CHILD SEXUAL EXPLOITATION PRACTICE: INNOVATION AND MOVING FORWARD

VictimFocus
CHALLENGE | CHANGE | INFLUENCE

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March 2020

Commissioned research and report by UK local authority

Research ethics complied with The BPS Code of Human Research Ethics

Research and report delivered by Dr Jessica Taylor of VictimFocus

Research conducted 2018-2019

Report Content

Introduction

This report contains the views of professionals across a UK local authority (LA), when asked about how current child sexual exploitation and abuse practice could change and innovate in the future. As part of a commissioned project by the LA, the researcher was tasked with exploring how professionals in a range of different roles both within the LA and working in partner agencies felt about key issues in CSE practice and how they would solve some of the most common problems and difficulties.

Child sexual exploitation is both a very new and very old field of safeguarding. Children have been sexually exploited for centuries and authors have been writing about the sexual exploitation of children for just as long (Hallett, 2017). However, as the country attempted to respond to large cases of child sexual exploitation of hundreds of girls that was being perceived and treated as consensual child prostitution of promiscuous and troubled children; it began to develop the CSE response that the public and professionals perceived to be 'new'.

Rather than learning from decades of child sexual abuse practice and evidence from related fields such as domestic abuse, there were calls for new research, new strategies, new policies, new toolkits and new definitions in child sexual exploitation which further cemented the issue as 'new' and 'different'.

Now, a decade after the term 'child sexual exploitation' came into common usage and four years after the derogatory and harmful terms 'child prostitution' and 'child pornography' were removed from law, questions are being raised about whether CSE practice can become more innovative, more child centred and less blaming of children.

This project sought to explore how that reality could be achieved by consulting with professionals working in policing, health, safeguarding, education, mental health and therapeutic practice to understand what they felt needed to change and how that could be achieved.

Method

This project was commissioned in 2018 by a large UK local authority children's service. The project began with a consultation meeting to discuss the aims of the project.

The key aims were:

- To explore the way the CSE team currently works with children who are suspected or confirmed to have been sexually abused and exploited
- To conduct literature review of innovative practice in CSA, CSE and other related harms
- To develop research materials to conduct the project including interview structure and confidential questionnaires
- To conduct confidential interviews and to launch confidential questionnaire to explore current practice and frontline ideas of innovative practice for the future
- To write a report to present the findings of the project

A literature review was conducted to explore the academic literature, evidence, reports and alternative approaches to practice in CSE/CSA and related harms. Findings and key arguments are detailed in the literature evidence section below.

Links to the questionnaire were circulated within THE LA by Heads of Service, Directors and the Principle Social Worker throughout a three-month period with encouragement for everyone at all levels and in all roles to take part and share their ideas of current and future practice. The questions asked in the online questionnaire are available in appendix A and the information sheet provided to all staff members is available in appendix B.

The questionnaire was a comprehensive tool with multiple choice questions, scenario questions and a section which asked participants to complete sentences with their own ending. Multiple choice questions and sentence completion tasks were negatively, neutrally and positively framed. In total, there were 27 questions for participants to answer (including the scenario questions for each of the three children in the scenarios and basic demographic details).

Data from the online questionnaire was analysed both quantitatively for frequencies and averages, and qualitatively with free text questions with thematic analysis. From each qualitative question, themes were derived by looking for frequent words, meanings and arguments in the data.

As the findings and themes from the questionnaire emerged, some answers presented further questions which would benefit from being explored in further depth in interviews and focus groups. Questions were then created to explore eight key issues (list of questions can be seen in appendix D). Participants for the interviews and focus groups were recruited via emails that were sent to all staff members in THE LA and partner agencies. Dates were offered for telephone interviews, face to face interviews and focus groups with anyone who wanted to take part.

One large focus group was conducted amongst a large team of CSE specialist workers who had agreed to take part as a group (N=14) and a further 10 interviews were conducted with individual professionals in a range of roles. Data was transcribed and analysed to look for themes using basic thematic analysis. Each section was written to demonstrate pertinent themes and presented with examples of real excerpts from participants.

Ethical practice

The ethical standards of this project were aligned with the BPS Code of Human Research Ethics. Notably, this included free choice to participate, informed consent of all participants, the right to withdraw from participation or to withdraw their data during or after participation and the right to remain confidential.

Staff members were not able to remain completely anonymous as their sex, role titles and experience would have made them identifiable, therefore they were known to the researcher, but their identities are confidential. For this reason, it was discussed with staff and stakeholders that their sex, specific titles and experience would not be shared in the findings as this could breach their confidentiality.

However, confidentiality did not supersede the duty to safeguard children or to report harmful practice. In this project, confidentiality was not breached, and no staff members reported safeguarding concerns or reported harmful practice.

Participants

There were 136 respondents to the questionnaire and 24 participants to the interviews and focus groups. Focus group participants included a significant proportion of the CSE support service team staff and most of the individual interviews were professionals working within the LA. Respondents to the questionnaire were more diverse and included education professionals, police, NHS staff, third sector workers and professionals working within the LA in a variety of roles.

Literature evidence

There have been several definitions of child sexual exploitation over the years, and whilst it has continued to CSE support service, the definition has still not reached a form that is accepted by everyone. Before 'child sexual exploitation' became a term in common usage, children being sexually exploited by adults were generally called 'child prostitutes' (Hallett, 2017). The term was written into law, with the Sexual Offences Act (2003) containing offences pertaining to 'child prostitution' and 'child prostitutes' until it was amended in 2015.

Campaigners including individual professionals, politicians, feminist groups and children's rights groups argued that children could not be 'prostitutes', and if they were being sold for sex, or found 'selling sex', they were always being sexually abused and exploited by adults. They argued that the act of calling them 'prostitutes' conveyed a level of choice, agency and knowledge that they did not and could not have as minors. The term was changed to 'abuse through prostitution' and then 'commercial exploitation'.

Whilst these terms signalled a shift away from perceiving children as choice-making individuals 'selling sex'; there was still a lack of focus on the fact that the victims were children being abused by adults. Finally, the term 'child sexual exploitation' and acronym 'CSE' was adopted into common usage around 2009, positioning the victim firmly as a child, and the crime as the sexual exploitation of the person. However, whilst the improvement from 'child prostitute' to 'child sexual exploitation' was something to celebrate, the definition of child sexual exploitation continued to remain in flux for many years – and still contains remnants from the days of 'child prostitution'.

The definition of CSE has also been raised by Gladman and Heal (2017) who argued that the term 'child sexual exploitation' had become hygienic and abstract, whereby the definition does not represent the true harm, violence, injuries and death of children, but describes a vague process of exchange with no reference to harm or trauma to the child.

The definition of child sexual exploitation is central to critical discussions of preventing sexual violence. Whilst the definition still positions the child as having the agency to perform an exchange, prevention approaches will focus on changing the behaviours and decision making of the child, rather than protecting the child from adults who are raping, trafficking and abusing them. Arguably, this assertion can be seen in the approaches, prevention methods and responses to victims in recent years, including the higher level of victim blaming of girls who had been 'sexually exploited' when compared to victim blaming of children who had been 'sexually abused' (Eaton & Holmes, 2017).

The term 'victim blaming' or 'blaming the victim' was first coined in a book discussing the way Black people were blamed for suffering injustice and racism from white people in the ruling class (Ryan, 1971); but became applicable to many other forms of crime, including sexual offences. Victim blaming is defined as the act of transferring blame away from the perpetrator of a crime and towards the victim of the crime (Eaton & Paterson-Young, 2018). Examples of victim blaming vary widely, from what the victim was doing or saying right through to their ethnicity or upbringing to 'blame' them for what a perpetrator did to them. However, most victim blaming can be categorised into behavioural blame, characterological blame and situational blame.

