East Sussex

Child Sexual Exploitation

Multi-Agency Operational Instructions and Practice Guidance

CONTENTS

1. Introduction

1.1. This practice guidance has been developed to provide day to day practical guidance for practitioners in East Sussex and complements the Pan Sussex Safeguarding Procedures.

http://sussexchildprotection.procedures.org.uk/tkyyh/children-in-specific-circumstances/sexual-exploitation.

1.2. Research suggests that a high number of children and young people experience sexual abuse before the age of 18 with studies nationally estimating that it affects 16% of children under 16, 21% of girls 11% of boys . Between 2012/2013, 35% of all sexual crimes and 39% of rapes were against children. While the vast majority of sexual abuse is perpetrated by people known to the victim, most often family members, there has also been growing recognition about the numbers of young people being sexually exploited outside of the family. A UK-wide study found that between 2009/2010 over 3000 young people were accessing services for sexual exploitation while in 2011 CEOP estimated there to be 6500 children in the UK at risk of sexual exploitation. The significant number of exploited young people who reported previous intra-familial sexual abuse led to the recent inquiry by the Office of the Children's Commissioner, specifically looking at the professional response to child sexual abuse and services for children.

1.3. **Child sexual abuse (CSA)** is described in Working Together 2015 as abuse that

'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. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.'

1.4. The current definition of child sexual exploitation (CSE) was published in the 2009 guidance "Safeguarding Children and Young People from Sexual Exploitation"3.

'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'.

1.5. Over time, a number of alternative definitions have been developed by voluntary organisations and devolved administrations and agencies. This has led to agencies using different definitions or using the terms 'child sexual abuse' and 'child sexual exploitation' interchangeably, creating inconsistencies in risk assessment and data collection. This has led to some confusion and additional challenge for practitioners working with children and families. The "What to do if you're worried a child is being abused"4 (WTDI) advice to practitioners published in March 2015, gave a non-statutory definition which was welcomed for being simpler and more concise.

'Child sexual exploitation is a form of sexual abuse where children are sexually exploited for money, power or status. It can involve violent, humiliating and degrading sexual assaults. In some cases, young people are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection or status. Consent cannot be given, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation doesn't always involve physical contact and can happen online. A significant number of children who are victims of sexual exploitation go missing from home, care and education at some point.'

1.6. The DFE are currently consulting about a revised definition of CSE.

'Child sexual exploitation is a form of child abuse. It occurs where anyone under the age of 18 is persuaded, coerced or forced into sexual activity in exchange for, amongst other things, money, drugs/alcohol, gifts, affection or status. Consent is irrelevant, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation does not always involve physical contact and may occur online.'

1.7. It is accepted that three broad types of CSE are occurring in Sussex:

Type 1: CSE involves the forming of inappropriate relationships between offender and victim, and is the most common form of CSE recorded in Sussex. It usually involves one perpetrator

- In 2015, 55% of intelligence logs refer to this type
- This relationship primarily involves a female aged around 13 to 17 years, and a male in his late teens or early twenties.
- There is not necessarily a clear imbalance of power but it should be noted that as the age gap widens, the use of coercion (e.g. money / alcohol) becomes more prevalent.
- The use of social media is reported regularly (39%). This does not include the use of a mobile phone for texting and calls and so the true level of communication using technology is judged to be much greater.
- There is intelligence suggesting the online process is the foundation for an escalation in activity between victims towards interaction with multiple offenders, and into the offline world

Type 2 CSE is characterised by increased offline contact with a victim, with *multiple offenders* recorded

- In 2015, 39% of intelligence logs refer to this type
- Has been identified within Sussex and often a result of development of Type 1 intelligence.
- The perpetrator befriends and grooms a young person into a 'relationship' and then coerces or forces them to have sex with friends or associates.
- Sometimes this can be associated with gang activity.
- A group of male drug dealers who operate in the Hastings area are reported to use teenage girls to aid them in the movement and storage of their drugs and money. This is seen by the offending group as a way to reduce the personal risk of their activities. Intelligence suggests sexual activity has occurred in the form of relationship style exploitation (type 2), and offending where girls are passed around groups of men with evidence of coercion and drug taking (type 3)..

Type 3 CSE is characterised by *organised prostitution and trafficking*

- Has been identified within Sussex. Requires development of Type 2 intelligence (6% of intelligence logs refer to this type)
- There is highly likely to be payment, use of drugs and alcohol, coercion through threats and violence.
- Young people (often connected) are passed through networks, possibly over geographical distances, between towns and cities where they may be forced /coerced into sexual activity with multiple perpetrators. Young people may be used as agents to recruit others into the network.
- There is a higher level of organisation occurring between offenders when compared to type 2.

1.8. A significant number of children who are vulnerable to or experiencing sexual exploitation may have previously experienced child sexual abuse and may or may not have talked to anyone about this experience. It is therefore important that professionals working with children who appear vulnerable to CSE remain professionally curious about the child's experience to date and the

possibility that they may have experienced child sexual abuse and that professionals working with children where there are concerns that the child may have been sexually abused either within a familial or non - familial context understand the assessment and support arrangements and are aware of the increased vulnerability of the child to CSE

1.9. Whilst the victims may often be older children and young people it is important that professionals recognise that CSE is **child abuse** and in order to reinforce this in East Sussex we deliberately refer to all 'children and young people' as '**children'** throughout this guidance.

2. Pathways for advice and referral

MASH consultation

2.1. If a professional is concerned that a child may be at risk of CSE they should contact Children's Services via SPOA and ask to speak to a **MASH** social worker who will also be able to consult the MASH police officer. Prior to speaking to the MASH social worker they should consider the aide memoir below to help to organise their thoughts about their concerns

2.1.1. When seeking advice professionals should consider **what makes a child vulnerable to sexual exploitation?** This can include, but is not limited to, one or a number of the following

- They go missing regularly, from home, care or school
- There is history of domestic, sexual, physical or emotional abuse or neglect in the family
- They misuse drugs or alcohol or have parents who misuse drugs or alcohol
- They are young carers within the family
- They're living in poverty and feel socially excluded or isolated
- They've experienced recent bereavement or loss
- They have unsupervised access to social networking sites or chat rooms
- They're experiencing mental ill health
- They have social or learning difficulties
- They have low self-esteem or self-confidence
- They're unsure about their sexual orientation or gender identity and feel unable to confide in anyone
- They have been or are currently excluded from education
- They are involved with gangs
- They have friends, or go to school with, other children who are being sexually exploited
- They are being bullied
- They have older friends
- They are homeless.

