

Key messages from research on child sexual exploitation: Staff working in health settings

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

Key messages

- Child sexual exploitation is a form of child sexual abuse and can happen to young people from all backgrounds. Whilst girls and young women are the majority of victims, boys and young men are also exploited.
- There is no 'typical' victim. That said, some young people may be more vulnerable than others, and a range of indicators have been highlighted to which staff should be alert. These include: prior abuse, homelessness, misusing alcohol and drugs, disability, being in care, being out of education, running away/ going missing from home or care, or gang-association.
- A deep understanding of coercion and intimidation, and the abuses of power involved in exploitation and abuse, is essential for all health-care staff.
- Sexually exploited young people may access a broad range of healthcare in different settings, so it is vital that health care staff are curious about sexual exploitation and ask questions to establish what is going on.
- Ensuring young people are seen alone and privately and beginning sensitive and inquisitive conversations about the origin of injuries can create space for young people to talk.
- Indicators of sexual exploitation may include sexual health issues, physical abuse, drug and alcohol use and mental health difficulties, including self-harm.
- All health workers – irrespective of their role – should see beyond clinical needs by taking a holistic approach and considering what sits behind the presenting issue.
- It is important to create an 'invitation to tell' for young people, by making them feel cared about and building trust.
- There should be clear referral pathways in place for all health staff to know where to report any concerns they have about sexual exploitation.
- Health care staff should engage in multi-agency work to protect young people, identify patterns in abuse and disrupt perpetrators.

Child Sexual Exploitation

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

[\(New England definition 2017\)](#)

There is no one way that CSE is perpetrated (Child Exploitation and Online Protection Centre, 2011; Berelowitz et al. 2012; Gohir, 2013; Research in Practice and University of Greenwich, 2015). Grooming is common in some forms of CSE, but it is not always present (Beckett, 2011; Melrose, 2013). Online and offline exploitation can overlap (Fox and Kalkan, 2016). That young

people may appear to co-operate cannot be taken as consent: they are legally minors and subject to many forms of coercion and control. These abuses of power are similar to those which are recognised in domestic violence and they may lead to young people being unable to recognise what is happening to them as abuse.

The majority of offenders are men, and a minority are women. Sexual exploitation can also involve peers in complex ways – as facilitators, abusers or bystanders (Firmin, 2011; Beckett et al. 2013). Whilst all of the research evidence to date shows that girls and young women are the majority of victims, boys and young men are also exploited. The average age at which concerns are first identified is at 12 to 15 years, although recent studies show increasing rates of referrals for 8 to 11 year olds, particularly in relation to online exploitation (Department for Education, 2017). Less is known about the exploitation of those from Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) communities (Ward and Patel, 2006; Gohir, 2013; Coy, 2016; Sharp, 2013; Fox, 2016) although research suggests these groups may face additional barriers to disclosure, including ideas about masculinity (what it means to be a boy or young man) and codes of ‘honour’ (Beckett et al. 2015; Brayley et al. 2014; Sharp, 2015).

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

Identifying indicators

Sexual health issues are a strong indicator of exploitation and abuse (Kirtley, 2013; Nelson, 2016). These may include: sexually transmitted infections; requesting (emergency) contraception; pregnancy tests; terminations; test for urinary tract infections; heavy bleeding from vagina and/or rectum; and abdominal pains (Berelowitz et al 2012.; Department of Health, 2014; Jay, 2014; Myers and Carmi, 2016). Health staff in pharmacies can be alert to sexual exploitation if a young woman seeks emergency contraception by looking to see if someone is waiting for her outside (Kirtley, 2013). In addition to recognising that pregnancy may arise from sexual exploitation, midwives can also consider whether a young woman has become pregnant as a way of trying to stop exploitation from continuing (Kirtley, 2013).

Some sexually exploited young people may also present with physical injuries, including lacerations and bruises. Paramedics and staff in accident and emergency (A&E) departments and urgent care or walk-in clinics/centres may come into contact with young people through their injuries, including those incurred through self-harm (Berelowitz et al, 2012; Kirtley, 2013; Marshall, 2014). Ensuring young people are seen alone and privately and beginning sensitive and inquisitive conversations about the origin of injuries can create space for young people to talk. General Practitioners (GPs) will be alerted to A&E unplanned care and walk-in centre reports and can follow up concerns. School nurses are also well placed to identify and respond to sexual exploitation, as their regular contact with young people means they are likely to observe change as well as be a potential source of health advice (Goldblatt Grace et al. 2012).

Drug and alcohol misuse is linked to sexual exploitation (Berelowitz et al 2012; Child Exploitation and Online Protection Centre, 2011; Coy, 2009; Department of Health, 2014; Jay, 2014; McClelland, 2011); they may be used as part of the grooming process to exercise control over young people, and/or by young people as a coping strategy.

Mental health is an important issue. Young people with existing mental health difficulties may be more likely to be targeted by abusers. (Berelowitz et al, 2012; Child Exploitation and Online Protection Centre, 2011; Department of Health; 2014; Jay, 2014; Marshall, 2014; McClelland, 2011). As with other forms of sexual abuse, exploitation has a range of psychological impacts, including anxiety, depression, flashbacks, post-traumatic stress and psychosis (Royal College of Psychiatrists, 2012; Marshall, 2014). These can manifest in challenging behaviours. Young people may engage in self-harm and/or self-injury as a coping strategy (Coy, 2008) or express distress through their bodies by developing eating disorders. Substance misuse is also often a way to manage the impacts of exploitation and abuse (Coy, 2009). These impacts are likely to be amplified for young people who have previously experienced sexual and/or physical abuse.