As many rape myth studies and victim blaming studies tend to focus on the actions and characters of adult women, it would be reasonable to expect that rape myths and victim blaming would not apply to children being raped, trafficked and sexually exploited, especially as many of them cannot legally consent to sexual activity. However, several serious case reviews, inquiries and even published

policies and risk assessment toolkits used in child sexual exploitation practice actively reference or employ rape myths with children who are being sexually exploited.

Examples of rape myths used to blame children subjected to sexual exploitation:

- She asked for it/deserved it/wanted it
- She put herself in that position
- He did it to get something he wanted (drugs, alcohol, gifts)
- She lies about rape and abuse
- Children bring CSE upon themselves by their behaviours or characteristics
- Only vulnerable children are abused or raped
- Girls are sexually exploited because they wear 'revealing' clothing

This in part, leads to approaches to CSE practice which try to quantify the 'vulnerabilities' and 'risk taking' of children to assess whether they will be sexually exploited.

One of the most common methods of identifying and responding to children who are, or are suspected of, being sexually exploited is to measure factors known as 'risk indicators' and by changing or reducing the 'risk level' of the child by changing their behaviours in some way. Professionals in multi-agency teams measure the risk of child sexual exploitation happening to the child using a matrix of 'CSE risk indicators' on a toolkit adopted by each local authority, police force or larger strategy area. Notice, that they do not measure the risk of the offender, but the risk of the child.

The items on the CSE toolkits have a central focus on the child, their behaviours, their backgrounds, upbringing, character and appearance. Professionals are required to tick or score the indicator on the toolkit to raise concerns or make referrals for children to safeguarding teams or specialist CSE teams. CSE toolkits vary from authority to authority but are generally based on original or hybrid versions of the SERAF Tool from Barnardo's and the NWG CSE Toolkit. Both toolkits contained long lists of 'risk indicator' items, which when scored, give a calculated outcome of the 'risk' the child is at. Brown et al. (2016) found over 110 individual indicators being used to assess children despite the items having never been validated or evaluated empirically or in practice. Further, the authors concluded that the CSE toolkits were perpetuating victim stereotypes in CSE and causing professionals to focus on the characters and behaviours of the child, rather than where the risk was really coming from: the perpetrator.

Brown et al. (2016;2017) published a second report about the use of CSE toolkits with children which explored the way social workers and other professionals understood and employed the CSE risk toolkits and indicator lists across the UK. The authors concluded that CSE risk toolkits were unreliable and should not be used to make decisions about children.

CSE risk toolkits are generally understood to be a preventative measure, in which professionals calculate the 'risk level' of children (usually 'low', 'medium' and 'high') and then take action to protect the child. However, as Brown et al. (2016;2017) pointed out, many of the items that measure risk are evidence of sexual abuse or are current sexual offences, not risk indicators that the child may be sexually abused in the future.

The focus on measuring risk also leads to children being framed as 'risk takers' or 'displaying risky behaviours' rather than the perpetrators being seen as the risk. When it comes to prevention, this has influenced the way children are supported and protected. Rather than the offender being risk

assessed and changed, stopped or apprehended, CSE strategies focus on changing the 'risk level' of the child.

At professionals' meetings, children are assessed based on the CSE risk toolkit and given a 'risk level'. Based on the risk level they fall within; each child will then be prescribed general interventions and support based on reducing their own risk level in an attempt to stop or prevent the sexual exploitation from occurring or continuing. This approach essentially erases the perpetrator from the crimes against the child, leaving the child as the cause and the solution to the sexual harm they are being subjected to. Interventions can include stopping the child from going to certain places, seeing friends, walking to school alone, wearing certain clothing and makeup, using the internet, having a mobile phone, having a games console or even living in their hometown.

The second core assumption in CSE practice is that children with specific vulnerabilities are more likely to be sexually abused than other children with little or no vulnerabilities. This assumption is not specific to CSE, however, and many studies have been published that seek to discover the vulnerabilities of the victim that make rape, sexual abuse and domestic abuse more likely. Despite the ongoing search for vulnerabilities that lead to sexual violence, findings are highly contested and variable (Eaton & Holmes, 2017; Brown et al., 2016). When it comes to child sexual exploitation, for example, there is very little evidence that any 'vulnerabilities' are linked to a higher chance of being sexually exploited (Brown et al., 2016).

To begin, it is important to define what is meant by 'vulnerabilities to CSE'. Society tends to perceive children as inherently vulnerable, due to being children (James & Prout, 1997), however, if we did see all children as vulnerable to sexual abuse and exploitation, there would not be specific lists of vulnerabilities that children are scored and measured against. Lists of vulnerabilities to CSE are widely used in practice, with many lists of vulnerabilities attached to the previously discussed CSE risk toolkit. The lists of vulnerabilities vary widely from toolkit to toolkit and have not been validated or evaluated to show causation or correlation as yet (Brown et al., 2016;2017). Vulnerabilities include having a learning disability, being a looked after child and witnessing domestic abuse at home. Generally, the lists of vulnerabilities include adverse experiences from throughout the lifespan of the child, however, some are vaguer and include moving to secondary school, illness of a family member and having lowered self-esteem.

It is thought that the more vulnerabilities the child has, the more likely they are to be sexually exploited. This approach to working with children represents a deficit model of children, rather than a strengths-based model of understanding their lives and potential.

Across the UK, there are more innovative and explorative approaches to CSE practice to combat some of the issues discussed here. Organisations are exploring practice without CSE toolkits, authorities are investing in research into trauma informed practice with people who have experienced adverse childhood experiences and new models, structures and teams are being piloted. Even progress in the criminal justice system has been seen with significant improvements since the prosecutions of the Rochdale CSE perpetrators and more recently, the successful pilot and roll out of the Section 28 pilot to allow children to use pre-recorded cross examination in court to protect them from further traumatisation. It is a good time to begin to look at embedded or traditional practice that may need critical thought or innovation.

Questionnaire findings

This section will detail the quantitative and qualitative findings from each question in the online questionnaire for staff members of THE LA and their partners working in CSE and CSA. In total, 136 professionals participated in the questionnaire but only 80 completed all questions. The majority of professionals were employees of the LA (61%), but there were also significant responses from Local Police, The LA Abuse Counselling Services, Barnardo's, CAMHS, NHS and several schools.

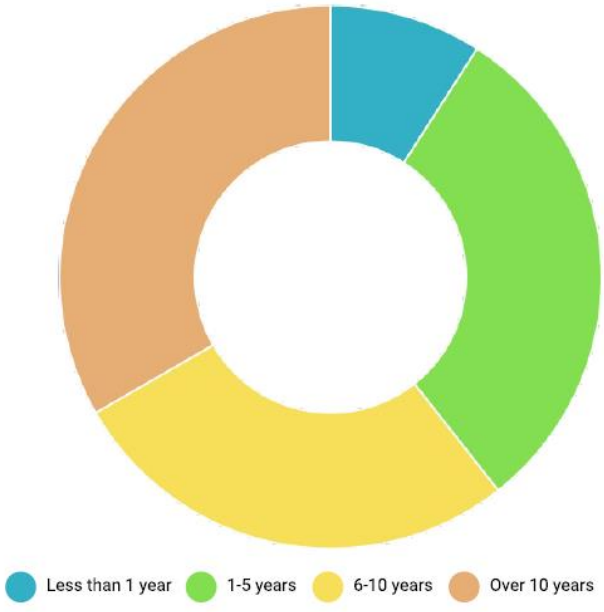
Section 1: Action taken with children suspected of or known to be sexually exploited and abused

1. **How are you involved in work relating to child sexual exploitation or abuse, or in the work of the CSE support service?**

The answers to this question varied widely from people who work frontline, solely with children who are sexually exploited and abused right the way through to managers who write training courses and direct development of staff teams. Professionals also reported that they made referrals to CSE support service, worked with children in care, worked with the whole family around the child being sexually exploited, investigated crimes of sexual abuse against children, providing therapeutic services to children subjected to sexual abuse, recruitment of foster carers, holding multiple cases of children subjected to CSE and offering health advice. Several professionals also wrote that they were adult survivors of CSE and CSA themselves, too.