2.1.2. Children from all types of backgrounds may be vulnerable to CSE. Children from loving and secure homes can also be victims of sexual exploitation. Children perceived to be street wise are not. They are often vulnerable with troubled backgrounds and find themselves in situations where they are at risk of exploitation. When considering seeking advice professionals should consider **What are the warning signs that a child is being sexually exploited?** These can include, but are not limited to, one or a number of the following:

- They're acting secretively, having mood swings or changes in temperament or emotional wellbeing

- They change their appearance dramatically maybe dressing in inappropriate clothes or sudden weight loss
- They become involved in petty crime such as shoplifting or stealing
- They're absent or truant from school or show a lack of interest or sudden poor performance
- They have unexplained gifts or new possessions such as mobile phones or jewellery
- They become suddenly hostile towards or estranged from their family or friends
- They go missing for periods of time or regularly return home late or are found somewhere they've no links to
- They have more than one or share their boyfriend or girlfriend
- They're seen getting into or out of vehicles with unknown adults
- They become sexually active, pregnant or seeking an abortion or treatment for sexual diseases
- They're getting phone calls and/or text messages from unknown adults
- They're using drugs and alcohol (often as a means of being controlled by their abusers)
- They have unexplained injuries consistent with sexual or physical assault
- They self-harm or are having suicidal thoughts or tendencies
- They're behaving inappropriately, being over-familiar with strangers, sending sexual images via the internet or mobile phones

MACSE Referral

2.2. Following consultation with the MASH team you may be asked to complete a MACSE referral form which is to be completed to refer victims/those considered to be at risk of CSE into the Multi Agency MACSE monthly meeting. The MACSE referral form is now available as part of the Children's Services LCS recording system and can be completed at any point of the assessment and care planning process.

2.3. Request for a child to be considered at the MACSE Bronze meeting should be made via the MASH in box for the East or West of the county dependent on where the child is living.

Police Intel Reporting

2.4. If a professional has intelligence or information that is not crime nor a safeguarding issue but could be an indicator of a perpetrator or hotspot for CSE or other information that supports CSE concerns they should complete the form below which has been developed to assist us in improving how we collate and assess intelligence relating to CSE. This form is NOT to be used to report matters of crime or immediate concerns regarding the safety and welfare of children/ young people, which should be reported via 101/999, whichever is most appropriate. The intel form below should be sent to

c22_eastdiv@sussex.pnn.police.uk and copied to the East or West MASH in box.

Reporting Child Sexual Exploitation Ir

Missing from Home or care

2.5. If a child goes Missing from Home or Care, the missing child should be reported to the police. Once a child is reported missing to the police a notification is sent to Missing People, the voluntary sector service who are commissioned to support children who go missing and their families and also undertake the Return Home Interviews where they will also consider the child's vulnerability to CSE

The full Missing People Operational Guidance included in the Pan Sussex Safeguarding Procedures and can be found here:

Missing Children Operational Instructior

Sexual Assault Referral Centre (SARC)

2.6. The SARC provides a single point of contact, by way of a telephone service that is contactable between 9am and 5pm, 7 days a week, 365/6 days a year. Operation guidance and referral pathway can be found through the link below

Care pathway - Child Sexual Abuse and use

SWIFT Consultation and Advice

2.7. SWIFT offer group supervision on a 6 weekly basis to two groups of Early Help workers, those who are working with children and young people who have been sexually abused and those who are assessing and intervening with young people with sexually harmful behaviour. This includes case discussion, assessment and intervention planning and resource sharing. SWIFT also offer consultation to social workers, Early Help workers and other professionals on individual cases.

3. Assessing and Managing Risk

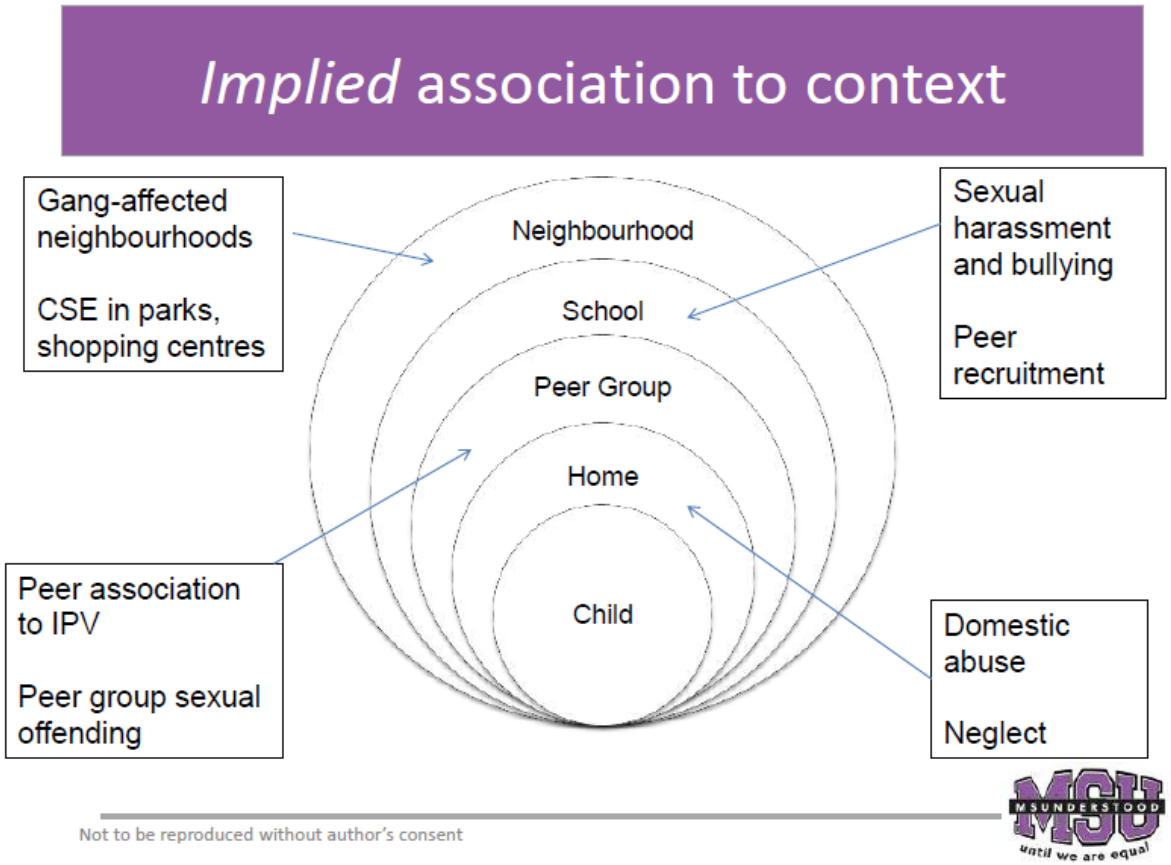
3.1. The original fuller definition of CSE is useful when assessing risk which is multi-faceted. When considering risk we acknowledge that sexual exploitation of children under 18 involves exploitative situations, contexts and relationships where children (or a third person or persons) receive 'something' (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 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.

