



Public Health
England

Protecting and improving the nation's health

Child sexual exploitation: How public health can support prevention and intervention



Children's
COMMISSIONER

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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Foreword

Child sexual exploitation: How public health can support prevention and intervention

The vast majority of children in this country have a safe and happy childhood, free from fear, but for a vulnerable minority, childhood has quite a different meaning. It means being targeted, groomed and subjected to appalling sexual abuse. Child sexual exploitation affects children and young people from all walks of life, male and female. The impact of abuse can be profound and devastating.

Public health teams have a vital part to play in the fight against child sexual exploitation.

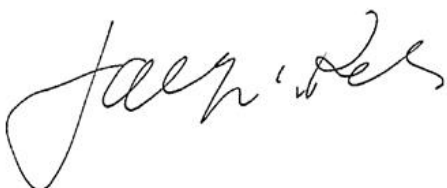
Local services and teams can take action to increase the ability of children and young people to realise they are being exploited and seek help. Local teams can identify those children at risk and get them to the help they need.

Prevention also includes making full use of licensing powers on those premises posing a risk to children, to education work in schools and local communities which not only gives children an awareness of sexual exploitation, but also the confidence to seek help for themselves and their friends.

Services such as those for drugs, alcohol and sexual health, all have contact with children and young people who may be at an increased risk of sexual exploitation. By providing support and encouraging disclosure, these services can help those affected by exploitation at the earliest possible opportunity.

This resource provides local public health teams with both the evidence base for their role on prevention, as well as a practical framework to help support public health leaders and commissioners to take effective action.

It will assist public health leaders to effectively turn evidence into action to help protect the health and wellbeing of our children and young people, and help them get their lives back.



Jackie Doyle-Price MP

Parliamentary Under Secretary of State for Care and Mental Health

Introduction

Our understanding of child sexual exploitation (CSE) is increasing. Case studies, locality reviews, and research are deepening our knowledge. Crucially, we are learning from young people themselves about their own experiences. The evidence shows that there is a critical role for public health in preventing CSE and disrupting the environments in which CSE can take place. For example, Directors of Public Health (DPHs) have an important part to play in licensing, working with local communities, promoting children and young people's health and wellbeing through public health programmes and in schools, as well as using data and intelligence to inform local strategies and plans.

The intention in producing this report is to learn from the evidence and research, and to use this to structure a public health framework to address CSE. The framework is set out overleaf and has been developed by our three organisations. It describes three key functions for public health: to **Lead** the public health response to CSE, to improve the **Understanding** of local contexts and risks, and specific areas where the Director of Public Health can **Act**.

In the framework we give examples of practice, guidance and resources – these are intended to stimulate ideas and they will give you a sound platform to build on. Many areas are already making great strides and we trust this adds to the growing body of knowledge about how important public health is to keeping children and young people safe.

The basis for the framework is then set out in a review of the research evidence on the relationship between public health and the prevention of CSE. This has been undertaken by The International Centre at the University of Bedfordshire, to whom we are grateful. A literature review to identify the latest research about effective interventions to prevent child sexual abuse and child sexual exploitation is published separately by PHE.

The Office of the Children's Commissioner, the Association of Directors of Public Health and Public Health England are committed to taking action to keeping children and young people safe. We trust that this resource proves helpful to local areas in translating evidence into practice.



Dr John Newton
Director of Health Improvement
Public Health England



Dr Andrew Furber
President
Association of Directors of
Public Health, UK



Anne Longfield, OBE
Children's Commissioner for
England

Part 1: A framework for public health to prevent and address child sexual exploitation

A framework based on an emerging evidence base and practice examples to support local leaders to establish a public health framework to address CSE.

Produced by Public Health England (PHE), the Office of the Children's Commissioner and the Association of Directors of Public Health

	Key prompts	Support
LEAD	a) Is public health evidence informing the development of local CSE prevention strategies and services?	<p>For example, section 38 of Ofsted's <i>thematic report on CSE</i>, sets out a holistic local response, which DPHs have a role in</p> <p>Are opportunities to embed effective learning in schools being utilised? For example in Relationships and Sex Education and/or PSHE. For example <i>The Shropshire Respect Yourself Relationship and Sex Education programme</i></p>
	b) Does the local public health plan make specific reference to actions that promote the welfare and safety of children and young people in relation to CSE?	<p>For example, Knowsley MBC's <i>Public Health Annual Report 2014/15</i> and PHE West Midlands <i>CSE self assessment tool</i> to identify and address gaps in the public health response to CSE</p> <p>Is the local plan making full use of the <i>NHS role and expertise on CSE</i>. For example, working with your local Designated Nurse (safeguarding children)</p>

	c) Does the Joint Strategic Needs Assessment, and Strategy, take a holistic approach to safeguarding children and young people from sexual exploitation?	For example, Manchester City Council's specific <i>section on CSE</i> as part of their 2015/16 JSNA Is the Local Government Association's <i>Tackling CSE resource pack</i> for councils being used?
UNDERSTAND	d) How are the views of children, young people and carers informing local strategies and service delivery?	For example, a <i>Guide to children and young people's participation</i> from the Office of the Children's Commissioner
	e) How are public health commissioned services collating and sharing relevant data to identify CSE?	For example, <i>Young people's substance misuse data: JSNA pack</i> by PHE
	f) How are children and young people's health data being used at a population level to identify potential risks?	Use PHE's <i>Children and Young People's Health Benchmarking Tool</i> ; <i>What About Youth</i> ; data on <i>mental health and wellbeing</i> ; and the <i>Young People's Health and Wellbeing Framework</i> and the <i>Youth Health Profiles</i>
ACT	g) Are all public health commissioned services young people friendly, with appropriately trained staff?	Examples include: <ul style="list-style-type: none"> - Service quality standards set out in <i>You're Welcome</i> by the Department of Health - Staff have accessed training, including online resources from the Department of Health and Brook on <i>Combatting CSE – an e-Learning resource for health professionals</i> and the Department of Health/NHS E/Children's Society e-learning resource <i>Seen and Heard</i> and the Child Exploitation and Online Protection Centre <i>Thinkuknow</i> resources, training and support, including a tool for reporting CSE