2. **How long have you been working with children subjected to child sexual abuse or exploitation?**

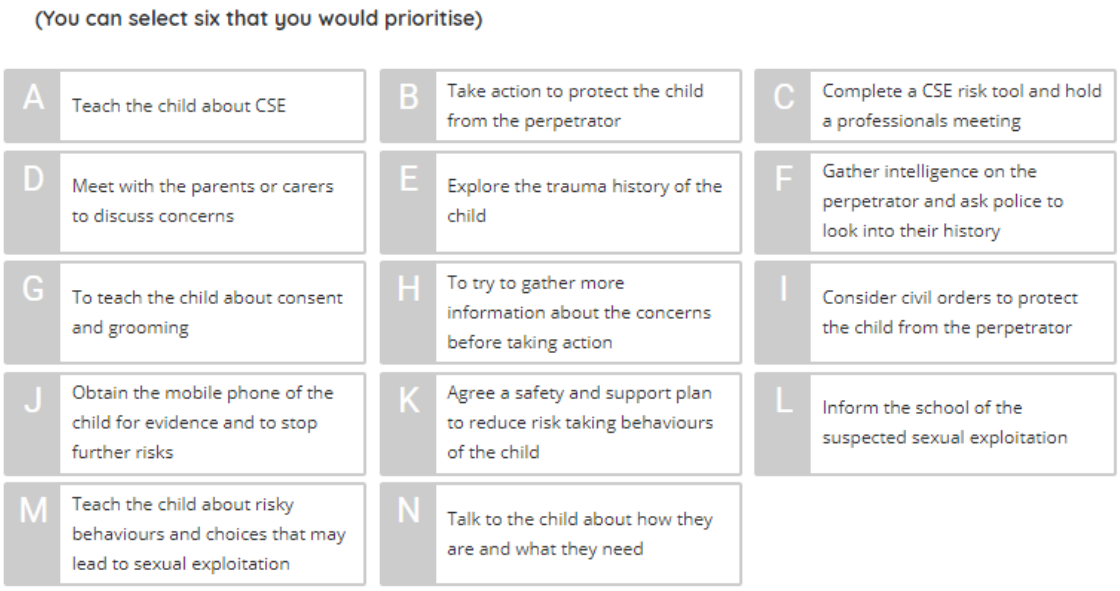
Of all participants, the majority of them had been working with children who had been sexually abused or exploited for between 1 and 10 years. Only 9% of participants reported working with children affected by these forms of abuse for less than a year. The rest had worked with children affected by abuse for 1-5 years (30%), 6-10 years (27%) and over 10 years (33%). Therefore, the vast majority of respondents (91%) had suitable experience of working with children subjected to child sexual abuse and exploitation to provide informed views of current and future practice.



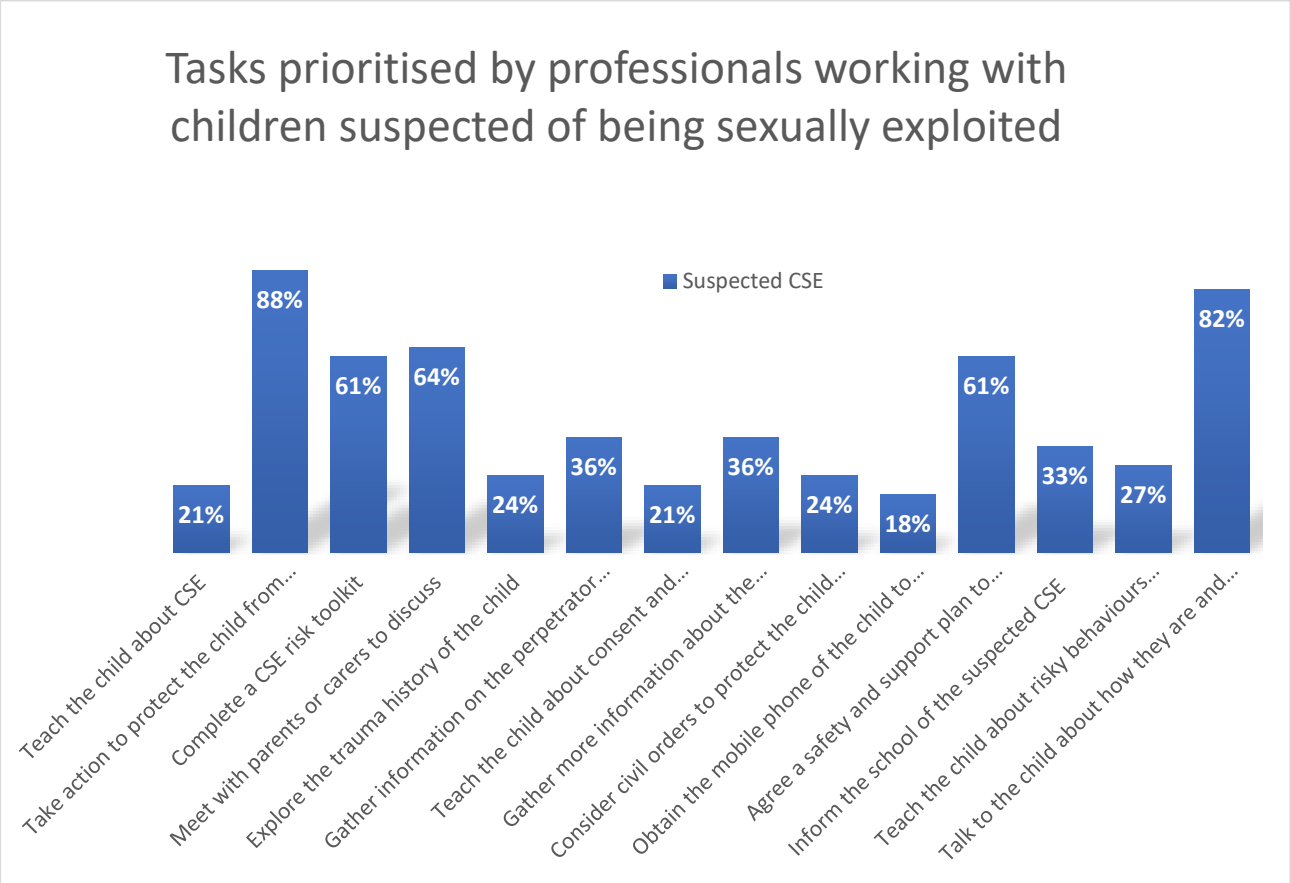
3. **When we *suspect* that a child is being sexually exploited, what do you think the main priorities should be? (Please select up to six tasks that you would prioritise out of the available 14 tasks)**

This question sought to explore what professionals prioritised when working with children who they suspected to be at risk of child sexual exploitation and abuse, rather than the children whom they knew to already have been subject to significant harm through sexual abuse and exploitation. This question was paired with question 4, which then asked professionals what they would prioritise if they knew the child had already been sexually abused or exploited. Findings to each question are reported below, and then compared at the end of this section.