3.2. The MACSE risk assessment and referral form includes a range of trigger questions that are considered by the multi-agency group (MACSE) in order to agree a risk rating and inform the development of a risk management plan. The format facilitates a consistent approach. As with any assessment it is important to record the evidence to support the risk factors but the individual contextual information and analysis in the supporting explanation section is important in informing the plan to manage the risk and reduce the vulnerability.

3.3. The diagram below from the University of Bedfordshire illustrates the context for assessing risk associated with vulnerability to CSE. It is important to consider the risks to the child within the context of their home, peer group, school and neighbourhood or community setting.

3.4. For example, whilst it is generally accepted that non- school attendance is considered a risk factor that may increase the vulnerability of a child, it is also important to consider the child's experience in the school setting – there may be peer group sexual offending or peer recruitment.

3.5. Risk management often considers the physical safety of a child in relation to their placement or community. However, it is not only important to consider physical safety but also relational safety. Moving a child to a different area may disrupt safe relationships with trusted adults or peers or may increase the risks adding in a pull back to home or neighbourhood.



3.6. It is important, therefore, to consider *where* the young people may be at risk of exploitation and addressing the environmental risk factors in addition to individual vulnerability, in order to decrease risk.

3.7. The majority of exploited children are not living in care but at home when the exploitation starts and while some may have family members who are involved in exploitation themselves, others will have parents or family members who want to, or could, help. The YouGov report "*Are parents in the picture? Professional and parental perspectives of child sexual exploitation*" (Autumn 2013) highlighted that parents are often side-lined or ignored as "forgotten safeguarders" or deemed as "failed carers". It is considered important, where safe and appropriate to do so, to work with parents and carers when planning to meet the needs of young people who experience both running away and sexual exploitation.

3.8. Best practice guidance has been written by Parents Against Child Sexual Exploitation (PACE). They describe a Relational Safeguarding Model (2014) in which it is recommended that professionals work in partnership with parents, facilitating and supporting them, in order to maximise the ability and capacity of statutory agencies' and families' to safeguard a child at risk of/being sexually exploited. The relational safeguarding model focuses on:

- Maximising the capacity of parents and carers to safeguard their children and contribute to the prevention of abuse and the disruption and conviction of perpetrators.
- Early intervention and prevention.
- Enabling family involvement in safeguarding processes around the child, including decision making.
- Ensuring the safety and wellbeing of the family in recognition of the impact of CSE.
- Balancing the child's identity as both an individual and as part of a family unit.

3.9. Multi-agency risk assessment and risk management in relation to individual and groups of children is managed through a system of multi-agency meetings and the MASH team has a vital role to play in joining up information shared at individual strategy meetings to identify possible patterns of victims and perpetrators and also support the MACSE Bronze group.

3.10. **Strategy Discussions** play a significant part in ensuring a shared understanding of risk and risk management for individual children. It is also recognised that it is important to join up information shared at individual strategy discussion in order to understand and manage the risks for other children who may be vulnerable to CSE.

3.10.1. Individual strategy discussions are held in accordance with Working Together 2015. All requests for strategy discussions are made via the Police DS based in the MASH.

3.10.2. Where a child is not currently open to a social worker and information is received either via the police or consultation with the MASH social workers, the MASH DS and the MASH practice manager will take responsibility for convening the strategy discussion.

3.10.3. Where a child is open to a social worker, and new information is received or an incident occurs that triggers the need for a strategy discussion to consider CSE risks, the practice manager for the child will consult the MASH DS and the MASH practice manager to convene a strategy discussion. In most cases the strategy discussion will be chaired by the MASH PM and the attendance of the child's PM will be at their discretion. The rationale behind the MASH PM chairing CSE strategy discussion is their unique position within the MASH and their link with the MACSE meetings which enables them to identify potential links between victims and perpetrators and apply consistency of practice response to children at risk of CSE. The MASH practice managers also manage the MASH social workers who are CSE practice champions and who work closely with police colleagues to undertake ABEi work.

3.10.4. The discussion about the need for, and timing of, a strategy discussion must consider the forensic window and whether immediate action is needed. The Child Sexual Abuse and SARC pathway outlined in section 2 must be followed:

Care pathway - Child Sexual Abuse and use

3.10.5. The strategy discussion will follow the standard strategy discussion agenda and the record must clearly record that the meeting is considering an allegation of sexual abuse, this is because any form of CSE is sexual abuse.

3.10.6. Where Strategy Discussions are considering multiple children either as victim or alleged perpetrators a **Scoping Meeting** should be convened to ensure all such children are identified and fully considered within the safeguarding and investigation plan. The Scoping Meeting needs to decide whether a Complex Abuse investigation is commenced. This needs to have direct input from a Senior Child Protection Manager in Children's Social Care (or their nominee), together with Police Detective Inspector (or their nominee) and any other agency manager whose involvement is significant. There are separate procedures here that must be followed governing the criteria for such a complex abuse investigation:

http://sussexchildprotection.procedures.org.uk/tklp/children-in-specific-circumstances/complex-organised-and-multiple-abuse#s212

3.10.7. Wherever possible **the strategy discussion should identify who the child identifies as a trusted adult** and which professional has the most trusted relationship with the child as this will inform ongoing roles and responsibilities within the child's plan to reduce vulnerability.

3.10.8. Strategy discussions should be clear about both welfare decisions and criminal investigation decisions and actions and **review strategy discussions should be planned to ensure updates in relation to criminal investigations are shared and the impact on welfare decisions considered.**

3.10.9. Information shared at strategy meetings and scoping meetings will be assessed by the attending police officer and where appropriate an **intelligence report submitted**. The MASH Practice Manager will ensure that a full copy of the Strategy Discussion is made available at the MACSE Bronze meeting relevant to that child..

3.11. **The MACSE Bronze Meeting** is the mechanism to facilitate multi-agency operational senior management oversight of risk management for individual children and groups of children identified as being vulnerable to CSE.

3.11.1. The purpose of the meeting is:

- To identify and track children, both at home and in care, who are frequently absent and missing

- To identify and track children, both at home and in care, who are risk assessed using the MACSE referral and risk assessment tool as Amber or Red rating

- To share up to date information across all agencies of high risk children who go missing and are at risk of CSE in order to agree a shared understanding of risk and plan to reduce the vulnerability to CSE.