	<p>h) Are all public health roles on social and built environment factors being fully used to prevent and disrupt CSE?</p>	<p>For an example of community based CSE prevention initiatives see Barnardo's <i>FCASE</i> (Families and Communities Against Sexual Exploitation project)</p> <p>For an example, Kirklees Council's <i>Licensing Policy (2015-20)</i> makes effective use of its powers under Section 2.21 from <i>Revised Guidance issued under section 182 of the Licensing Act 2003</i> on child sexual exploitation</p>
	<p>i) Is the Healthy Child Programme effectively incorporating prevention and early intervention?</p>	<p>The use of a whole school approach on CSE is promoted by <i>Healthy Schools Wiltshire</i>, including the role of PSHE in schools</p> <p>Are school nurses using the DH/PHE <i>helping school nurses to tackle CSE Pathway</i>?</p>

Part 2: UK CSE Literature Review: learning for public health

Written by Joanne Walker and Dr Helen Beckett, University of Bedfordshire

Introduction

This paper provides a high level summary of the UK research evidence around the issue of child sexual exploitation (CSE), through the lens of what an effective local public health response to the issue might look like. This paper has been produced by 'The International Centre: Researching Child Sexual Exploitation, Violence and Trafficking' at the University of Bedfordshire, with the support of other experts in health, public health, local government and the voluntary and community sector.

The literature search and screening was undertaken as part of a wider-scale review of UK CSE literature that the authors were undertaking for another commission; the scope of which was UK research, evaluation and policy literature on CSE published since 2009 when the concept of CSE was first introduced into policy discourse. This wide-ranging literature search was conducted in August 2015 and included a wide range of publications, from peer-reviewed articles in academic journals to small scale research and evaluations by charities working with victims, to local and national policy reviews. For the purpose of the review, CSE was defined based on four components. These components stated that CSE:

1. Is a form of child sexual abuse
2. Can affect any child under 18
3. Occurs in a context of exploitation, manipulation and/or coercion, with a power differential between victim and perpetrator
4. Involves a concept of exchange; that the abuse involves some form of exchange to the 'benefit' of the child and/or the perpetrator.

The focus of the work for this commission was on reviewing this literature through the lens of learning for public health.

The paper is structured into three main sections:

- An overview of the issue of CSE and its relevance to public health;
- An overview of what the evidence suggests an effective response to CSE should look like; and
- An exploration of what a local public health response to these issues may look like.

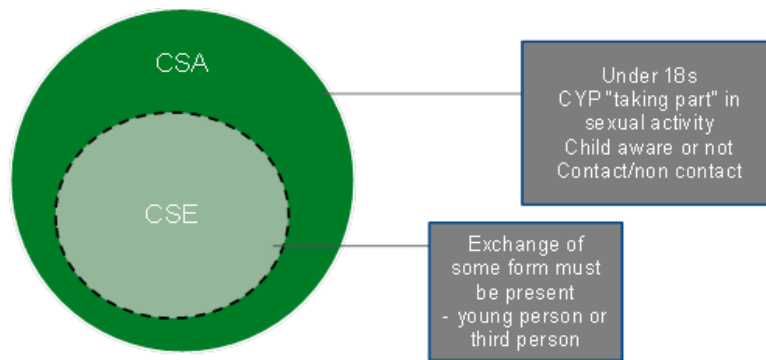
It is important to note that there is a limited evidence base that explicitly considers a public health response to CSE and, as such, commentary around the potential role of public health has been extrapolated from more generic evidence about what is required. It is also important to note that whilst the evidence base on CSE is rapidly expanding, there is no definitive evidence base on the specifics of 'what works' in addressing this issue. There is however an emerging consensus from across the fields of research, evaluation, inspection and case review as to the key elements of a required response and that is what this paper presents, with reference to the role of public health within this.

1. Understanding CSE and its relevance to public health

The last few years have seen rapidly increasing awareness of the issue of CSE across the UK. However, significant confusion remains as to what CSE actually is, the different forms in which it can manifest and who it affects.

The core principle to remember when considering the issue of CSE is that it is a form of child sexual abuse.ⁱ

Diagram 1: The relationship between CSE and other forms of CSA (Beckett 2016)



(Beckett 2016)

As illustrated in Diagram 1 above, the key factor that distinguishes CSE from other forms of child sexual abuse within the current policy framework is the presence of some form of exchange - the fact that the child (and/or someone else) receives 'something' in return for the sexual activity. As the new statutory definition explains:

"Child sexual exploitation is a form of child sexual abuse. It occurs 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. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology." (Department for Education 2017:5)

ⁱ "Child sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening" (HM Government 2015 Working Together to Safeguard Children).

As the extended guidance document further explains:

“If someone takes advantage of an imbalance of power to get a child/young person to engage in sexual activity, it is child sexual exploitation if:

(1) The child/young person receives, or believes they will receive, something they need or want (tangible or intangible gain or the avoidance of harm) in exchange for the sexual activity.ⁱⁱ

AND/OR

(2) The perpetrator/facilitator gains financial advantage or enhanced status from the abuse.

Where it is the victim who is offered, promised or given something they need or want, the exchange can include both tangible (money, drugs or alcohol, for example) and intangible rewards (status, protection or perceived receipt of love or affection, for example). **It is critical to remember the unequal power dynamic within which this exchange occurs and to remember that the receipt of something by a child/young person does not make them any less of a victim.** It is also important to note that the prevention of something negative can also fulfil the requirement for exchange; for example, a child who engages in sexual activity to stop someone carrying out a threat to harm his/her family.