Each participant was presented with 14 options from which to prioritise 6 that they felt were the most important ones to carry out with children whom they suspected to be being abused or exploited by perpetrators but did not yet have evidence or a disclosure from the child.



Participants answered in a variety of ways but there were very clear trends that emerged from the answers as can be seen below. The most common responses were to take action to protect the child from the perpetrator (88%), talk to the child about how they are and what they need (82%), followed by meeting with parents and carers (64%), completing a CSE risk toolkit (61%) and agree a safety and support plan to reduce the risk taking behaviours of the child (61%).



The top three responses should be considered positive and helpful. Professionals clearly prioritised talking to the child to learn how they are and what they need from them, taking action to protect them child from suspected perpetrators and talking to families and carers. It is concerning to see that 61% of professionals would prioritise an approach that positions the child as having 'risk taking behaviours' rather than being abused. However in contrast, only 21% of professionals would teach children about CSE, grooming and consent and only 27% of professionals would teach children about risky behaviours when they suspected the child was being abused, with most professionals preferring to use preventative or protective approaches towards the child rather than attempting the educate the child at this stage.

3a. Could you please explain why you chose those six priorities and whether there are any options here that you felt were missing or that you would not do at all?

Participants responded to this question in a free text box asking them to explain their choices. Answers were analysed for recurring themes and they are presented below. The four main themes emerging from the data were protecting the child, child centred approaches, educating the child to avoid being abused and reducing victim blaming of children in preventative work.

Protect the child

The first theme is protecting the child. Participants reported that their first and main focus is the protection of the child to ensure that they are not harmed by perpetrators.

The main priority is to keep the young person safe

Priority above all things should be to take action to protect the child from immediate threats of exploitation / potential exploitation.

The main priority is to ensure the child's immediate safety.

All areas should be prioritised however I feel the points highlighted would be useful in minimising risk and creating safety planning for the children

Child safety should be a priority, without making assumptions.

It is important to prioritise the needs of the child and seek to stop the risk from the perpetrator immediately, ensuring the individuals who can protect the child (such as a parent/carer) can act protectively and the perpetrator is not able to contact or influence the young person further.

Child centred approach

The second theme which emerged from the data was child centred approaches to CSE practice in which children are consulted and listened to before taking action. Participants discussed the importance of the wishes and feelings of the child and listening to their views.

Talking to the child is priority in order to determine their wishes and feelings and see how they are. This will determine future support needed for them.

We would try not to create panic in the child as they may panic and not tell us anymore. So, asking the child what they need is important.

A child can never consent to their own abuse, action is required by partner agencies to safeguard the child from the perpetrator. The child should be central and the key focus to all decision making. The child's voice should be heard, and views gained.

Speaking to the child is important to understand their view on the situation and gather information, children are usually not aware that they are a victim and it is important that this information is gathered.

Important to talk to the child and others who know the child better than I do. Our direct involvement with children is often short term. I would involve others e.g. school/CSE support service in any action therefore, and for me it would be important to gather more information. Action would be in collaboration; that does not mean not taking action but it would be important to put together a plan that would work for the young person and their family and that took into account their strengths and needs holistically.

Professionals should work with the victim to understand their context before taking action that may alienate them or reduce the chance that they might be empowered to speak up.

Education of children to protect themselves

The third theme to emerge from the data for this question was educating children so that they can protect themselves from sex offenders. Participants talked about the importance of teaching

children how to keep themselves safe, improve their choices, reduce risk taking behaviours and stop putting themselves at risk of CSE.

> *If we can empower our young people to understand CSE and how perpetrators work, hopefully they will see the signs and be able to keep themselves safe.*
>
> *The child needs to be safe and made aware that they are putting themselves at risks.*
>
> *Teaching a child about grooming and consent can give them further insight and hopefully give them the knowledge to keep themselves safe when they are away from the family home. It also provides them knowledge that they may not have had before.*
>
> *I believe it is important to teach the child about the risks of CSE, the warning signs and to create a heightened awareness.*
>
> *Teaching the child about consent, abuse, grooming, choices and risky behaviours to increase their understanding, reduce their risk and avoid actual abuse.*

Victim blaming and responsibility of children

The fourth theme to emerge from this question was participants responding to the items that were related to placing responsibility or educating children. What is interesting about this theme is that it is almost the opposite of the third theme, in which participants were supporting the education of children. Instead in this theme, participants were criticising the option of talking to children about 'risky behaviours' and educating children to protect themselves from sex offenders.

> *I would never place the responsibility on the child for their abuse and indicate to them that their behaviour has made them vulnerable or at risk of abuse*
>
> *I would not talk to the child about 'risky behaviours' -these are subjective and seek to apportion responsibility for safety to the potential victim.*
>
> *The behaviour should not be labelled as risk tasking as the children are victims and are not to blame therefore they should not be made to feel that by their choices that they are to blame.*
>
> *Some of the options above focus responsibility on the child for keeping themselves safe; for example educating them about CSE or "risk-taking behaviour"; I feel this falls into a culture of victim-blaming, where children are spoken about in terms of "putting themselves at risk". That is not to say that education about consent is not crucial to young people's healthy sexual development; it is - but if there are concerns that a child is being sexually exploited this does not address the concern.*
>
> *I do not feel that individuals should be viewed in the context of a reductionist perspective where they can be measured or blamed for their situations.*
>
> *We need to shift the focus of CSE/CSA from the child as autonomous or "responsible" in any way and see them simply as victims who require sensitive support whilst aggressively targeting and dealing perpetrators. We risk re-traumatising children as an agency and making their situation worse.*

4. **When we know that the child is already being sexually exploited, abused or has recently been raped or assaulted what do you think the main priorities should be? (Please select up to six tasks that you would prioritise out of the available 14 tasks)**

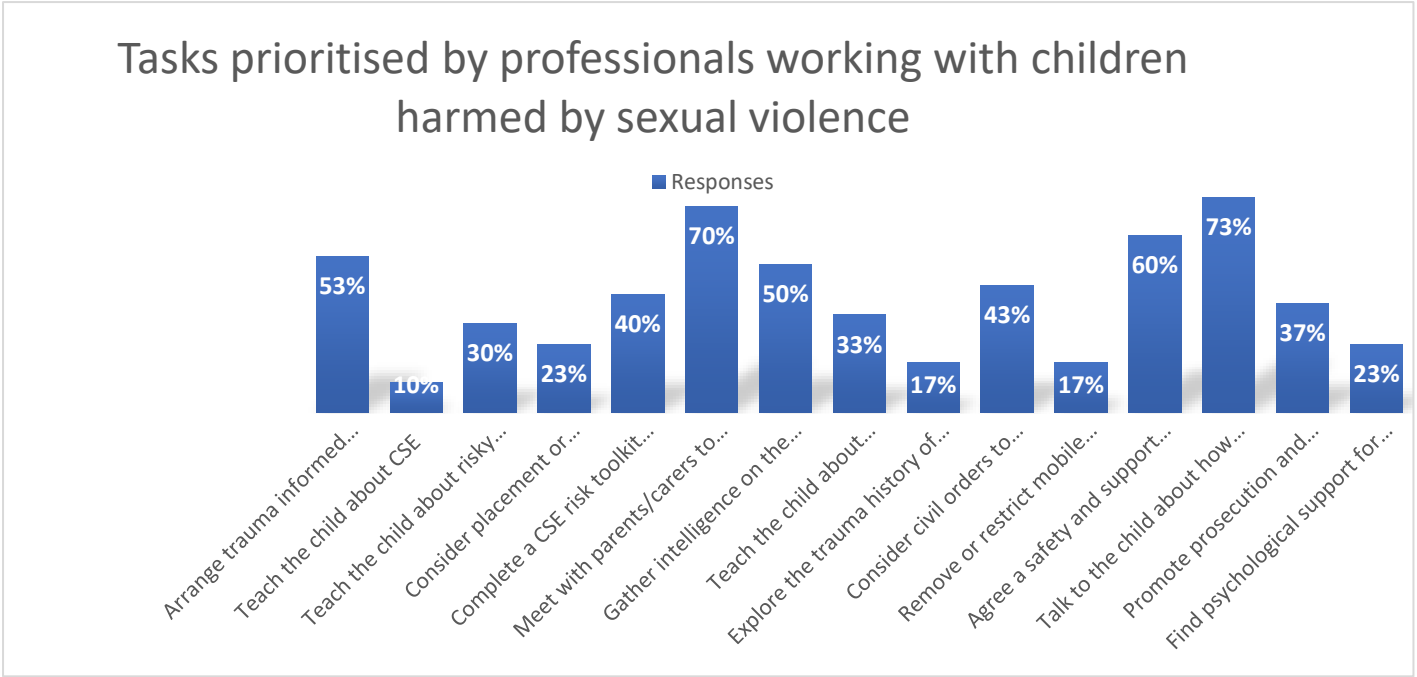
This question sought to explore what professionals prioritised when working with children whom they knew had already been abused, assaulted or exploited by a perpetrator.