- To keep the level of risk under review, ensure actions to reduce risk have been implemented by nominated and named agencies and to escalate actions where needed

- To consider links between individual and groups of children who go missing and/or are vulnerable to CSE in order to understand patterns or trends, proactively manage risk and take action to disrupt exploitation. This analysis should consider potential wider links between CSE, gangs, organised crime, drug related activity and community safety.

3.11.2. The membership of the group comprises:

- DI - SIU - co chair
- DS Missing
- Police MISPER co-ordinators
- MASH OM - co chair
- LAC OM
- MASH PM
- Missing People senior co-ordinator
- Missing Education manager
- YOT lead manager
- YOT police
- U19SMS senior practitioner
- Health CSE –co-ordinator
- YES service co-ordinator

3.11.3. The group meets monthly on the East and West of County and reports to CSE Silver Group

3.11.4. The MACSE Bronze meetings are supported and administered by the MASH teams. All MACSE referrals should be made to the MASH in box and the MASH Practice Manager and DS for the MISPER team will organise the agenda for each meeting including new referrals and updates.

3.11.5. Social worker and/or PM will be booked in slots to present the case information (along with child's trusted adult if this is someone different). To support evidence based decision making, in addition to the MACSE referral and risk assessment record, the social worker should bring the child's plan and any recent strategy discussion records with them to the meeting.

3.11.6. For cases already known to the MACSE meeting, the social worker should update the MACSE referral form and risk assessment, prior to the meeting update and submit to MASH for circulation in advance of the meeting.

3.11.7. The MACSE meetings follow a standard agenda:

a. Missing children
b. New CSE referrals
c. Review of current red
d. Review of current amber
e. Green - it is the social worker's responsibility to review the risk assessment and role of the group is to agree recommendation for escalation; retain or remove
f. Update on wider operations and consideration of strategic response needed to respond to hotspots or links with wider issues such as gangs, organised crime, drug related activity and community safety.

3.11.8. The discussion about each child will confirm who is the child's trusted adult; share the up to date information on the MACSE referral and risk assessment record; consider any missing or additional information (for example intel; information from strategy discussions; links to other children; review the actions agreed as part of the child's plan to manage the risk and reduce vulnerability have been undertaken and agree further action with clear responsibilities and timescales; agree the current risk score and quality assure whether that accurately reflects the understood level of risk for the child;

3.11.9. The MACSE referral risk assessment record is the primary document for recording the shared understanding of current risk and actions to be taken to mitigate this risk should be captured against the relevant indicators on the record and should be consistently reflected in the child's plan. This document should be updated in the meeting and then updated on LCS and shared and uploaded onto the Police system within 24 hours of the meeting.

3.11.10. The MACSE meeting considers ALL children who meet the criteria and are living in East Sussex including LAC children placed in East Sussex by Other Local Authorities (OLA). For OLA children, MASH will nominate a MASH social worker to act as link person between the OLA and East Sussex. The MASH worker will ask the OLA social worker to complete the MACSE referral form and together will complete the risk assessment. The MASH social worker will share the updated MACSE record with the OLA and where the child is assessed as MACSE RED the record will also be sent to the Head of Safeguarding for the placing OLA and to the Head of Locality Social Work in order to share decision making about whether the child can be effectively safeguarded in East Sussex

4. The Child's Plan

4.1. Any child who is referred to the MACSE Bronze group must have an objective in their child's plan that specifically focuses on reducing their vulnerability to CSE. This is needed irrespective of their legal status so needs to be explicit in CiN, Child Protection, LAC or care -leaver pathway plans.

4.2. This section of the child's plan should identify who has been identified as the child's trusted adult and if the child has been unable to identify someone to trust then the social worker and, if the child has missing episodes, the Missing People worker should work with the child to help them to identify an adult they can trust and talk to. It is recognised that some children may prefer to build trust and talk to someone other than a social worker or professional from a statutory agency.

4.3. This section of the child's plan should be clear about who is doing what and when to help to reduce the vulnerabilities to CSE and the effectiveness of these actions should be reviewed by the MACSE Bronze group. These actions should include details of interventions such as police activity to disrupt exploitation such as use of Child Abduction Warning Notices.

4.4. Plans should also include explicit detail about the trigger for when the child should be reported missing e.g. it may be appropriate to report a child missing a soon as they leave placement without permission or within 10 minutes of them failing to return on time or make contact with a carer as agreed. This is particularly important for older children where it would be usual for a teenager to push boundaries about staying out but there is specific concern about factors that may be pulling to child into exploitation.

5. Understanding barriers for children vulnerable to or experiencing CSE

5.1. It is important that all professionals working with children have an understanding of the **impact of substance misuse** and other factors that impact on a young person's capacity to consent and informing risk assessment and planning

5.1.1. The impact of substance misuse in respect of any individual Child's vulnerability to CSE needs to be considered and understood in a broad context looking not only at the illicit substances a child may be using but also giving consideration to the use of prescribed medication such as Diazepam (Valium) or Ketamine.

5.1.2. In respect of risk assessment and safety planning particular reference and consideration needs to be given to the context of the supply of the substances and the motivations behind this.

5.1.3. Professionals need to remember that <u>all</u> illicit drugs are illegal and no child Under 18 is able to buy alcohol or purchase Novel Psychoactive Substances. Therefore the assumption should be made that at some point behind a child's use of substances an adult, either knowingly or unknowingly has contributed to a child's access and use.

5.1.4. Novel Psychoactive Substances are often accessed via on-line websites. Professionals in these cases should not only consider the purchase of the substances but also consider in risk assessment the potential for the child to become a victim of CSE via on-line grooming or coercion if they purchase Novel Psychoactive Substances in this way.

5.1.5. The development of a child's brain also needs to be considered in relation to the understanding of how the use of substances may have a more significant impact on a child and young person. This has the potential to increase their vulnerabilities to CSE and make them far more susceptible to other substance related led exploitation than adults.

5.1.6. The teenage brain is developing and malleable (neuroplasticity). Development is varied across brain areas. In relation to substance misuse and the potential for disinhibition the limbic system matures earlier in the brain this is where emotional responses are driven from, such as risk taking and reward and pain (crucial drivers for adolescent drug use). What remains undeveloped during teenage years is the pre-frontal cortex which is responsible for assessing situations, controlling emotions and impulses and helping us make sound decisions. Professionals may want to think of this in the context of an adolescent

brain having a 'well developed accelerator however the brakes are not fully working' and evaluate the impact on ability to consent and broader vulnerabilities of this neuroplasticity on a child further disinhibited by substance use.

5.1.7. All substances are mind altering and disinhibiting. Professionals can access comprehensive information and advice for themselves and young people and their families via the FRANK website http://www.talktofrank.com/.