1.1 No ‘typical’ case of CSE

Although much of the public discourse around this issue has focused on group-based contact models of CSE, research and practice have uncovered many different interconnected forms of CSEⁱⁱⁱ including:¹

- Sexually exploitative relationships with an individual (in which the child believes he/she is in a consensual sexual relationship and the abuse is only by that individual);^{iv}
- Third-party facilitated exploitation (in which an individual or group facilitates the involvement of others in abuse, often benefitting financially^v from this role);

ⁱⁱ Whilst there can be gifts or treats involved in other forms of sexual abuse (e.g a father/mother who sexually abuses but also buys the child toys) it would only be classed as child sexual exploitation if the ‘exchange’ is the core dynamic at play.

ⁱⁱⁱ It is important to note that this is not an exhaustive list. Nor indeed are these mutually exclusive categories, with perpetrators often utilising, and young people often experiencing, different manifestations of CSE either simultaneously or over time.

^{iv} Sometimes called ‘the boyfriend model’ but better described in gender-neutral terms given that perpetrators can be both male and female.

^v Financially in this context can relate to money, the discharge of a debt or free/discounted goods or services as per the Sexual Offences 2003 legislation.

- Paying for the sexual services of a child (language as per Sexual Offences Act 2003; includes sexual activity in return for any pre-agreed financial advantage);^{vi}
- The party house model (in which young people are typically introduced to a party scene, provided with drugs or alcohol^{vii} and then expected/forced to engage in sexual activity as a consequence of this);
- Online abuse in the virtual environment;
- Trafficking for sexual exploitation (this can be into, or within, the UK).²

It is important to note that this is not an exhaustive list of ways in which CSE can manifest, and to remain open to the emergence of new or adapted forms. It is also important to be alert to the fact that different areas may experience different manifestations of the issue, and the subsequent need to ensure that local responses are based on a local understanding of the issue.

1.2 Patterns of victimhood and perpetration

Any child or young person under the age of 18 years – including those aged 16 or 17 who can legally consent to sex - can be a victim of these or other manifestations of CSE.^{viii} Whilst younger children can also experience CSE, this form of abuse is most frequently documented amongst those of a post-primary age, with the average age at which concerns are first identified being 12-15 years of age.³

Although most identified cases of CSE relate to young females, research repeatedly shows that young males are also abused in this manner, with their abuse less likely to be identified than that of females.⁴ Similarly, both males and females can perpetrate CSE, individually or as part of an organised or informal network of abusers.⁵

Research demonstrates that CSE exists across every ethnic grouping, both in terms of those perpetrating and those experiencing the abuse.⁶ Whilst much public attention has been on perpetration of CSE by those not previously known to the child, CSE can also be perpetrated by family members, those who supervise youth activities or those in formal positions of trust.⁷ Similarly, whilst most of our focus historically has been on adults abusing children through CSE, we are increasingly learning about peer on peer forms of CSE and the risk that young people can face within their own social settings. Within this, we are also observing an overlap

^{vi} Previously referred to as 'abuse through prostitution' or 'commercial sexual exploitation'. The Serious Crime Act 2015 amended the language of the Sexual Offences Act from 'abuse through prostitution or pornography' to 'abuse through sexual exploitation'. However as the parameters of the legal offences differ from those of policy and practice guidance, the subsidiary descriptor of 'paying for the sexual services of a child' is used here so as not to cause confusion.

^{vii} Although a particular defining feature of this form of CSE, it is important to note that drugs/alcohol are often present in other manifestations.

^{viii} This is not to say that all adolescent sexual activity is abusive, but rather, to recognise that adolescents (even those who can legally consent to have sex) can be victims of abuse where their experience of sexual activity occurs in situations characterised by exchange, a power differential and/or an absence of freely given, informed consent.

between the traditionally distinct roles of 'victim' and 'perpetrator'.⁸ We are also witnessing cases of CSE being perpetrated by those known to the child including family members and those in positions of trust.

View the short film '10 key facts about sexual exploitation' at https://www.beds.ac.uk/ic/films

Although CSE can affect any child, there are a number of recognised factors (including adverse childhood experiences) that can heighten vulnerability to this form of abuse. Examples of these include:

- Prior (sexual) abuse;
- Chaotic or dysfunctional family background;
- Being in (residential) care;
- Substance misuse;
- Going missing;
- Social isolation and/or low self-esteem;
- Absence of a safe environment to explore sexuality; and
- Disability.⁹

Whilst recognition of these additional vulnerability factors is critical in terms of a comprehensive preventative approach to CSE, it is important to bear in mind that they are not, in and of themselves, an explanation for, or pre-determinant of, CSE. Rather, "it is the interplay of these and other factors, together with exposure to someone who would take advantage of these vulnerabilities and inadequate protective structures to mediate against this risk, that culminate in a young person being abused through sexual exploitation."¹⁰

A comprehensive response to CSE must be built around this recognition of interconnectedness and complexity – and consider these with reference to wider contextual factors (such as societal messages around abuse or sexual norms, or the expanding contact opportunities offered by an increasingly networked world) - as illustrated in Diagram 2 below.¹¹

Diagram 2: Interconnected conditions for CSE (Beckett 2011)



It is also important to remember that CSE can occur in the absence of any known vulnerability factors, with recent research indicating that this may be particularly true of online forms of abuse.¹²

1.3 The extent of the issue

Research indicates that one of the key challenges in mapping the extent of CSE is the fact that young people rarely report these experiences of abuse and may not want to be ‘rescued’ by professionals.^{ix13} Similarly, professionals may not always identify or register concerns around CSE.^{x14} These recognition and reporting challenges, together with a lack of definitional and data clarity, mean that we cannot offer any definitive count of the extent of CSE. We do however know from research, inquiries, reviews and inspections that both risk and actuality exist across the country.^{xi}

^{ix} There are many different reasons for this including not seeing themselves as a victim of abuse; fear of not being believed; loyalty to, or fear of, the perpetrator; and the fact that the exchange element of this particular form of abuse means that the young person is often receiving something they want or need in return for the abusive act.