Each participant was presented with 14 options from which to prioritise 6 that they felt were the most important ones to carry out with children who had been subjected to sexual violence.

(You can select six that you would prioritise)

A Arrange trauma informed therapy provision for the child	B Teach the child about CSE	C Teach the child about risky behaviours and choices so they can stay safe in future
D Consider placement or movement of the child to keep them safe in another area	E Complete a CSE risk tool and hold a professionals meeting	F Meet with the parents or carers to discuss how to support their child with sexual trauma
G Gather intelligence on the perpetrator in order to take action	H Teach the child about consent, grooming and healthy relationships	I Explore the trauma history of the child
J Consider civil orders to protect the child from the perpetrator	K Remove or restrict mobile phone, gaming or internet access of the child	L Agree a safety and support plan to reduce risk taking behaviours of the child
M Talk to the child about how they are and ask what they need	N Promote prosecution and support the child to give evidence	O Find psychological support for the parents/carers

The most common responses were to talk to the child and ask how they are (73%), meet with parents and carers to discuss how to support their child with sexual trauma (70%), agree a safety and support plan to reduce risk taking behaviours of the child (60%) and arrange trauma informed therapy for the child (53%).



The top two priorities centre the child, parents and carers in practice; with the child being consulted and the parents and carers being supported to improve support with their own children. However, the third most common priority was to agree a plan to support the child to reduce risk taking behaviours of the child (60%). This finding means that even after the child has been subject to significant harm, a large proportion of participants would still prioritise a plan which focussed on the child reducing their 'risk taking behaviours'. This approach was criticised by other participants in the previous question. As before, participants were then asked to explain their choices and the data was analysed for themes.

4a. Could you please explain why you chose those six priorities and whether there are any options here that you felt were missing or that you would not do at all?

Participants responded to this question in a free text box asking them to explain their choices. Answers were analysed for recurring themes and they are presented below. When the child is known to have already been subjected to sexual violence, the four main themes emerging from the data were keeping the child safe from perpetrators, trauma-informed approaches, criminal prosecution and supporting the parents and carers of the child.

Keeping the child safe from perpetrators

The first theme to emerge from the data was the same in question 3a: keeping children safe from perpetrators as the priority. Almost 60% of comments contained reference to keeping the child safe as being the main focus of any action.

> *The priority is that the young person comes to no further harm and that any other children are protected from the perpetrator.*
>
> *Making sure the child's voice is heard and that they are not at any immediate risk of harm is the first step*
>
> *Ensuring the child is as safe as they can be is the priority for me. this means forming an effective and helpful relationship with the child and work alongside them*
>
> *The child's safety is paramount and to ensure the child is safe from further harm a place of safety may be necessary as the risks may well be heightened from the perpetrator to prevent arrest therefore may become more threatening and cause further fear and harm to the child.*
>
> *The main priority should be keeping the child safe and away from the perpetrator of the abuse; some of the options I have chosen above are to support that.*

Trauma-informed approaches

The second theme to emerge from the data for this question was reference to child-centred and trauma-informed approaches and therapy, which became much more prevalent in the free text answers when the child was known to have already been subjected to sexual violence. Participants commented about why children might need therapy or how they would use trauma-informed approaches to support the child or reduce victim blaming.

Talk to the child about what they need. Trauma-informed therapy is likely to be needed to help the child come to terms with what happened and to reduce the chance of long-term mental health issues.

The trauma history needs to be addressed in therapy

The child's view is extremely important and when adults are making life changing decisions for a child this can cause further distance from services and reluctance to give evidence. The child needs to be included and voice heard in all planning and decision making to give the child empowerment and strength to progress through the trauma.

The child requires patience and consistency- although preventative work is beneficial the child has already been harmed by a perpetrator and therefore emotional well-being and safety would be addressed first. I believe that we would not deliver keep safe work immediately to a woman/man who has suffered a sexual assault as this is victim blaming and misplacing responsibility to the victim, harm has occurred, and emphasis has to be on the perpetrator that has inflicted harm.

Talking to children about healthy relationships once they are being abused is much too late. More focus on supporting children who are at risk.

I believe all work and investigations should be led by the victim with focus on protecting the child from the perpetrator not the child keeping themselves safe

Criminal prosecution

The third theme to emerge from the data was the importance of prosecution of perpetrators as either a form of justice, form of protection or form of closure for children and families.

It is important that perpetrators are brought to justice as they are likely to reoffend if they are not punished.

The focus needs to be firmly on bringing the perpetrator to justice to prevent them causing any further harm

If the child agrees to this, we need to encourage them to prosecute or give evidence as this will help them to protect others and will give the child closure on what happened to them

Prosecution should be considered if it is part of the identified wish of the child, however this should be for the benefit of the child.

agenda to use children to secure convictions is in my opinion unethical and disempowering.

Promoting prosecution by sharing relevant information and providing support to the young person in any trial provides the beginning of closure and helps to stop the perpetrators.

