were there and it became a going upstairs with one person type of thing, but then it came down to being the only girl with four or five men and it became quite frightening. There was also a separate pornography side to it, and they were getting pulled into that as well'

4.0 PREVALENCE OF CHILD SEXUAL EXPLOITATION

Prevalence data for child sexual exploitation is difficult to capture for various reasons including:

- The low levels of reporting by young people themselves. Young people may not perceive themselves as sexually exploited. They may experience obstacles to disclosure when they do try to tell someone.

- The variable levels of awareness and confusion around the definition. Professionals may not perceive situations as exploitative when they are e.g. seeing a young person as making a 'choice' about a sexual relationship, or having misperceptions about what a typical victim would look like, e.g. assuming that if someone seems 'streetwise' they would not be at risk.

- The difficulties around intelligence gathering and information sharing - in some health settings there are dilemmas about information-sharing which may lead to under-reporting of child sexual exploitation. There can be a lack of clarity about information sharing between agencies, which may have different ways of working (professional culture) and levels of confidentiality.

- The inconsistent recording of data – child sexual exploitation is not a diagnosis so it is hard to get good data on it from health settings.

For all these reasons, it is very likely that the available data represents an under-reporting of the extent of child sexual exploitation. The data sources that do exist show the following picture:

- 16,500 children at risk of child sexual exploitation in England during the period from April 2010 to March 2011 – this estimate is from the information submitted to the Office of the Children's Commissioner Inquiry into Child Sexual Exploitation in Gangs and Groups.[4]

- 2,409 children confirmed as victims of sexual exploitation in gangs and groups in England during the period from August 2010 to October 2011.[4]

- 1,875 cases of localised grooming reported by the Child Exploitation and Online Protection Centre (CEOP 2011).[6]

- Child sexual exploitation is an issue of concern for 1 in 7 young people known to social services in Northern Ireland; 1 in 5 is deemed to be at significant risk (Beckett 2011).[5]

Data on child sexual abuse of all types will include some cases of child sexual exploitation within the data set:

- One in 20 children (4.8%) have experienced contact sexual abuse (NSPCC data on children age 11-17, Radford et al, 2011).[7]

- International studies indicate that 8-31% in girls and 3-17% in boys have experienced sexual abuse. (Barth et al, 2012).[8] *

Given the relatively small number of sexually abused children and young people receiving assistance from services, the studies would suggest that child sexual abuse is under-reported and not always recognised by those in contact with affected children and young people.

* The variation is due to differences in definitions (e.g if you include non-contact abuse that increases rates) and in the way the study is carried out

5.0 LEGAL FRAMEWORK

Although there is no specific offence of child sexual exploitation, the Sexual Offences Act 2003 provides clarity on the protection of children from sexual exploitation as follows:

- Children under 13 cannot legally consent to sex (it is statutory rape)
- Sexual activity by adults with children under 16 is unlawful
- Provides further information regarding child sex offences committed by children or young persons under 18
- Provides an offence of arranging or facilitating commission of a child sex offence
- Provides an offence of meeting a child following sexual grooming
- Covers sexual offences of children under 18 where the offender has abused a position of trust
- Covers exploitation of children through prostitution and pornography which is for children up to age 18, i.e. includes 16 and 17 year olds.

The above legislation applies to England and Wales. Scotland and Northern Ireland are considered as separate jurisdictions – for more information on legislation in each jurisdiction see http://www.fpa.org.uk/factsheets/law-on-sex

6.0 OTHER KEY REPORTS AND GUIDANCE

The DCSF 2009 supplementary guidance to Working Together, on Safeguarding Children and Young People from Sexual Exploitation [3], provides a clear framework for the assistance of children and young people in this situation. The key areas are:

- Prevention
- Identification
- Intervention
- Protection
- Prosecution

The guidance is clear about the specific responsibilities for health services. Health services are seen as being in a key position to recognise and assist children and young people who are suffering sexual exploitation. They may also be in a position to identify concerns about adults who may be perpetrators of sexual exploitation.