^x Again, there are many reasons for this including: systemic difficulties and workload demands; the absence of a validated risk assessment tool for CSE; a focus on presenting behaviours and/or other presenting issues (missing, educational disruption etc) rather than causal factors; and conceptualising victims as ‘problematic teenagers’ who are ‘making active lifestyle choices’ rather than a child in need.

^{xi} An Inquiry by the Office of the Children’s Commissioner in 2013, for example, recorded 2,409 confirmed cases of gang or group-associated CSE in England, with an estimated 16,500 at high risk of the same (Berelowitz et al 2013). A 2014 Barnardo’s study reported 9,042 young people at risk of/affected by CSE engaging with their services over a five year period (McNaughton et al 2014).

We also know that areas that proactively look for CSE, and create the appropriate conditions for identifying and responding to it, are uncovering a problem. Good practice guidance on CSE therefore states that all areas should assume that CSE is occurring within their area unless they have evidence to indicate otherwise, be alert to the likelihood of this and plan to protect children and young people accordingly.¹⁵

1.4 The impact of CSE

Research indicates that the health and wellbeing impacts of CSE can be profound and long lasting. CSE can result in a range of physical, sexual and mental health difficulties including Sexually Transmitted Infections (STIs) and gynaecological problems, drug or alcohol problems, depression, post-traumatic stress disorder, self-harm or suicidal ideation.¹⁶ Research also illustrates links between CSE and higher rates of youth offending, risk of forced marriage, involvement in adult sex work and poor educational prospects, amongst other things, all of which hold negative impacts for young people's wellbeing in both the short and longer terms.¹⁷ Risk of re-victimisation is also a very real concern where appropriate interventions are missing.¹⁸ The effects of CSE can extend beyond the individual, with damaging consequences for a family's cohesion, health, social life and economic stability and, depending on the nature and reach of the abuse, potentially destabilising impacts on a community.¹⁹

1.5 CSE as a public health concern

CSE has implications for the health and wellbeing of children and young people, both in terms of the impacts of the abuse itself and in terms of its frequent connections to wider health and wellbeing concerns. As illustrated in the discussions about vulnerability and impact above, these concerns can both predate, and result from, the abuse experienced.

From a statutory perspective, CSE has traditionally been responded to as a child protection and criminal justice concern. Associated intervention thresholds have meant a primarily reactive response, focused on protecting children who are known to have been abused through CSE or identified as at particular risk of the same.²⁰

Whilst the provision of such interventions is critical, equally critical is concurrent investment in a proactive preventative approach that prioritises education and awareness raising, early intervention and targeted preventative work (with both potential perpetrators and victims). To date, this remains vastly underdeveloped,²¹ offering an opportunity for public health to drive forward this critical preventative agenda. Public health also has an important role to play in terms of the issue of recovery and reintegration for those who have been abused through CSE. These individuals require a range of services to meet their needs and enable recovery, as indeed may their families and wider social circles. Research strongly indicates the need for on-going developments within this field, particularly in relation to the provision of long-term

therapeutic support and holistic engagement with associated vulnerabilities and disadvantage.²²

Straddling the preventative and responsive agendas, the application of a holistic public health approach to CSE is much needed and has much to offer. A public health approach could, amongst other things, enhance both individual and population-wide resilience to CSE and associated vulnerabilities. It should protect and improve children and young people's health and wellbeing through both preventative and responsive initiatives. In doing so it could address the inequalities, vulnerabilities and broader social detriments that can impact on health and wellbeing in children and young people which create the context for CSE. It should also address the consequent vulnerabilities and inequalities that can result from it.²³

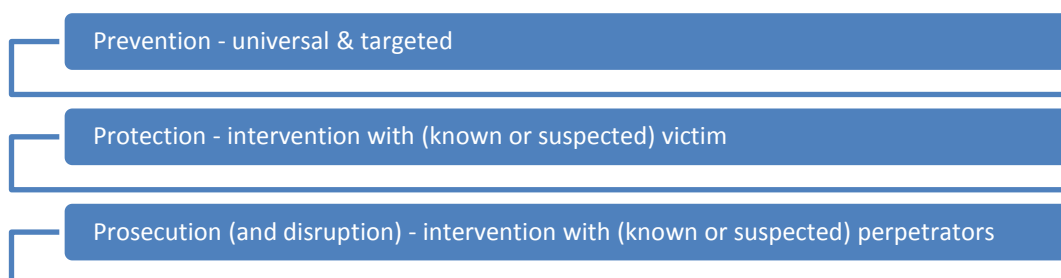
2. An effective response to CSE

The research literature indicates that an effective response to CSE is one that:

- Is collaborative and multi-agency, with clear roles and responsibilities and clear lines of communication and accountability within this;
- Takes learning from the national context but is locally informed and based on an up-to-date understanding of the local profile;
- Is contextual, both in terms of locating CSE within a wider context of risk and harm and moving beyond a case by case response;
- Straddles both the preventative and responsive agendas; and
- Focuses on both victims and perpetrators.²⁴

The latter of these requirements has been variously conceptualised in different contexts, but common to all, and accepted across all professional disciplines, is a focus on three inter-connected elements, often referred to as 'The 3Ps'.²⁵

Diagram 3: The 3Ps (DCSF 09)



These are explored in turn below, through the lens of relevance to a public health response.