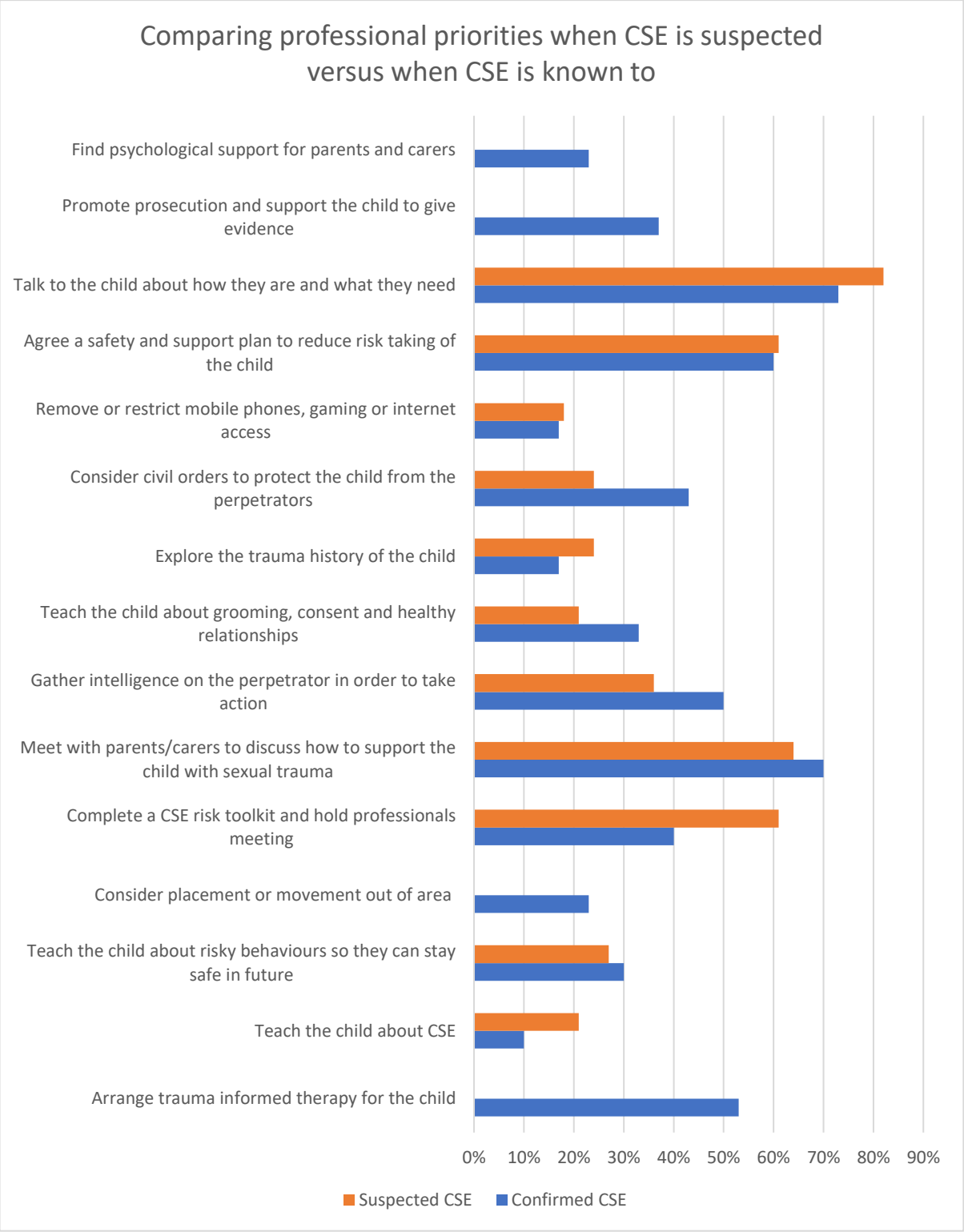
Support parents and carers of the child

The fourth theme to emerge from the data was a focus on supporting the parents and carers of the children who had been subjected to abuse, to enable parents and carers to support their child to the

best of their ability. Some participants also suggested that parents and carers need psychological support too, due to the impact the exploitation or abuse of their children may have on them.

> *The parents and carers need to be empowered to support the child as the key people in their lives*
>
> *Parental support - Parents/ carers love their child and are likely to need support in how best to help their child cope with what has happened to them and avoid this happening again.*
>
> *I would be considering therapeutic services etc for the child and family*
>
> *he young person views are very important, getting professional therapeutic help for both the young person and parents will help them understand and give them the support they need.*
>
> *The key to the children being safe often lies with the parents and they need to be supported to do this where possible, including receiving therapeutic support for themselves.*

Comparing the two sets of data: What do professionals prioritise before and after children are subjected to sexual exploitation?



Section 2: Learning from Scenarios

In this section of the questionnaire, all participants were asked to read three scenarios and to answer two questions for each scenario, based on how practice would currently respond to the issues raised, and how they might like to see practice to respond in the future or in an 'ideal world' situation. The purpose of these scenarios is based on the approach from solution focussed therapies called 'The Miracle Question'. Often, by asking people to imagine what the solution to a problem would be in an ideal world or if they had all resources required, they can identify solutions and ways to move forward.

Each scenario therefore asked participants to begin by describing how they thought the child would be supported with current practice, theories, models and resources before being asked how they would like the child to be supported in the 'ideal' future in which practice had all knowledge, resources and support required.

Scenarios were written to contain salient details and issues, to draw out particular solutions and ideas from staff members and partner agencies.

Mikel's case study presented a middle class, wealthy, popular and confident teenage boy who is receiving links to porn and naked images from a man online. This scenario enables the researcher to examine perceptions of male victims, social class and wealth and non-stereotypical victim behaviours.

Jaimie's case study presented a 17-year-old girl who had been sexually exploited and trafficked – and been subjected to earlier familial sexual abuse. She is described as implicit in the abuse and hard to engage. This case study was written to examine the perception of older victims of CSE over the age of 16 years old and to consider how participants would respond to a case study that was written to contain victim blaming and inappropriate descriptions of the child.

Deona's case study presented a 13-year-old girl in a 'relationship' with a 17-year-old boy. The case study describes her parents as very supportive of the relationship despite the professional remaining concerned that she is being isolated from her friends and activities by the boyfriend. In the case study, the professional seeks advice but gets inappropriate advice from a colleague. This case study was written to examine the responses to children in abusive relationships with older children in which the parents do not see any danger and where other professionals also do not share concerns.

Findings from Scenario 1: Mikel

Mikel is 14 years old and fancies himself as a bit of a gangster. He has lots of friends and is generally confident and happy. Teachers complain that he smells of weed sometimes after lunch break. He is from a wealthy family and has three older brothers. He has all of the latest tech and has set up a chatroom on his favourite Xbox game online. Him and his mates play on there for hours on a weekend with some other guys from around the world. A teacher overhears Mikel and his mates laughing about some guy who keeps sending them links to porn and pictures of himself naked. They are all calling him Mikel's 'boyfriend', but Mikel laughs it off and says it's hilarious. The teacher has rung through to the MASH to talk to someone as they don't know what to do.

Key findings: Mikel	
If this scenario was happening in the LA now, what do you think the response to Mikel would be?	**If this scenario happened in the LA in the future, and you had all of the knowledge, resources and approaches you needed, what do you think the best possible response is for Mikel?**
• I don't know • Talk to Mikel about healthy relationships and appropriate behaviours • Host a strategy meeting • Report to the police • Identification of the perpetrator if possible • Concerns should be reported to MASH as soon as raised • Education on grooming, consent, risky behaviours and healthy relationships • Work with Mikel about how to keep himself safe in future • Mikel needs to know he is not in trouble and ask him if he needs support • Support and advise his parents	• Education about grooming, sex and abuse to be standard part of school curriculum • Police able to press charges against anyone sending inappropriate material to children • A named person in each school that children could talk to about abuse, exploitation, grooming and harm • Make sure communication is non-shaming • Give Mikel choices on how he wants to proceed and what action he wants us to take • Better resources to work with or address perpetrators across borders and forces • A dedicated keywork allocated to Mikel • Strengths based individually tailored work with Mikel to look for opportunities and talents • Recognising and not overreacting to normal curious behaviours and responses • A specialist placed within MASH who could give evidence-based advice on risk assessment and responses • Educating and training for all parents

Commentary

When asked about the current response, the answers accurately describe traditional current responses including referrals to specialist services, strategy meetings, assessments, educative work with the child and advice for the parents.

When asked about the 'ideal' response to Mikel in the future, there were many more references to child-centred, strengths-based, anti-shame and anti-blame responses than in the 'current' responses. Participants frequently discussed the need for dedicated keyworkers or youth workers within youth projects rather than within a CSE team to focus on strengths based, future focussed work with Mikel. Many participants stressed that the scenario raised wider cultural issues that need to be embedded into the curriculum and resources in the future, including sex, abuse, grooming, bullying, homophobia, online safety and information about unsafe adults. Participants made several comments about the identification and disruption of perpetrators being better in the 'ideal response'. Finally, participants mentioned the educating and training of all parents and carers in a more globalised way so that parents had more insight and knowledge to talk to their children and to protect them.