Sexual health services, genito-urinary medicine services and community contraceptive clinics will be aware of sexually active young people and may pick up indicators of sexual exploitation. They should always be alert to these signs and should follow safeguarding processes.

Paediatric and Accident and Emergency staff may identify signs of sexual and physical abuse or signs of violence when young people present with injuries. Young people may also present due to alcohol or drug misuse or overdose. These staff may be able to refer to other agencies for assistance, but also (with consent), collect evidence through their medical examinations, which may assist in investigation and prosecution (e.g. DNA from semen, photographs of injuries).

Mental health services, including child and adolescent mental health services (CAMHS), adult mental health services, and substance misuse services may encounter children and young people at risk of or suffering sexual exploitation, or they may have concerns about adults suspected of being perpetrators of sexual exploitation. Health staff working with looked after children and care leavers should be aware of the indicators of sexual exploitation and be alert to concerns in this vulnerable group.

The Deputy Children's Commissioner recently chaired a two year Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG), which started in October 2011 and reported in November 2013. The interim report in 2012 '*I thought I was the only one. The only one in the world*' gave information about the nature and scale of the problem.[4] It also highlighted the additional physical and emotional abuse that some of these young people experienced. A useful 'Warning Signs and Vulnerabilities Checklist' was developed to assist practitioners in recognising children and young people at risk of sexual exploitation (interim report, 2012).[4]

The final CSEGG report *'If Only Someone had Listened'* (2013) identifies the foundations of good practice to help this vulnerable group: a focus on the child, gaining a child's confidence, effective leadership, strategic planning; 'everyone on the alert', spotting the warning signs, joined up working, early identification and pre-emptive action in order to break up networks, scrutiny and oversight to ensure that outcomes are being met.[9]

The Department of Health has been exploring what more can be done to highlight the particular needs of children and young people, who have been sexually exploited, through a health working group, which reported in Jan 2014.[10] The recommendations included further work to develop the evidence base, the need for health professionals to receive appropriate training in this area in order to improve recognition and response and the need to support the involvement of health professionals in multi-agency work and the development of local care pathways for treatment and recovery services. The report gave clear guidance on information-sharing highlighting the importance of safeguarding children and young people in this situation.

A recent NSPCC report *'No one noticed, no one heard - a study of disclosures of childhood abuse'* (2013) highlighted the problems young people encountered in disclosing.[11] Sixty young adults, who had experienced different types of abuse and violence in childhood, were interviewed about their experience of disclosure. The key points were that the majority (80%) had tried to tell someone about the abuse during their childhood; many disclosures were either not recognised or understood, or they were dismissed, played down or ignored, with no action being taken to support the young person.

The young people said that they wanted someone to notice that something was wrong and to be asked direct questions. They wanted professionals to investigate sensitively but thoroughly and they wanted to be kept informed about what was happening. Disclosing abuse was difficult and the majority had negative experiences at some point, often to do with people responding poorly. Positive experiences were around being believed, protective actions being taken and the provision of emotional support.

7.0 IDENTIFYING CHILD SEXUAL EXPLOITATION

Vulnerability factors for CSE
Whilst generally more females than males suffer from CSE and the average age when concerns are first identified is 13-15 years old, no one is immune. Particular life experiences associated with increased risk of CSE are:

- Family dysfunction
- Prior (sexual) abuse or neglect
- Going missing / running away
- Substance misuse
- Disengagement from education
- Social isolation
- Low self esteem
- Socio-economic disadvantage
- Learning difficulties / disabilities
- Peers who are sexually exploited
- Gang-association
- Attachment issues
- Homelessness
- Being in care

Possible warning signs of CSE (drawn from CCSEGG interim report, 2012)[4]

- Missing from home or care
- Physical injuries
- Drug or alcohol misuse
- Involvement in offending
- Repeated STIs, pregnancies and termination
- Absent from school
- Change in physical appearance
- Evidence of sexual bullying/vulnerability through the internet and/or social networking sites