5.1.8. In the context of CSE, alongside the factors in section 2.1.2, the professional assumption informing capacity to consent, risk assessment and planning should be that any substance use by a child will in all cases to a degree depending on amounts, types of substances, environments, expectations;

- Disinhibit the child.
- Impair the child's ability to make informed choices.
- Increase the potential for a child's risk taking behaviours.
- Accentuate any other vulnerability which may be present in the child's profile.
- Affect the child's capacity and ability to consent.

5.1.9. Professionals in relation to CSE and its correlation with substance misuse need to examine the extent of vulnerabilities balanced against protective factors with a professional bias that;

- The source of supply is exploitative or not monitored.
- The impacts of the substance/substances on a child's functioning will be greater because of neuroplasticity.
- The younger the child the more unusual the use of substances is.
- For children and young people cannabis is the usual disclosed drug of use; do not assume it is the only substance used professionals will need to ask about others.

5.1.10. **The combination of substances, neuroplasticity and broader CSE identified vulnerabilities makes capacity to consent in Under 18's extremely unlikely**.

5.1.11. Any involvement with substances; the use of, the supply of, A&E admissions, school exclusions, offences related to substances indicates a vulnerability to potential CSE.

5.1.12. Professionals must consider that a substance related incident i.e. a **substance related school exclusion may indicate a potential victim of CSE**, rather than assume a 'troublesome' child and be directed

towards a criminal justice pathway without a full investigation of the circumstances.

5.1.13. The child and professionals involved with any CSE involving substance misuse will need access to specialist substance misuse services for advice, consultation and in some cases treatment.

5.1.14. Personal bias to substance use particularly alcohol use can impact on professional decision making. Protection against this bias is available via the Chief Medical Officers advice 'Guidance on the consumption of alcohol by children and young people' this should inform all professional decision making in the context of alcohol use by children and young people. Guidance-on-the-consumption-of-alcohol-by-children-and-young-people.pdf

5.1.15. Peer influences, ethnicity and sexuality in relation to adolescent substance use, attitudes and expectations need careful consideration. The impacts can be overt as in direct peer pressure, or related to an expectation of by just being part of the group substance misuse is part of this 'belonging.' Professionals will need to consider this in relation to the potential for CSE to occur; in a peer environment they can go hand in hand the expectation that substances will be used/supplied and also the expectation that with this sexual activity is also a 'requirement'

5.2. Concerns about **confidentiality and consent to share information** can also be a barrier to effective engagement with professionals and it important that professional have a good **understanding about what can be shared between health professionals; and between health professionals and other agencies.**

5.2.1. Where there is suspicion that a child is being exploited, this suspicion **MUST** be shared with other appropriate agencies, **even where there may be issues with consent.**

5.2.2. Sharing information can mean the difference between life and death for a child.

5.2.3. Nothing should stand in the way of sharing information particularly in relation to sexual exploitation. The effective identification, disruption, intervention, protection and prosecution of perpetrators of this crime depend on effective multi-agency working.

5.2.4. Sharing small clues such as unofficial places where children might gather can have a big impact on the disruption and prevention of this criminal activity.

5.2.5. For further support regarding sharing information contact your local Named and Designated Safeguarding Professionals or access the following guide Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

5.3. **'Consent' is an important issue when dealing with sexual exploitation of children.**

5.3.1. The legal age of consent to sexual activity is 16, however when a young person is receiving something in return for sexual favours i.e. accommodation, drugs, alcohol etc, this would be deemed exploitative and legally the young person cannot give consent to their own exploitation under the age of 18.

5.3.2. A child aged 16 to 18 cannot consent if they are under the influence of drink or drugs as their capacity to choose whether to engage in sexual activity has been temporarily lost.

5.3.3. Child protection rules apply for all children under the age of 18. This means that if a boy or girl is 17 and has given consent the child protection statutory guidance still applies.

5.3.4. For further information download the Department of Health 'What is consent' information leaflet (PDF, 238kb)

6. Identifying Perpetrators

6.1. The pathway for sharing information outlined in section 2.4, alongside information shared at strategy discussions and MACSE Bronze meetings feeds into the police led process for identifying perpetrators.

6.2. The identification of perpetrators and potential victims is captured within the process of the Public Protection Intelligence meetings which are held monthly. The meeting is minuted and task driven.

6.3. Intelligence from all sources relating to CSE and other public protection areas is assessed by Detective SPOCS prior to the meeting for signs of threat, harm and risk, which enables current intelligence to be tasked and developed at the earliest opportunity.

6.4. The meeting is chaired by police and shared across a number of other departments. These include; the Misper Team, the Visor team, Neighbourhood Police Teams (NPT), and Senior Analysts within the Intelligence Units.

6.5. The Public Protection intelligence meeting will risk assess all intelligence on potential victims and perpetrators reviewing; tasking, actions and ownership. Intelligence will be escalated, developed and if necessary allocated for criminal investigation or specialist referral.

7. Proactive use of legislation

7.1. A Child Abduction Warning Notice (CAWN) is an important and valuable safeguarding tool. The issuing of a CAWN should be an administrative process for early disruption opportunities to deter suspects from associating with children. If used correctly, CAWNs can provide evidence to support the prosecution of criminal offences or civil proceedings under the relevant legislation**.**

7.2. CAWNs are designed to be used to tackle the undesirable activities of adults who are associating with a child against the wishes of their parents or the Local Authority. They should be seen as:-

- As an early disruption tool where arrest / prosecution is not appropriate at the time.
- To safeguard the child concerned and to actively build a case in the first stages of a potential prosecution of an offence, under the relevant legislation.
- To support applications, such as Sexual Offender Prevention Order (SOPO) and Risk of Sexual Harm Order (ROSHO).
- To inform the suspect of the age of the child, so this can not be used as a defence later.

7.3. There are two types of CAWNs, which apply to:

- Children <u>under 16 who are not</u> in Local Authority care
- Children <u>under 18 who are in</u> Local Authority care

The correct CAWN must be issued otherwise it will lose its value both in evidential terms and as a safeguarding tool.

7.4. Children **<u>under 16 who are not</u> in Local Authority care**:

CAWNs for children who are under 16 and are not in Local Authority care are issued in respect of Section 2 of the Child Abduction Act 1984. This relates to the offence of abduction of a child by other persons.

7.5. Children **<u>under 18 who are in</u> Local Authority care**

CAWNs for children who are under 18 and are in Local Authority care (under Section 31 of the Children Act 1989) are issued in respect of Section 49 of the Children Act 1989. This relates to the abduction of children in care.