Findings from Scenario 2: Jaimie

Jaimie is a 17-year-old girl who has been sexually exploited and trafficked a number of times since she was 12 years old. Before that, she experienced familial sexual abuse as a child that was not picked up and she didn't disclose until recently. Jaimie has had significant support from CSE specialist workers and appears to understand what they are saying but a few months later, she goes back to the perpetrators and the abuse happens all over again. The police have been supportive and managed to convict a man and a woman a few years back but even that didn't seem to stop the exploitation of Jaimie. Yesterday, she told you that she was raped, and someone filmed it. She tells you she needs to escape, wants to report them all to the police and this time she will never go back. Her file says that she is implicit in her own abuse and often says that she won't go back but then retracts all of her statements and goes back to the abusers. Someone has written on her file that she is selling sex for drugs which means she keeps going back to them when she needs more of the drug - and that is why the support isn't working.

Key findings: Jaimie	
If this scenario was happening in the LA now, what do you think the response to Jaimie would be?	**If this scenario happened in the LA in the future, and you had all of the knowledge, resources and approaches you needed, what do you think the best possible response is for Jaimie?**
• Referral to VARM meeting to discuss action • Work on Jaimie's self confidence as she is putting herself at risk • Work on Jaimie's drug problems • Current responses might be affected by how her behaviour is viewed by professionals • Safety plan put in place to reduce her risk taking • We need to work alongside her and at her own pace • Reinforce that she is not to blame • Be consistent and non-judgemental • Consider support from The LA Rise and a safe house • Her past should not affect the way we protect her now • She needs to be supported to prosecute • Section 47 investigation and support plan • Place Jaimie out of area and treat drug addiction • The language and victim blaming needs to be challenged • Arrange trauma therapy or support	• A look back at the abuse Jaimie experienced and seek to prosecute or investigate her family members • She needs therapy that reinforces that this was not her fault or responsibility • A long-term form of support with one person or team to meet all of her different needs • A flexible service that can understand and take into account her leaving and coming back to the service without giving up on her or blaming her • Trauma services that can help Jaimie to work through all of the earlier and more recent traumas • Support that does not end at 18 years old • Support that has a close working relationship with adult social services, so her support doesn't end • A service that can give her informal, reliable and flexible support into adulthood • Specialist rehabilitative or female-only refuge spaces for women trying to escape abusers • Victimless prosecutions with enough evidence

Commentary

In this scenario, when participants described the current response it was mixed. Many participants described a response which would support Jaimie with her long and complex trauma history, but several others still described a response which focussed on getting her to stop 'putting herself at risk' and focussed on solving her 'drug problem' which was inferred from the victim blaming comments on her file. Of interest was that some participants condemned the victim blaming of Jaimie but did not question the comment that she was 'selling sex for drugs' which was taken as fact. There was nothing else in the scenario that described Jaimie as having an addiction, but over 60% of responses described responding to a 'drug addiction'. Despite this, many participants reacted to the negative way the scenario was written which resulted in many answers challenging the language of the scenario and the assumptions being made about her behaviours.

In the 'ideal future' answers, participants described an ideal, flexible, reliable, person-centred and trauma-informed service that could provide support and advice to Jaimie over a longer period of time without traditional time restrictions and case-closing procedures when people disengage and reengage. Participants often discussed a worry that Jaimie would lose services at 18 years old and proposed that in an ideal scenario, there would either be a service that would continue to support her after she reached 18, or a team that worked across adult and children's services that could provide continuity of care at that transition point. Around 30% of participants also stressed the need to seek comprehensive trauma support and therapy for Jaimie that would be long enough to allow her to explore the childhood traumas from the familial abuse rather than only focussing on the current abuse.

Deona

Deona is a 13-year-old girl who says she has a 17-year-old boyfriend, Marcus. Her parents are comfortable with the 'relationship' and say they have known the boy and his family their whole lives. You are still very concerned and feel the 'relationship' is exploitative. Deona has started taking selfies (some nude) and sending them to Marcus. She hangs around with him all of the time and rarely sees her friends anymore. Her mum says its 'young love' and that she met Deona's Dad when they were a similar age. You speak to your colleague about your concerns and they say that teenage boys are driven by sex, that Deona is bringing this on herself and you should teach her more about sexting and grooming. You agree to teach her more about sexting and grooming the next time you see her, but you can't help but feel something else needs to be done here.

Key findings: Deona	
If this scenario was happening in the LA now, what do you think the response to Deona would be?	**If this scenario happened in the LA in the future, and you had all of the knowledge, resources and approaches you needed, what do you think the best possible response is for Deona?**
• Report to police and refer to child protection procedures • Concerns that current response might be too intrusive or heavy handed • Work with Deona about healthy relationships, risk taking behaviours, grooming and keeping herself safe • Work with parents around boundaries and supervision of children • CSE screening tool and refer to MASH • Speaking with or action taken against Marcus • Education of Deona about CSE • Hold strategy meeting • Support Deona to engage in prosecution • Give Deona online safety education • Parents need to be challenged about condoning the relationship with Marcus • I fear this would be seen as her own choice in current responses • Refer to CSE SUPPORT SERVICE, but this probably would not hit their criteria as medium or high risk • Challenge my colleague's assumptions	• More focus would be on Marcus and not on the behaviours of Deona • Parents of both Deona and Marcus need educating or challenging • Child-centred support for Deona, working alongside her to understand how she feels about the relationship and why her other friendships have broken down • Work on her self-esteem and confidence • The colleague needs to be challenged and may even need more training as this was appalling advice • Work with Marcus too, to explore his relationship with Deona, whether he is exploitative or abusive and why he is in a relationship with a much younger child • Deeper analysis of the family life, working holistically with whole family to understand dynamics and family cultural norms • Encourage attendance and involvement with a young women's group or a youth group for Deona • Deona needs to be protected by us and Marcus needs to be disrupted

Commentary

For the 'current' response to this scenario, participants mostly talked about educating Deona, taking action against or support Marcus and challenging the parent's perceptions of their daughter's relationship with Marcus. Several participants commented that they would be concerned about the way current practice would respond to Deona, with some suggesting the intervention may be too intrusive or may blame her. One participant stated that they would refer to the CSE support service but did not think this case would hit the criteria to be accepted for specialist support. Whilst the final sentences about the inappropriate advice of the colleague were included to deliberately explore whether participants would respond to them, most participants agreed that Deona needed to be educated and only a small number of participants said that they would challenge their colleague's comments about Deona and Marcus.

In the 'ideal future' response to this scenario, there were more holistic and comprehensive suggestions – and there was much more focus on the behaviours and actions of Marcus. Over half of participants argued that the ideal response to this scenario would be to work with Marcus, or (if required) take action against Marcus. This was often argued as being an alternative to 'educating' Deona to reduce her risks or to change her behaviours. There was much more discussion about the challenging and educating of both Deona and Marcus's parents, as many participants reported feeling uneasy that the parents encouraged and condoned a relationship with a large power imbalance. As frequently mentioned in the answers to the previous scenarios, there was more talk of a flexible, child-centred group or service such as a women's group, a youth group or support service for Deona that would have the time and resources to commit to Deona.

One pertinent message in these answers was that whilst participants felt strongly that the wellbeing and needs of the victim must come first, they must also not be positioned as the reason or solution of the abuse. In the 'ideal future' responses, there was more focus on the behaviours and actions of perpetrators or the people posing the risk and more strengths-based, supportive work with the victims.