2.1 Prevention

The evidence base demonstrates that a lack of awareness and understanding around CSE – on the part of children and young people, parents/carers, professionals and wider society – has contributed to our failure to adequately protect children and young people from this form of abuse.²⁶ The sections that follow highlight the key messages from research, reviews and inspections as to the required elements of an effective preventative strategy around CSE and the degree to which these are currently being implemented. This includes both universal awareness-raising initiatives and supplementary targeted preventative measures where known vulnerabilities or heightened risk are identified.^{xii} Early intervention and post-abuse interventions are considered in the section on protection below.

2.1.1 Work with children and young people

Research demonstrates a need for universal education programmes with children and young people to address their documented lack of/misunderstanding around CSE. It also demonstrates the need to educate around the closely related concepts of consent, healthy and unhealthy relationships, pornography and the unacceptability of (sexual) violence and abuse and an apparent gap between children's and young people's conceptual understanding of sexual harm and the ability to identify this in their own lives.²⁷ The existing body of evidence repeatedly highlights the critical role of Personal, Social, Health and Economic (PSHE) and Relationship and Sex Education (RSE) in addressing these issues.²⁸

Although there is no evidenced blueprint as to the most effective means of communicating messaging around CSE to children and young people, a range of studies highlight the benefit of the following principles of practice:

- Education and awareness raising being seen as an on-going process rather than a discrete deliverable;²⁹
- Educative work commencing in an age-appropriate manner with primary aged children, given the increasingly young age at which children are now being referred for concerns around CSE;^{xiii 30}
- Locating discussions of CSE with reference to wider constructs of gender, power and sexuality and challenging harmful social norms in relation to these;³¹
- Exploring links with related issues such as drug or alcohol misuse or going missing;³²
- Using educative opportunities to minimise likelihood of perpetration as well as victimisation;³³

^{xii} Often respectively referred to as primary and secondary prevention. Tertiary prevention, involving interventions aimed at those already affected by CSE in order to prevent subsequent abuse and revictimisation, is explored in the section below on protection.

^{xiii} CSE services report working with children as young as eight or ten years.

- Adopting a strengths-based approach that considers resilience alongside risk;**Error! Bookmark not defined.**
- Ensuring that messaging is of relevance to, and accessible for, all children and young people, irrespective of their individual biographies;³⁴
- Ensuring children and young people outside of mainstream education also receive appropriate education;³⁵
- Recognising the importance of a safe environment when delivering these messages (and recognising that the school environment, or community environment, may itself be a site of risk);³⁶
- Educating parents/carers and wider communities about the importance of preventative work with children and young people;³⁷
- Ensuring accurate and consistent messaging across different methods, audiences and settings;³⁸
- Exploring the use of resources made by young people for young people;³⁹
- Messages being delivered by ‘credible individuals’ who are confident discussing these issues and gently challenging unhelpful perceptions;⁴⁰ and
- Provision of accessible and appropriate support mechanisms should issues of concern be identified by children and young people, their friends or family, or those working with them.⁴¹

Whilst such educative work is critical, it is only one element of a comprehensive preventative strategy for children and young people. The existing evidence base also highlights the need for supplementary targeted preventative work with groups who are known to be at heightened risk of CSE because of a pre-existing vulnerability. It similarly emphasises the importance of a concurrent focus on enhancing resilience amongst children and young people and strengthening protective structures around them to help mediate risk. As one young male who had experienced CSE observes:

“This doesn’t just happen, it happens because either things just aren’t addressed, people are less able to fend for themselves and they don’t get the help that they need, for whatever reason, and are put into difficult positions and sometimes it DOES take them there and if people were there to help them in the first place then they wouldn’t, then this wouldn’t happen.”⁴²

Engagement in such work also offers the opportunity for early identification of risk and the provision of early intervention work with identified ‘high risk’ cases, as explored in section 2.2 below.

2.1.2 Work with parents/carers

The limited evidence base that exists around parents/carers and CSE indicates a need for greater understanding of the risks of CSE and a greater confidence in supporting their children

and young people around these. This is unsurprising given the lack of educative programmes targeted at this critically important group.⁴³

Research repeatedly highlights the critical role that (non-offending) parents/carers have to play in helping to protect their children from CSE and other forms of harm and abuse.⁴⁴ This is true both in terms of primary prevention (educating about sex and abuse, providing a safe base, enhancing resilience, and ensuring open channels of communication) and in terms of the vital role that parents can play in noticing changes, identifying concerns and seeking support prior to escalation of risk.⁴⁵ This is critical given the low levels of identification and reporting by children and young people themselves. As explored in section 1.3 above, parents/carers also have a critical role to play in supporting early intervention and in the recovery and reintegration of those who have been abused. Principles of practice that can support this include:

- Working in partnership with parents/carers (and other families members as relevant);
- Recognising the value of a strengths-based approach;
- Helping parents/carers to create and maintain open lines of communication with their children and young people;
- The provision of accessible resources that complement those provided to children and young people; and
- The ability to respond flexibly to different needs and circumstances.⁴⁶

2.1.3 Work with professionals

The existing evidence base demonstrates a pattern of missed opportunities to identify CSE amongst professionals tasked with the responsibility to safeguard and promote the welfare of children.⁴⁷ Whilst obviously not true of all professionals, this critique has been evidenced as applicable across the different disciplines and likely has multi-faceted causal factors – both systemic and individually-based - as outlined above. Of particular concern are:

- The presence of victim-blaming and harm-minimising conceptualisations of abuse amongst adolescents;
- Inadequate levels of professional curiosity;
- Insufficient challenge of harmful stereotypes around gender, ethnicity, victimisation and perpetration;
- Difficulties in reconciling practice tensions between confidentiality commitments, clinical needs and the identification and reporting of safeguarding concerns.⁴⁸

Recognising these as areas for redress, the existing evidence base offers some core principles that all professionals working with children and young people should be supported – through training, supervision and continuous professional development - to embed in their practice. This would in turn enhance their protective capacity in relation to CSE and their ability to identify

children and young people who would benefit from early intervention work, as explored in section 2.2 below. These include:

- Clarity as to their safeguarding responsibilities and local reporting routes in relation to this;⁴⁹
- Knowledge of local inter-agency working practices, and clarity around distinct roles and responsibilities and information sharing within this;⁵⁰
- Recognition that all under 18s are entitled to protection and support from the state and understanding that our statutory duty to safeguard does not depend on a young person's desire to be safeguarded;⁵¹
- Recognition of the need to proactively assess risk and exercise 'professional curiosity', together with the provision of skills of how to do this in practice;⁵²
- Moving beyond stereotypes to recognise the different forms that CSE can take, the different people who can perpetrate this and the fact that any child or young person can be affected by this;⁵³
- Recognising the potential overlap between 'victim' and 'perpetrator' within peer on peer abuse;⁵⁴
- Understanding of the interconnected nature of vulnerability, resilience and risk (as outlined in Diagram 2);⁵⁵
- Recognition of the complex ways in which a young person's capacity to make choices and their understanding of consent can be abused;⁵⁶
- Understanding of the impact of trauma on behaviour and presentation;⁵⁷
- Understanding of the many different forms that 'disclosure' can take, and an understanding of disclosure as a process rather than a discrete event;⁵⁸
- Recognition of the power of professional reactions to facilitate or close down access to support and protection;⁵⁹
- Practical skills in facilitating conversations with children and young people and creating safe spaces for disclosure or identification of risk;⁶⁰
- Ensuring access to support is not dependent on a disclosure;⁶¹ and
- Setting a positive example through a zero tolerance approach to any form of sexual harassment, bullying or abuse.⁶²

The evidence base also highlights the difficulty of identifying vulnerability in the absence of any presentation of victimisation, and the critical need to recognise the impact that working on these issues can have on professionals. As such, it emphasises the need for appropriate support and supervision of professionals, if children and young people are to be consistently and adequately protected from CSE.⁶³

2.1.4 Work with wider communities

In terms of identification and reporting of risk, research is increasingly illustrating the critical preventative role that can be played by individuals outside of the child or young person's immediate circles of influence.⁶⁴ This includes, for example, individuals working in the service industries or individuals living near party houses or other hotspots for abuse^{xiv} such as takeaways, shopping centres, parks and red light districts.⁶⁵ Recent years have seen an increased focus on community awareness-raising but these efforts vary considerably and often lack strategic co-ordination.⁶⁶

Lack of awareness and misconceptions about CSE amongst the general public can leave children and young people at considerable risk. It can also result in those who experience abuse being blamed.⁶⁷ So too can a culture of denial, resulting from community taboos or a fear of damaging community reputation.⁶⁸

Though still in its infancy,^{xv} research into community awareness-raising around CSE suggests that the following considerations may begin to construct a helpful scaffolding for such initiatives:⁶⁹

- Agencies working in partnership with community members and groups to identify joint solutions to the problem;
- Recognising that communities are not homogeneous entities and ensuring that 'community representatives' reflect the full range of interests within a community;
- Developing a range of resources and providing a range of engagement options to meet the different needs of different members of the community;
- Ensuring local relevance, rather than just 'importing' programmes from elsewhere and making sure community messaging is relevant to local manifestations of the problem; and
- Providing appropriate and accessible sources of further support and contact.

In addition to this preventative work, the evidence base illustrates a need for preventative efforts both locally and nationally to be directed towards realising fundamental social change around how CSE is viewed and promoting a zero tolerance approach to this issue. Within this, particular attention should be paid to unhelpful stereotyping around victimisation and perpetration, harmful messaging around blame and responsibility, and an apparent

^{xiv} It is important to note that CSE 'hotspots' are dynamic and constantly changing. The literature on CSE, for example, is increasingly recognising schools as CSE 'hotspots'.

^{xv} Whilst many local CSE campaigns have been undertaken throughout the UK, there has been very limited research into the effectiveness or impact of these campaigns.

acceptability of levels of sexual violence in adolescence that would not be tolerated with either younger children or older adults.⁷⁰

2.2 Protection

The second core element of a comprehensive response to CSE identified within the existing body of literature is that of protection, incorporating both targeted early intervention work with identified 'high risk' cases and recovery and reintegration work for those who have been exposed to abuse. This work is, of course, also preventative in nature in terms of minimising risk and preventing further abuse in the future, but is distinct from the primary preventative efforts outlined above.

The evidence base demonstrates the importance of early identification of risk and the implementation of early intervention measures to manage this risk, enhance protective structures and reconstruct safety.⁷¹ This should include targeted protective work with:

- Individuals who are known to have significant or multiple vulnerabilities^{xvi} that would heighten their risk of CSE (a previously sexually abused child whose peers or siblings are being sexually exploited, for example); and
- Those who are exhibiting indicators of potential exploitation or grooming (going missing, unexplained money and STI's for example).

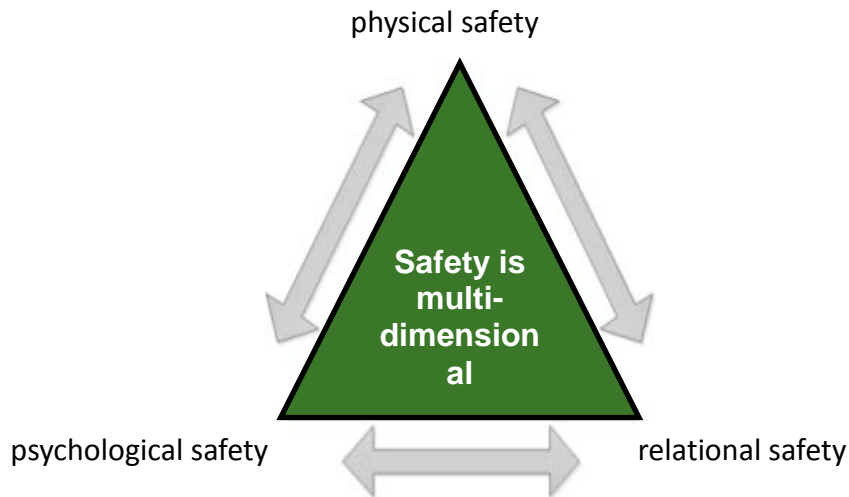
Although some instances of CSE can escalate quite quickly and without any obvious indicators, the evidence base demonstrates that in many other cases there is a process of grooming during which these indicators of risk may emerge. This offers a chance for targeted diversionary protective work, if these are appropriately identified and responded to. In addition to these diversionary protective efforts, the evidence base also demonstrates a need for recovery and reintegration work with those who have already been abused through CSE.⁷²