Having a physical or learning disability or difficulty is associated with an increased likelihood of being targeted by exploiters (Berelowitz et al, 2012; Cockbain et al, 2014; Jago et al. 2011; Smeaton, 2013). All health care staff who have regular contact with this group of young people should be particularly vigilant (Smeaton et al. 2015).

An invitation to tell

Sexual exploitation has both physical and emotional impacts, meaning that young people may access a range of healthcare in different settings. Many continue to use health services even when they have disconnected from other sources of support (Department of Health, 2014). It is vital that all health care staff are curious about sexual exploitation and create opportunities for young people to tell.

Young people will not always identify themselves as victims and may reject the idea that they are in need of support. Fear of being disbelieved or blamed, and feelings of embarrassment, anxiety and shame, can also be powerful barriers to disclosure.

“We want staff, including sexual health nurses and GPs to ask us better questions, be more inquisitive and if necessary to examine us when we ask for morning after pills, or seem very young for contraception. We may have hidden bruises and marks, so do not take everything we say at face value”¹

Young people may be told by abusers to lie about their circumstances and manipulated into doing so. Some abusers may even insist that young people take their mobile phones into the consultation room so that they can listen to what is said (Kirtley, 2013). A deep understanding of coercion and intimidation, and the abuses of power involved in exploitation and abuse, is essential for all health-care staff (Nelson, 2016). They should be both alert to the possibility of sexual exploitation and equipped to respond appropriately.

¹ Messages from children to professionals in Myers and Carmi, 2016

“Please treat children and young people as people, not a diagnosis. It makes you feel like an object that can be treated however people like. And I think it makes them feel OK to treat you like an object when you’re a label. But you’re not. You’re a person who’s been treated badly and they need to ask what’s happened to make you feel so sad and desperate”²

Training health staff about sexual exploitation will assist them in viewing the young person holistically and seeing beyond the presenting clinical issue (Research in Practice, 2015).

Sexual exploitation involves emotional, psychological, sexual and often physical abuse. The impacts of this can mean that young people appear as uncooperative or even aggressive and unwilling to engage (Coy, 2009; Beckett and Warrington, 2015; Hickle, 2016; Leon and Raws, 2016; Pearce, 2009). They may fear reprisal by their abusers or be dependent on them for affection, protection or drugs (Beckett and Warrington, 2015; Gilligan, 2016; Hughes and Thomas, 2016). It is important to create a connection based on kindness and empathy so that young people feel cared about and trust can begin to be built (Bartlett, 2016; Coy, 2009, 2016; Firmin, 2016; Sidebotham et al. 2016; Shuker, 2013). Assuring the young person that the questions asked are relevant to guiding the examination, determining what they think their health needs are, and making appropriate referrals can make a huge difference.

Be mindful not to inadvertently reproduce abusive dynamics by making young people feel disempowered or that situations are out of their control (Warrington, 2016). Building trust also rests on being clear about the limits of confidentiality. Where information has to be shared, young people should know who will be told and what might happen next.

Care pathways

Some health staff may not have much time to interact with a young person, but may nevertheless pick up some concerns. It is important that they know where and how to report (Kirtley, 2013; Marshall, 2014).

Young people need services which can offer them ongoing and consistent support. For those young people who may not yet view a perpetrator’s actions as abusive or controlling, local care pathways should include referrals to specialist CSE services in the statutory and voluntary sectors. Such services are often able to be more flexible, working with young people for as long as necessary and providing persistent outreach (Berelowitz et al. 2012; Department of Health, 2014; Gilligan, 2016; Coy, 2016; Research in Practice, 2015). Outreach services working on health related issues, such as substance misuse and sexual health are also important referral connections. Sexual exploitation does not stop at age 18 (Coy, 2016) and health projects for adults in the sex industry may be able to identify young people and pick up support.

Referrals to specialist services that can offer practical and therapeutic support are important, including Rape Crisis Centres and Sexual Assault Referral Centres.

Multi-agency working

Health staff can share information with other agencies when it is appropriate to do so. This can lead to the identification of significant patterns, such as visits to sexual health services/school

² Taskforce on the Health Aspects of Violence Against Women and Children, Consultation with Children (2011) cited in Department of Health, 2014

nurses coinciding with young women going missing or returning from being missing (Myers and Carmi, 2016). However, in order to share information effectively, there are a number of challenges that health services need to overcome.

As noted above, there are limits to confidentiality when safeguarding young people. This can cause confusion over what data health staff can share and in what circumstances (Jay, 2014; Myers and Carmi, 2016). Another challenge is the fragmentation of health care services which means that different health care staff do not always share information among themselves (Jay, 2014; Kirtley, 2013; Myers and Carmi, 2016). This makes it difficult to identify patterns in the way sexually exploited young people access health services; attending different sexual health clinics, for example. Health staff can explore with young people which other services they might have accessed.

One of the consequences of failing to link and share information is that intelligence may not be shared in ways that would enable health services to contribute to the disruption of perpetrators (Jago et al. 2011). Abusers and exploiters can often be identified through information from young people, including where the perpetrator is implicated in more than one case. Other useful intelligence that can be recorded and shared by health care staff may include locations where sexual exploitation takes place e.g. house parties.

It is clear that the role of all health staff is not limited to the health care that young people require but can involve identifying and helping to disrupt and prevent sexual exploitation.

Key messages from research on child sexual exploitation – also available

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

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