7.6. It is not an offence in itself to not comply with the requirements of a Child Abduction Warning Notice (CAWN), but the evidence of its content and the fact of the notice having been served on the suspect, can be used as evidence to:-

- Negate defences that the suspect was unaware of the child's age.
- Support bad character applications and bail / caution decisions.
- Support Civil applications such as Risk Of Sexual Harm Order (ROSHO), Anti-Social Behaviour Order (ASBO), Sexual Offences Prevention Order (SOPO) , evictions and injunctions.

7.7. Other criminal offences under the Sexual Offences Act 2003 must be considered.

- S59a Trafficking within the UK for the purpose of sexual exploitation
- S5 Rape of child under 13
- S7 Sexual assault of child under 13
- S8 Causing or inciting child into sexual activity
- S9 Sexual activity with a child
- S10 Causing or inciting a child to engage in sexual activity
- S12 Causing a child to watch a sexual act
- S13 Child Sex offences committed by children/younger persons
- S14 Arranging/facilitating commission of a child sex offence
- S15 Meeting a child following sexual grooming etc
- S47 - S50 Paying for sexual services of a child
- S48 – Causing or inciting sexual exploitation of a child
- S49 – Controlling a child in relation to sexual exploitation
- S50 – Arranging or facilitating child sexual exploitation

7.8. For the purposes of sections 48 – 50 a person (b) is sexually exploited if

(a) on at least one occasion and whether or not compelled to so, B offers or provides sexual services to another person in return for payment or a promise of a payment to B or a third person, or

(b) an indecent image of B is recorded;

and "sexual exploitation" is to be interpreted accordingly.

8. Looked After Children

Risk Assessment informing placement planning for Looked After Children

8.1. It is important to ensure placement decisions for looked after children are based on a clear assessment of need and the CSE risk assessment and that where a cross boundary placement is being considered the risks of such a placement are fully assessed. The current MACSE risk assessment should therefore be included with the referral for placement.

8.2. Agreement to place any East Sussex looked after child outside of East Sussex must be given by the Assistant Director. Regulation 11 (placement decision) of the Care Planning, Placement and Case Review Regulations (2010) also requires the responsible authority to consult with the area authority when they are considering making a distant placement, in good time to enable a thorough assessment of appropriateness. Where it is known that the child has been assessed as being at increased vulnerability to CSE it is important that that this risk assessed is shared with the potential provider and discussed with the OLA where it is proposed to place the child. It is also best practice to share this risk assessment with the local police in the area. The link below provides further guidance

http://intranet.escc.gov.uk/sites/cs/Docs/CS%20Documents/Placement%20of%20LAC%20and%20Care%20Leavers%20outside%20of%20ESCC.doc

Looked after children who are placed in children's homes

8.3. Looked after children who are placed in children's homes are subject to the Children's Homes Regulations 2015.

8.4. In particular, under Regulation 40(4), in relation to notification of serious events, the Registered Homes Manager must notify Ofsted and other relevant persons, (police, probation services, health professionals, social worker and others involved with the care and protection of the child), if one of the situations specified in Regulation 40(4) (a)-(d) occurs, or if there is an incident relation to the protection, safeguarding or welfare of child living in the home in which the registered person considers to be serious (40(4)(e)). Examples of incidents that are likely to be considered serious affecting the welfare of a child include**:**

- A child being the victim or perpetrator of a serious assault (this would include a sexual assault),
- A serious illness or accident

- A serious incident of self-harm
- Serious concerns over a child's missing behaviour or where they have been missing for a considerable period of time and their whereabouts is unknown.

8.5. The registered homes manager must make the notification within 24 hours and the record must include a description of the action and the outcome of any resulting investigation. In relation to events and incidences in relation to CSE, this would include the outcomes of any strategy meetings and actions put in place to reduce the risks of CSE.

8.6. Whilst it is the primary responsibility of the Practice Manager responsible for the child to ensure safeguarding procedures are followed for the child, as a safety net the Registered Home Manager should contact the MASH practice manager to discuss with them the need for a strategy discussion within the context of the serious event. By doing so this should support consistency and timeliness of response, particularly where incidents may have happened at night or over weekend when MASH will be well placed to consider the information held with a SCARF.

9. Services and ongoing support for victims and their families (including witness support)

9.1. Evidence based services and support

9.1.1. Sexual abuse can impact on every area of a child's development; psychological, cognitive, social, emotional, behavioural, physical and sexual. Sexual abuse can have short- and long-term effects on mental health, including anxiety, depression, PTSD, disassociation, low self-esteem, phobias, OCD, personality disorders, eating disorders, self-harm, increased risk of suicide and substance misuse[1]. Sexual abuse has been linked to the development of delinquent and aggressive behaviour, crime (1 in 3 women in prison found to have experienced sexual abuse[2]), relationship and parenting difficulties. Sexual abuse can lead to risky sexual behaviour (increased risk of STDs and unplanned pregnancies[3]), sexually harmful behaviour towards others[4][5], increased risk of further victimisation[6] and sexual exploitation and an increased risk of victims' own children being sexually abused.

9.1.2. The impact of sexual abuse does however vary, with research suggesting that not all children suffer later psychological ill-effects[7]. Each child's experience is unique with the degree of internalisation of abusive experience being influenced by: the nature of the abuse; the

[1] Roberts, R. O'Connor, T. Dunn, J. Golding, J. the ALSPAC study team (2004) The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring, *Child Abuse and Neglect*, Issue 28 pp 525 – 545.

[2] Corston, J. (2007) The Corston Report: The need for a distinct, radically different, visibly-led, strategic, proportionate, holistic, women-centred, integrated approach. HMSO: London.

[3] Taskforce on the Health Aspects of Violence against Women and Children (March 2010). Responding to violence against women and children – the role of the NHS

[4] Hackett, S., Phillips, J., Masson, H. and Balfe, M. (2013) Individual, Family and Abuse Characteristics of 700 British Child and Adolescent Sexual Abusers. *Child Abuse Review*, 22 (4), 232 – 245.

[5] Creeden, K. (2013) Taking a Developmental Approach to Treating Juvenile Sexual Behaviour Problems. *International Journal of Behavioural Consultation and Therapy* 8 (3 – 4), 12 – 16.

[6] Classen, C.C., Palesh, O.G. and Aggarwal, R. (2005). Sexual revictimisations: a review of the empirical literature. *Trauma, Violence, Abuse*, 6 (2), 103 – 29.

[7] Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional Psychology*, 21: 325–330.

circumstances in which it occurred; the relationship between the child and the perpetrator; the modus operandi of the abuser; the nature of the child's previous life experiences; the degree of support within the family and the child's wider social support networks; and, the child's natural resilience and strengths. When assessing possible outcomes and prognoses for the child, some of these factors will weigh more heavily than others meaning that each individual child's experience has to be considered in the child's own context.