- Estranged from their family
- Receipt of gifts from unknown sources
- Recruiting others into exploitative situations
- Poor mental health
- Self-harm or thoughts of or attempts at suicide

Identifying child sexual exploitation in health settings

PHYSICAL HEALTH presentations of CSE	MENTAL HEALTH presentations of CSE
These may include: • Poor self-care • Injuries • Sexually transmitted infections • Contraceptive advice • Termination • Pregnancy • Drug and alcohol problems • Medically unexplained symptoms	These may include: • Emotional symptoms • Trauma symptoms • Self-harming behaviour • Problem behaviours e.g. running away, risk-taking behaviours • Problems in relationships

Certain services have developed structured tools that can assist clinicians in identifying children and young people at risk of sexual exploitation. The King's Youth Sex Safeguarding Form (KYSS) used in King's College Hospital A&E in London is such a tool incorporating information about risk factors, questions to cover, and a decision tool to guide the clinician. (Appendix A). The British Association of Sexual Health and HIV (BASHH) in collaboration with Brook with the support of the Department of Health have developed a national pro forma for use by sexual health providers that may also be useful in other settings. (Appendix B).

8.0 THEMES FROM THE WORKING GROUP

- The ethics and challenge of treating young people who may not perceive themselves as exploited was explored. Young people may present to health settings with multiple complex factors rather than a single issue. Professionals may misunderstand and see young people as exercising choice rather than being exploited. The health professional needs to have good communication and engagement skills and to be persistent rather than give up.

- The challenge of getting good information from health professionals about this group in view of the dilemmas around confidentiality and information sharing was explored. The importance for health professionals of considering the child's safety and wellbeing as paramount and balancing safeguarding and confidentiality was considered.

- The need to raise awareness and identification of child sexual exploitation across the health sector and to develop good communication skills through training and continuing professional development was highlighted. In relation to this vulnerable group, health professionals need to avoid making automatic assumptions that young people are making informed choices about sexual relationships.

- The importance of helping young people to access physical health, and psychological and mental health services where appropriate was emphasised. This may involve the provision of managerial support for workers who form a relationship with a young person, where sufficient trust is built to facilitate initial disclosure, to work beyond the strict remits of their core task, in order to assist the process of engagement by this young person with the most relevant local service for addressing CSE-related needs. Good knowledge of local provision and referral pathways in both statutory and third sector is important. Third sector organisations such as Barnardos have developed innovative approaches to engaging and responding to this group.

Five key components were identified to improving the response of health professionals to child sexual exploitation:

- Training
- Awareness
- Recognition
- Response
- Supervision and support

The following practice example from a busy inner city Accident and Emergency Department, with partnership working between the NHS and the third sector, incorporates these components and demonstrates how these issues can be addressed in the everyday work programme of health settings:

PRACTICE EXAMPLE: KING'S YOUTH VIOLENCE PROJECT, KING'S COLLEGE HOSPITAL, LONDON

Project leads:
Dr Emer Sutherland, Clinical Lead for the ED, Tricia Fitzgerald, Head of Nursing ED and Trauma, John Poyton, CEO Redthread Youth.

King's College Hospital Emergency Department (ED) has been working in partnership with Redthread, a local youth work charity since 2006. The ED and youth work staff work together with victims of youth violence who are treated and discharged from the ED or admitted to the major trauma centre. In late 2013 the King's Youth Violence project was expanded, by recruiting experienced female youth workers and training staff, to try to identify and support young people, who are potentially victims of child sexual exploitation. A particular concern in the area was exploitation in the gang environment.

Medical and nursing staff are trained by including a scenario in their child safeguarding training in the ED. Adult ED staff are included to capture 16 and 17 year-olds. The topic of sexual abuse or exploitation of adolescents is explicitly discussed with reference to high profile cases in the media and case reports within a gang environment. A clinical scenario is discussed involving a 14 year-old who attends with abdominal pain; it transpires in questioning that she has been sexually exploited by older adolescents near her home. Risk factors or vulnerabilities for exploitation are discussed and potential referral options including social care and the in-house youth work team.