As previously highlighted, research illustrates that an experience of CSE (and indeed exposure to direct risk of this) can have a profound impact on a child's or young person's health and wellbeing, both in the short and longer-term. It is critical that appropriate environments are created in which the impact of the abuse can be identified and addressed, and the young person's sense of safety, health and wellbeing reconstructed.⁷³ As illustrated in Diagram 4 below, this entails restoration of psychological and relational safety alongside the more obvious concern of physical safety. Unsurprisingly, the evidence base demonstrates that this requires long term investment and a commitment to journey with the young person over what is unlikely to be a straightforward linear recovery process. For some, the need for support may continue

^{xvi} See a list of vulnerabilities on page 3.

into adulthood, an issue that research identifies as particularly problematic given current difficulties in transitioning between child and adult services.⁷⁴

Diagram 4: Constructs of safety for young people affected by CSE (Shuker 2013b)



There has been increasing attention to potential ways of working with children and young people affected by CSE in recent years. The emerging evidence base suggests that considerations, such as those outlined below, may contribute to a more effective response:

- Adopting a child-centred approach that adapts according to the needs, resources and capabilities of the individual child;
- Adopting a strengths-based approach that builds resilience and protective structures alongside minimising sources of risk;
- Working with a young person to help her/him identify the abusive nature of their situation rather than imposing professional interpretations upon them;
- Exploring what factors contributed to vulnerability and risk and co-producing potential solutions to these with young people;
- Meaningfully involving young people in decisions about their care wherever possible; and
- Seeing them as 'more than a victim of CSE'.⁷⁵

A message coming from the recent evidence base is that focussing only on individuals affected by CSE is only one part of a comprehensive protective response. Recent studies have highlighted the benefits of involving parents/carers in recovery and reintegration work, so long as the family is not the source of any risk.⁷⁶ Other developing programmes of work are indicating potential benefits from intervening in young people's peer networks or school

environments^{xvii} where patterns of risk emerge within these, in terms of both protecting that individual and others within the environment.⁷⁷

2.3 Prosecution

Although considered under the title of ‘prosecution’, both the disruption and prosecution of offenders can contribute to the protection of children and young people and to the prevention of further abuse. Whilst this may hold less direct relevance to public health than the preventative and protective agendas outlined above, it is a critical element of an effective response to CSE that cannot be delivered by criminal justice colleagues in isolation from other disciplines’ contributions. The evidence base suggests that public health can contribute to this in a number of different ways. Changing public attitudes around CSE, for example, could contribute to a reduction in incidence and/or higher rates of reporting and identification. Public health also has an important role to play in considering the needs of children and young people who engage in criminal justice processes as victims or witnesses.

Research has repeatedly demonstrated the traumatic nature of this process and the potential negative impacts that can ensue. There is an evidenced need for targeted support – including appropriate and accessible pre and post-trial therapy - if children and young people are not to experience longer-term detriments from their experiences of these processes.⁷⁸

The evidence base also indicates that professionals working across a range of disciplines, including health, social care and education, have a critical role to play in gathering intelligence, and sharing this with the police to support disruption and prosecution of suspects.⁷⁹

This is not, of course, without complications given the aforementioned tensions between confidentiality, practice considerations and safeguarding concerns. The literature recognises a need for greater clarity and confidence around information sharing and subsequent use of data by others, before this potential contribution to disruption and prosecution can be effectively realised.⁸⁰

3. The role of public health in tackling CSE

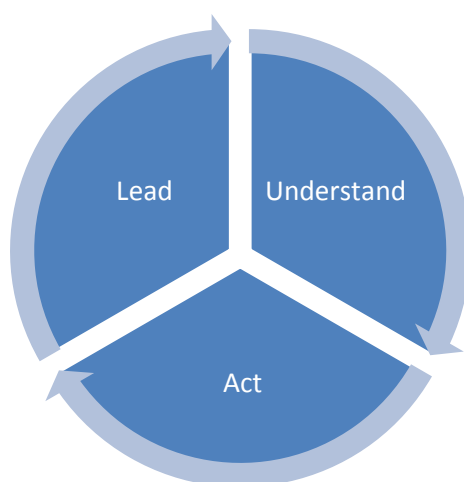
Public health can proactively contribute to a holistic and multi-agency response to CSE through the work of local authority Directors of Public Health and that of health and wellbeing board partners.

^{xvii} View the short film "Safeguarding teenagers from sexual exploitation and violence outside the home" <https://www.beds.ac.uk/ic/films>.

In 2014 the Department of Health published the Health Working Group report on Child Sexual Exploitation in which PHE committed to work with Directors of Public Health to support public health actions.⁸¹

This section of the report considers some of the ways public health can respond to CSE in local areas through an approach which provides leadership, is driven by a tactical, evidence-based strategy and contributes operationally to local responses to CSE, as depicted in Diagram 5 below.

Diagram 5: Ways in which public health can contribute to an enhanced response to CSE



3.1 Lead

Historically, local responses to CSE have been led by the police and/or children's social care.⁸² In their role as the statutory chief public health officers for their local authority and principal advisors on all health matters to elected members and officers, Directors of Public Health now have the opportunity to strengthen local responses to CSE.