9.1.3. The Children and Young People's Mental Health Taskforce[8] was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support from mental health services when needed and to improve how services are organised, commissioned and provided. The themes they identified as fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people are as follows:

- Promoting resilience, prevention and early intervention;
- Improving access to effective support;
- Care for the most vulnerable;
- Accountability and transparency;
- Developing the workforce.

9.1.4. The taskforce report stresses the importance of ensuring that those children who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services they need in a timely way.

9.1.5. In terms of the evidence base for therapeutic intervention, the NSPCC scoping study in 2011[9] found that:

- The types of therapy commonly provided fall into two broad categories: talking therapies (including cognitive behavioural therapy – CBT – psychodynamic psychotherapy and counselling) and creative therapies (including play therapy, art therapy or drama therapy).
- Abuse specific interventions, rather than non-directive therapies, appear to give the best results in relieving depressive symptoms.
- There is considerable evidence for the effectiveness of CBT with certain groups of children and young people, particularly in

[8] DoH (2015) Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. DoH: London.

[9] Allnock, D. and Hynes, P. (2011) Therapeutic Services for Sexually Abused Children and Young People: Scoping the Evidence Base. NSPCC: London.

alleviating PTSD and some behavioural problems. It has recommended as a first-line treatment for symptoms associated with sexual abuse by NICE.

- Therapy in general has been found to relieve aspects of distress among sexually abused children and young people.
- There is limited hard evidence on the effectiveness of different therapeutic approaches; however this is not to say they are not effective, rather they have not been rigorously researched.
- The therapeutic alliance between the therapist and the client is held to be key to successful therapy.
- The effectiveness of therapy with an abused child can often be improved if a non-abusing parent is involved in some way.
- It is important that practitioners are adequately trained and have good supervision, and that all relevant agencies concerned with the child work together.

9.1.6. **The other important factor to consider in relation to the provision of therapeutic support services for child victims of sexual abuse is the timescales in which the therapeutic intervention is offered**. If referral for therapeutic intervention is made soon after disclosure, the agency will need to consider whether there is a role for the child as a witness in a criminal trial. If so, there is practice guidance available which outlines that the therapist should be made aware of any pending criminal proceedings before commencing the therapy and should also be aware of the implications of using techniques which may result in the child's evidence being discredited. **This guidance is particularly important to take into account when referrals are derived from the SARC or pre Police /Social Care investigations following strategy discussions.**

9.1.7. Research indicates that intervention work with children is more effective when the non-abusing parent is also involved in the work. This is unsuprising as working with children in isolation from their families will not address the key family and communication issues that need to be resolved in order to make the child safer within, and outside, their family.

9.2. **SWIFT Specialist Services**

9.2.1. Taking a whole family approach, the risk of sexual harm to children and young people is addressed by SWIFT in the following ways:

- Assessing the risk of sexual harm posed by alleged and convicted adult perpetrators, both male and female, and children and young people with sexually problematic behaviour.

- Delivering one-to-one interventions to alleged and convicted adult perpetrators and children and young people with sexually problematic behaviour to reduce the risk of sexual harm.

- Assessing the non-abusing parent/carer's capacity to protect and delivering one-to-one psycho-educative protective parenting interventions to increase their knowledge and understanding of sexual abuse and offending and their capacity to protect.

- Improving family communication through the delivery of relationship work, couple work, parenting work and family therapy.

- Supporting families to devise family safety plans to keep children safe from sexual harm.

- Delivering protective behaviours programmes to children and young people when they have experienced sexual abuse or exploitation, where appropriate.

- Providing advice, information and guidance to social workers, Early Help workers and education staff on how children can be supported following disclosure.

- Providing advice, information and guidance to social workers and Early Help workers where there is a risk of sexual abuse or there are concerns a child is being abused but there has been no disclosure.

- Consulting with social workers and other lead professionals to enable them to deliver evidence based responses to children and carers (either via sexual risk or clinical assessment and management). This can include ongoing support to deliver protective behaviours intervention to a child or young person. Consultation is always undertaken as a stand alone process with a SWIFT formal recording of the case information shared and recommendations offered. This event may be submitted by the LA as evidence in court proceedings.

- Supporting foster carers (alongside fostering support workers) or parents/carers (alongside social workers) about how to support children in their care who are displaying sexually harmful behaviour.

9.3. East Sussex service offer

9.3.1. In order to effectively intervene to reduce the risk of sexual abuse a whole family approach is warranted wherever appropriate. Assessments of sexual risk and capacity to protect and interventions to address identified risks are integral to reducing the risk of sexual harm to children.

SWIFT and early help services now offers a robust service in relation to non-abusing parents/carers and perpetrators.

9.3.2. Different children will need different levels and types of interventions. Some children will benefit from a low level programme of protective behaviours work while others will need targeted therapeutic intervention and post-trauma work. Some will require both. Others will require an early assessment of their role as a child witness prior to a criminal trial. It therefore seems therapeutically appropriate, practical and economical for children to be assessed as to which service/s would best meet their need, according to their circumstances, presentation and what we know about their experiences.