The complexities of this history taking are summarised in a pro forma that also acts as a decision support tool. The KYSS form – King's Youth Sex Safeguarding, is a two-sided document that is intended to use for any sexual health presentation in an adolescent, and in any presentation of concern (see appendix A).

The youth work team are available to come and engage with young people in the ED. In addition to patients seen in the ED, the youth workers contact young people by phone who attend overnight or who do not wait to be seen. The youth workers can be called by the triage nurse, doctor or nurse practitioner. They can advocate and support the young person in real time in the ED and then follow them up in the community. If the criteria for social services referral are met in the ED a referral is made immediately and supported by the hospital safeguarding children's team.

If the social services criteria are not met, but staff have concerns, the youth workers continue to engage with the young person in the community in a youth friendly manner. They work together to understand the issues that the young person faces and support them in engaging with statutory partners. There is also a weekly A&E safeguarding meeting where children and young people presenting risks can be discussed with senior colleagues.

The project is in its infancy but there are emerging themes around young women attending with a "physical assault" who later come to disclose, with youth work support, that they have previously been sexually assaulted. There are young women seen, who may deny that there is any problem, and even being aggressive to hospital staff when the subject is raised, yet will engage with youth workers in the community, and slowly explore issues around violence and control in their lives. An evaluation is commencing.

OTHER PRACTICE EXAMPLES

Appendix C illustrates how health can contribute to multi-agency working to assist children and young people at risk of sexual exploitation through Multi-Agency Sexual Exploitation (MASE) Panels.

Appendix D provides an example of an approach that engages hard-to-reach young people.

9.0 RECOMMENDATIONS

The Academy Child Sexual Exploitation Working Group makes the following recommendations:

1. As part of their curricula review process, medical Royal Colleges and Faculties need to ensure that child sexual exploitation (CSE) is appropriately reflected for the relevant specialties, particularly with regard to recognising:

   a). that CSE may present through a wide variety of health scenarios and

   b). the importance of good communication and engagement skills with young people.

The Academy CSE Working Group hope that this document provides Colleges with relevant information that could be included in training materials.

2. The Generic Capabilities Review, being led by the GMC and due to complete by December 2014, should include consideration of skills relevant to engaging with hard to reach young people. This is a skill set of benefit to all health practitioners and encompasses a broad range of presenting health scenarios as well as those involving Child Sexual Exploitation.

3. The revised Caldicott principles include principle 7: *The duty to share information can be as important as the duty to protect patient confidentiality. Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.*[12]

   Medical Royal Colleges and Faculties should consider how they can reinforce their support for this message to their members, both generally and in regard to Child Sexual Exploitation, in their communications, policy and training activities. Medical Royal Colleges and Faculties should consider how they would advise members seeking guidance on information sharing in relation to an instance of suspected or confirmed child sexual exploitation.

4. The medical Royal Colleges and Faculties should encourage their members to keep up to date with local safeguarding protocols, local referrals and care pathways for children and young people affected by sexual exploitation. This might include, for example, drawing members' attention to this report through the usual College and Faculty communication channels and highlighting this recommendation.

5. The medical Royal Colleges and Faculties should publicly confirm their support for the principle of multi-agency joined up approaches towards tackling child sexual exploitation; recognising the implicit difficulty in this work and providing appropriate backing to individual members seeking to make contributions to such approaches or supporting their colleagues in their teams to do so.

6. The medical Royal Colleges and Faculties should publicly confirm their support for the consideration of new partnerships with other sectors as a way to increase capacity for outreach and holistic response to young people at risk, and provide appropriate backing to individual members seeking to explore and establish such approaches.

7. Whilst provision is a local responsibility, the medical Royal Colleges and Faculties should consider how they can encourage the availability and access to appropriate support and supervision for their members working with children who present safeguarding risks.

8. The Faculty for Public Health should consider how they can encourage their members to work closely with local safeguarding children boards to improve awareness in parents, communities, and schools of indicators of child sexual exploitation and of available help. This would also include a focus on primary prevention to help build awareness and resilience in children and young people to prevent them being sexually exploited.