As highlighted previously, there is a particularly critical need for this leadership within the preventative domain, and in ensuring appropriate recovery and reintegration for victims. This can be achieved both through improvements to CSE frameworks and through more general improvements to the range of health issues and services that intersect with it. These include school nursing services, public mental health services, alcohol and drug misuse services, health visiting, sexual health and reproductive services, and public health aspects of the promotion of community safety, violence prevention and response.⁸³ This includes supporting schools and colleges to deliver comprehensive sex and relationships education.

Joint Health and Wellbeing Strategies (JHWSs), in particular, offer an opportunity to develop a holistic strategic response to CSE with clear outcomes that will, in turn, inform local

commissioning of services for victims and perpetrators.⁸⁴ In developing JHWSs it would be helpful to consider factors such as:

- How the planned CSE response complements existing CSE strategies and those governing responses to associated issues such as substance misuse, gang-association, disability, going missing; community safety, planning and licensing;⁸⁵
- How to address existing confusion around professional roles and responsibilities, and the lines of communication and accountability between these – both within and across disciplines;⁸⁶
- How different disciplines can contribute to the effective realisation of desired outcomes;
- How to effectively utilise the expertise and knowledge of the voluntary sector within this;⁸⁷ and
- Potential barriers to implementation and associated solutions.⁸⁸

3.2 Understand

The evidence base indicates that different local authority areas may have different profiles of CSE,⁸⁹ highlighting the consequent necessity of CSE strategies and commissioning arrangements being based on an accurate and comprehensive mapping of the local manifestation of the issue.⁹⁰

The inclusion of CSE in Joint Strategic Needs Assessments (JSNAs), as is currently the case in some local authority areas,⁹¹ offers an effective mechanism for facilitating this. Key points to consider in relation to this include:

- The contribution of both qualitative and quantitative data within this;
- The fact that counts of known CSE cases are always likely to be an under-estimation of the problem given widely documented under-reporting and under-identification of the issue;
- Variation in data categorisation and the use of different definitional boundaries both within and between different local authorities and professional disciplines;⁹²
- A likely bias within CSE counts given variable levels of identification and reporting across different groups of children and young people (with young females in residential care likely to be included, for example, and young BME males unlikely to be so);
- The potential for CSE to be identified and recorded as another form of abuse, or not appear in statistics if other issues are recording as the primary presenting concern;⁹³
- The need to consider links between CSE datasets and those relating to associated vulnerabilities such as going missing, looked-after children, substance misuse, educational disengagement, domestic abuse or mental health concerns;⁹⁴

- Relatedly, the need to triangulate counts from multiple data sources given the range of services (both statutory and voluntary; including, for example, drug and alcohol services, CAMHS, sexual health services or housing services) likely to be working with young people affected by CSE;⁹⁵ and
- Resistance to information sharing and its impact on both intelligence gathering and identification of harm, and the sharing of data between agencies.⁹⁶

The requirement to involve other partners and community representatives in the development of JHWSs⁹⁷ offers an additional opportunity to ensure that Health and Wellbeing Boards are accurately understanding the issues to be tackled and the needs of those affected by them. Boards should consider how to involve the voluntary and community sector, the local community, service users and their families in the local strategy development process. This involvement should be continuous throughout the JHWS process, with appropriate capacity and confidence building preceding this to make engagement a meaningful process.⁹⁸

Specifically considering the engagement of children and young people within these processes, the existing evidence base demonstrates the need to move beyond ‘tokenistic’ and inconsistent engagement. Whilst meaningful engagement of children and young people is not without its challenges, research repeatedly demonstrates the unique and valuable contribution they can make to solution-identification in this field.⁹⁹ It also demonstrates a frequent gap between how children and young people view their experiences and support needs and how these are conceptualised by professionals; a further justification for the necessity of their contribution.¹⁰⁰

3.3 Act

Current commissioning arrangements offer an opportunity to develop a needs-informed locally-responsive service landscape that:

- Is based on, and informed by JSNAs and JHWSs, leading to locally led initiatives that meet those outcomes and address local need;
- Is directly informed by the voices of those affected by these issues, and those that support them;
- Is integrated in nature, considering how the range of services that fall under the Director of Public Health’s commissioning responsibilities can complement one another to tackle CSE. This includes school health services, public mental health services, alcohol and drug misuse services, health visiting, sexual health and reproductive services, and public health aspects of the promotion of community safety, violence prevention and response.¹⁰¹ It is also important that the contribution of these services is considered with reference to that of wider services such as education, social care and criminal justice;
- Delivers preventive and early intervention initiatives that concurrently consider risk and resilience and empower young people to identify potentially abusive situations;
- Prioritises outreach to marginalised and disenfranchised groups such as looked after children, children with disabilities or those from BME backgrounds;

- Prioritises early response, recovery and reintegration and supports a young person throughout their care pathway, including the critical transition to adult services;
- Considers the contextual environment of risk as well as individual risk and, by working with community safety partnerships, addresses harmful public spaces as well as around harmful individuals; and
- Can ensure minimum standards of training around the complexities of CSE and the challenges of working in this field, thereby minimising risk of harm to children and young people accessing services.

In addition to the mapping, strategic and commissioning roles outlined above, Directors of Public Health can also support the protection of children and young people, and the disruption and prosecution of perpetrators, through their role in licencing. Directors should consider the ways in which in their position as 'responsible authorities' under the 2003 Licencing Act enables them to promote public health interests relating to CSE. They should also consider ways in which they can work with local authority partners^{xviii} to effectively use local licencing laws to disrupt CSE through, for example, use of new powers introduced under the Antisocial Behaviour Crime and Policing Act 2014 to close down premises believed to be used for sexual offending against children.

^{xviii} Including police, fire service, health and safety, environmental health, child protection services, trading standards, planning, the licensing authority.

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