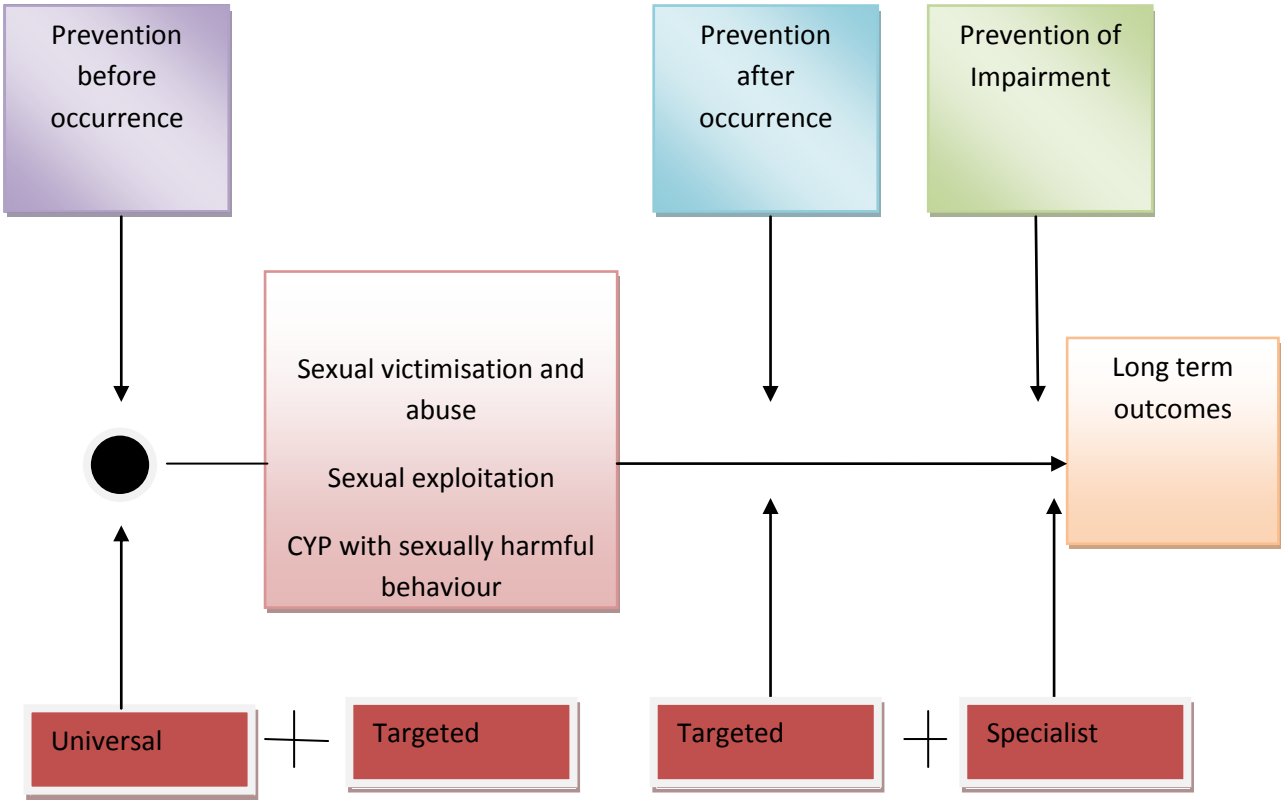
9.3.3. A preliminary screening tool has been developed to assist professionals from any agency to assess the child's current presentation and likely future needs. This can then be used to target services effectively and take into account the provision of therapy for child witnesses prior to criminal trial. For further information contact SWIFT

9.3.4. Within East Sussex it is also important that we build upon the shared partnership framework of delivering service responses across a continuum of need (CON). Operational services across the continuum should identify their relevant agency delivery threshold and equip workers to provide evidence based interventions to victims of sexual abuse and their family. In those circumstances where more than one service is felt to be necessary, services should work together to achieve co-ordinated, appropriate and timely intervention.

9.3.5. The diagram below is based on the DSCF Staying Safe Service Framework[10], adapted to focus solely on sexual abuse, victimisation and harmful sexual behaviour. It proposes that universal and targeted services are best placed to deliver preventative and early intervention responses to children and their families. At this time, targeted services such as Social Care and Early Help will require supervision and consultation in order to support them in delivering their work.

[10] DSCF (2008) Staying Safe: Action Plan. London: HMSO.

The DSCF Staying Safe Service Framework (2008)



Universal services	**Targeted services**	**Specialist services**
For all children and their families. Includes NHS GPs, midwives, health visitors, sexual health services, Sure Start Children's Centres and neighbourhood nurseries. These services can undertake primary prevention, promoting health and awareness and early intervention to prevent abuse occurring.	For children who are at risk of sexual abuse/ victimisation or have already been abused/ victimised or those displaying sexually harmful behaviour. Includes Local Authority children's social care services (FST, YST, LAC), early help services and locally based children's third sector services, where available and appropriate. These services can provide secondary prevention – that is, timely, appropriate intervention to stop abuse that has been identified early and rehabilitate the child and their family.	For children who have been sexually abused and who are at risk of permanent emotional and psychological impairment. Includes NHS specialist CAMHS community and residential services, LAC and AdCAMHS services, SWIFT, specialist third sector services and youth justice services, including the secure estate.

9.3.7. By applying this framework to the service offer for children across the CON the following responses are appropriate:

Level 1 – For children whose sexual activity and behaviour is age appropriate. Providers include schools, sexual health services and GP's; delivery mechanisms such as school's PSHE sessions to include Scarlett's Story, Operation Kite information dissemination and interventions which promote healthy relationships.

Level 2 – For children for whom there are **emerging concerns about sexual activity** and additional risks such as Looked After Children or Substance Abuse. The MACSE Referral and Risk Assessment can be used as a baseline screening tool and for children at level 2 the MACSE risk rating would be low/Green. Providers include LAC social worker, Foyer worker, YOT worker, Family Key Worker. Interventions should include support to parents/carers and the delivery of psycho educational programmes to children; targeted at preventing abuse or exploitation.

The level 1 and 2 offer will be further developed in consultation with schools and WiSE (What is Sexual Exploitation)

Level 3 – For children displaying increased risk of vulnerability to sexual abuse or have already been abused, the MACSE Referral and Risk Assessment rating is likely to be Amber with the level of risk decreasing. A targeted service is required often to children with multiple problems that is timely and can prevent abuse from continuing and rehabilitate the child with their family and community. Providers include Early Help workers, case holding services such as Youth Offending, Under 19's SMS and 3rd sector such as Missing Person services. Interventions include protective behaviours work with family and MACSE referral and planning oversight.

Support is offered via SWIFT through training, group supervision and individual case consultation. This is in line with the current service model delivered to young people who are displaying sexually harmful behaviours. SWIFT offer group supervision on a 6 weekly basis to TYS Early Help workers who are assessing and intervening. This includes case discussion, assessment and intervention planning and resource sharing. SWIFT also offer consultation to locality social workers, TYS Early Help workers and other professionals on individual cases.

Level 4 – For children who have been sexually abused/exploited and who are at risk of permanent emotional and psychological impairment or in need of current safeguarding responses. MACSE Referral and Risk Assessment rating is Red/high or Amber with the level of risk increasing. Providers include SARC, social care, SWIFT and CAMHS. Interventions include specialist interventions to reduce current risks and keep the child safe. The CSE support offer is integrated within the broader CSA offer in recognition that CSE is Child Sexual Abuse

The MASH /Paediatric SARC care pathway designates a specific role for the SWIFT Sexual Risk team to oversee and/or directly deliver a CSA response to meet the therapeutic and safeguarding needs of children who are victims of CSA.

SWIFT is continuing to develop a level 4 intervention offer and ensure the implementation of a new care pathway between the SARC/MASH, CPS, early help and local voluntary sector. SWIFT sexual risk team oversees the delivery of CSA responses across a continuum of need and will deliver therapeutic interventions, case consultation and training. The SWIFT Child Assessment and Treatment Team will also support and consult sexual risk specialists on the development of the programme of therapeutic intervention and offer ongoing supervision to practitioners undertaking the work.

Where there is evidence of mental health symptomology, including trauma, these children and young people should be supported through SWIFT or CAMHS.