9. The Academy's Quality Improvement Network should review progress against the recommendations above in Summer 2015 and consider what, if any, further action may be required.

APPENDIX A
KYSS FORM FROM KCH PROGRAMME

King's College Hospital NHS
NHS Foundation Trust

KYSS FORM **KING'S YOUTH SEX SAFEGUARDING FORM**

Name: **No:** **Date:**

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

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

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

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

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

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

SEXUAL HEALTH SAFEGUARDING ASSESSMENT IN UNDER 18 YEAR OLDS

PATIENT FACTORS

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

PARTNER FACTORS

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

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

Discussed case with ED Consultant / SpR Paediatrics / Safeguarding team

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

Do you still have safeguarding concerns? Y / N

If **YES**, please specify:

Action plan: (1) **Social Services referral** □ consented □ OR informed □

(2) **School Nurse referral** □

(3) **Youth Work referral** □

(4) Inform Police – important if <13 yrs □

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

Youth work referral □ consented □ mobile number checked □

Leaflet on sexual health services given □ Youth work card □

Safer sex and future contraception discussed □

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

Name of clinician: **Designation:**

APPENDIX B
SPOTTING THE SIGNS. A NATIONAL *PRO FORMA* FOR IDENTIFYING RISK OF CHILD SEXUAL EXPLOITATION IN SEXUAL HEALTH SERVICES.

K Rogstad and G Johnson
http://www.bashh.org/BASHH/News/BASHH/News/News_Items/Spotting_the_Signs_-_CSE_Proforma.aspx

Visit Number			
Confidentiality discussed and understood:			
Age	Gender	Ethnicity	
Education			
school / education other than school / pupil referral unit / college / training / employment?	Do you attend regularly?	Do you enjoy it?	Is there anyone there who you can talk to?
Family Relationships			
Who do you live with?	How are things at home?	Do you feel like you can talk to someone at home about sex and relationships?	Young carer: Looked after child: Homeless: Runaway: Family bereavement: Learning or physical disability:
Are you involved with any other agencies or professionals such as social workers or mental health services?		If so, would you be happy for us to contact them if we feel we need to?	
Friendships			
Do you have friends your own age who you can talk to?		Do your friends like and know the person you have sex with (if you are involved with or having sex with anyone)?	

Relationships			
Are you having sexual contact with anyone? (If no) When was the last time you did?	(If yes) Are you happy with the person you're going out with/the person you have sex with?	How old is the person you are having sex with?	How many people have you had sexual contact with in the past three months? In the past 12 months?
Where do you spend time together?		Where did you meet the person you have sex with?	
Consent			
Have you ever been made to feel scared or uncomfortable by the person/s you have been having sexual contact with?	Have you ever been made to do something sexual that you didn't want to do, or been intimidated?	Do you feel you could say no to sex?	
Has anyone ever given you something like gifts, money, drugs, alcohol or protection for sex?	Where do you have sex?	Who else is or was there when you have sex (or any other form of sexual contact)?	
Sexual Health			
What contraception do you use?		Do you feel like you can talk to the person you have sex with about using condoms or other forms of contraception?	
Have you ever had an STI test?		Have you ever had an STI? If yes, which, and how many times?	
Do you ever use drugs and / or alcohol?			
Do you often drink or take drugs before having sex?			
Do you suffer from feeling down / depression?	Have you ever tried to hurt yourself or self-harm?	Have you ever been involved in sending or receiving messages of a sexual nature? Does anyone have pictures of you of a sexual nature?	

Professional analysis
Is there evidence of any of these within their relationship? Coercion: Overt aggression (physical or verbal): Suspicion of sexual exploitation/grooming: Sexual abuse: Power imbalance: Other vulnerabilities (please give details): If you have identified risks or concerns please discuss with your CSE or Safeguarding Lead by _____ (date) and follow your own child protection policy and procedure.
Additional information

Signed	Printed

Fraser guidelines	Yes	No
The young person understands the health professional's advice. The young person is aware that the health professional cannot inform his / her parents that he / she is seeking sexual health advice without consent, nor persuade the young person to inform his / her parents. The young person is very likely to begin having, or continue to have, intercourse with or without contraceptive / sexual health treatment. Unless he / she receives contraceptive advice or treatment the young person's physical or mental health, or both, are likely to suffer. The young person's best interests require the health professional to give contraceptive advice, treatment, or both without parental consent.		

APPENDIX C
MASE PANEL – HOW HEALTH CAN CONTRIBUTE TO MULTI-AGENCY WORKING

The following example of a multi-agency panel process is drawn from the Southwark protocol for children and young people at risk of sexual exploitation. There are representatives from child health and from CAMHS on the panel that can help advise on specific services that young people can access in relation to physical and mental health. The panel provides opportunities for joint planning and joint work where needed.

Multi-Agency Sexual Exploitation Panel (MASE)
Individual case meetings will be scheduled to take place within designated MASE Panel Days. These will be held monthly at Sumner House and will be attended by a core group of professionals from Children's Services, Youth Offending Team, Health, Education, CAMHS, third sector and the Police. Individual social workers and other key professionals will be invited for the individual meetings about the specific young person. All referrals will go into a PPD mailbox - intelligence research will be completed by the PPD and a referral passed to the relevant investigation unit eg CAIT, Sapphire. This unit will be responsible for attending the MASE panel where appropriate and necessary. The meetings will be chaired by a Child Protection Coordinator from Quality Assurance Unit. A record of the meeting will be completed and sent to all participants. **Purpose of MASE Strategy Meetings/PANEL:** • Share and clarify information • Establish exact nature of concerns • Establish risk for child and any other children • Consider action against and the likelihood of prosecution of relevant adults • Agree on action and make recommendations to address concerns **Possible Outcomes of MASE Strategy Meeting/PANEL:** • No concerns identified and no need for further Children's Services involvement • Concerns identified /Safeguarding /Disruption Plan agreed/possible review MASE strategy meeting • Concerns identified and decision to convene a Child Protection Conference

APPENDIX D
AN APPROACH THAT ENGAGES HARD-TO-REACH YOUNG PEOPLE

AMBIT (Adolescent Mentalization-based Integrative Treatment)
CASUS, an NHS child and adolescent substance use service in Cambridgeshire, works with young people, many of whom are at risk, or are victims, of child sexual exploitation. The team places a strong emphasis on developing authentic trusting relationships between young people and individual workers, using an assertive outreach "mentalization-based" approach, called AMBIT. Mentalization refers to the imaginative activity of making sense of human behaviour by reference to the intentional mind (mentality) that 'caused' that behaviour (Mentalization-Based Treatment [MBT] is a NICE recommended treatment for borderline personality disorder). AMBIT counteracts the risks attached to forming strong individual relationships with single workers by placing an equally powerful emphasis on the relationships between team members. Although it is delivered primarily through individual relationships, it is very much a team approach, designed to improve the engagement of young people as well as the support for outreach workers. There is also an emphasis on applying focused effort and specific techniques to address the fragmentation that commonly occurs in multi-professional and multi-agency networks. AMBIT has been developed as an "open source" approach to developing effective ways of working for hard-to-reach youth at the Anna Freud Centre, London (http://ambit.tiddlyspace.com).

APPENDIX E
HELP FOR PROFESSIONALS ON DEALING WITH CHILD SEXUAL EXPLOITATION

NHS Choices Website
http://www.nhs.uk/aboutnhschoices/professionals/healthandcareprofessionals/child-sexual-exploitation/pages/cse-guide-for-professionals.aspx

Department for Education (2012) *What to do if you suspect a child is being sexually exploited*. *A step-by-step guide for frontline practitioners*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279511/step_by_step_guide.pdf

APPENDIX F
WORKING GROUP MEMBERSHIP

Chair

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Project support

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APPENDIX G
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