Section 3: Exploring solutions to common CSE/CSA problems in practice

The final section of the questionnaire asked participants for their opinions on the solutions to common issues and problems in CSE/A practice and procedure. All participants read the sentences and were asked 'For each problem or issue, how would you solve it, if it was up to you?'

This was a sentence completion task in which participants were presented with ten sentences about CSE and CSA practice. Some participants finished the sentences whilst some chose to write larger, more complex comments and arguments prompted by the first half of the sentence.

Below, the most common themes are presented for each sentence, with examples of real answers from participants.

5. When children don't want to press charges against the people sexually abusing them…

The responses to this question were mixed. Some participants advocated victimless prosecutions, some stated that they would respect the decision of the child, some argued that the entire system needs to be reviewed but a large number of participants argued that professionals should keep working with the child until they change their mind. A concerning tactic cited by around 8% of participants was to tell the child that they should prosecute in order to protect other children from the perpetrator or to change the perpetrators behaviours. Interestingly, whilst the questionnaire was confidential and completed individually by participants, some answers pre-empted this response from their colleagues and argued that children should not be held responsible for protecting other potential victims or for changing the behaviour of the perpetrator.

Continue to encourage them to prosecute

> *'Work with them until they change their mind'*
>
> *'Try to work with the child to find out what their fears about pressing charges are and keep working with them to get around this.'*
>
> *'Work with them to get them to understand the risk the perpetrator might pose in future, to them or to other young people.'*
>
> *'The child will need lots of support from trusted adults to get them through the prosecution process.'*
>
> *'Keep working with them until they understand why it is important for them to press charges to stop the perps doing this to others and continuing their behaviours.'*

Respect their decision not to prosecute

> *'Remove them from the process all together and work with them to see what they want to do.'*
>
> *'Don't. Find other ways to intervene that would mean the child having to press charges. Find other ways to place responsibility on the abuser that doesn't rely on the child.'*
>
> *'We are all responsible for the wellbeing and safety of the child and that includes not putting them through traumatising processes.'*

'We would find other ways of supporting them that doesn't rely on this. It is okay for them not to want to press charges and it is not their responsibility to protect others.'

Continue with prosecution, but utilise victimless prosecution

'Social care and police should be able to pursue charges against the offenders on behalf of the child in which the child does not need to be there.'

'Greater emphasis needs to be placed on seeking victimless prosecutions which would require more input and support from the CPS.'

'Support their decision and look for ways to carry out a victimless prosecution'.

'The police should be able to take this further without the child and go for a victimless prosecution if they already have some evidence.'

Change the system

'I think we need to get to a place in society where it isn't necessary to rely on a child to make a decision to press charges as we already have a duty to take action and protect all children.'

'There needs to be a new process that supports victims in a criminal case without interrogation and intimidation, could a judge speak to them separately for example?'

'I think we should find a new way of doing this as an LA via the CPS. The police have the evidence. So, do we. So we already have accounts and records we could use without the child. We need to be putting in place exclusion zones and abduction notices and the police should continue to monitor their behaviours and movements, passing that information back to us freely and without hesitation!'

6. When professionals blame the vulnerabilities or behaviours of the child for CSE…

The responses to this were heavily weighted towards condemnation of this practice, and a call for more challenge and more training of staff. The majority of all answers (over 90%) were participants describing how inappropriate and harmful the discussions around vulnerabilities and behaviours 'leading to CSE' can be for children and what to do to stop this in future practice. Many participants discussed both training and robust challenge in the workplace. However, there were around 10% of participants who did not condemn the statement or discuss training or challenge, but agreed that vulnerabilities and behaviours of children are the reason for CSE and discuss ways to change the child, their vulnerabilities or behaviours to stop them from being sexually abused.

Training for staff

'This is a training issue.'

'We have to work out where these attitudes are coming from?'

'Educate the worker through supervision and training courses.'

'Educate these people on what CSE actually is.'

'Training for staff to ensure they fully understand abuse and exploitation and that the child is never to blame for abuse.'

Challenging each other and reporting poor practice

'If this happens in our organisation, we have to learn to challenge this – as a learning process rather than blaming each other for it.'

'Challenge this view and provide them with reasons why it is not the child's fault, and then report to their manager.'

'Professionals need to be challenged and need to remember that children need protecting, they are not making a choice to be sexually abused.'

'This should be challenged robustly and appropriately with the staff and the management, and report to my own senior management if I think it is affecting the case.'

Vulnerabilities or behaviours do lead to CSE

'We would need to look at what behaviours and vulnerabilities are prevalent and why the child keeps choosing to spend time with these individuals.'

'Refer to appropriate services that can look at changing their behaviours, so they make wiser choices in future.'

'Educate and empower the child to change.'

'Address the vulnerabilities to make sure they understand the risks. For example, if a child is deaf and that's one of their vulnerabilities then we need to make sure they have an interpreter.'

7. When the CSE toolkit says 'low risk' but you just know something is happening to the child…

The responses to this sentence were incredibly similar in nature with very little variation across participants. Generally, their answers fit into two themes: ignoring the toolkit outcome and escalating the case further whilst also making sure the support continues for the child even if the toolkit says the child is at a low risk. This suggests that all participants of the questionnaire were prepared to ignore or minimise the outcome of the toolkit and preferred to base their judgements and decision making on their own experience and knowledge of the child. This is a positive outcome but does raise the question of the role of the toolkit when every participant advocated ignoring it or using it more casually.

Ignore the toolkit and escalate

'Raise it higher. Escalate it.'

'Root any assessment of the child in their life and their context, not what some checklist says.'

'Screw the toolkit! Your professional opinion and gut instinct is a stronger indicator of risk than any piece of paper.'

'The toolkit is only a toolkit, it should never replace our professional judgement.'

'The toolkit is just a guide. Where the professional can articulate what their fears or concerns are, they should be taken seriously and closely looked into.'

'At our CSE service, you use your discretion. If there is other information to suggest that more is happening for the child than is on the toolkit, we wouldn't put them at low risk. Young people do not fit into a box, the toolkit is just a guide.'

'You should always go with your gut and not the tool.'

Continue supporting the child no matter what the toolkit says

'Keep exploring, don't stop supporting the child and seek supervision to discuss it.'

'If you complete a risk toolkit and it comes out low, but you know something is happening to that child, you need to seek further evidence and advice but the most important thing is to continue working with that child even if it says 'low risk'.'

'Keep working with the child and the family even if it says low risk.'

'The risk level on the toolkit does not dictate to me the type of work I do with the child or the family, no matter what it says, I would offer support to the child.'

8. When the child keeps going back to the abusers even after lots of work has been done with the child…

The responses to this question were child-centred and reflective. Almost every response included a strong message that professionals should not give up on the child. As the sentence completion task is about how they would resolve current issues in practice, it is interesting just how many participants used the phrase 'do not give up on the child' which was used by over 40 individual participants in their answers, and was paraphrased or explained by almost 90% of participants in different ways. The second theme to emerge in these answers was a reflective message to look critically at practice, stand back and work out what is not working. The final theme was linked strongly to the second theme, in which many participants went on to say that many of the interventions that don't work are the ones which focus too much on changing or restricting the child and don't focus enough on stopping the perpetrator. Therefore, the third theme was made of several responses that argued that the response should focus much more on the perpetrator.

Don't give up on the child

'Understand and stick with them.'

'We need to keep going and keep caring. All agencies need to remain supportive and responsive.'

'Continue to support the child and their family. Don't give up on the child!'

'This is very difficult to address but we need to keep the support going for the child.'

'This is to be expected sometimes, but we need to understand trauma bonding and keep working with the child. The intervention needs to increase as the risks from the perpetrator increase.'

Work out why your intervention is not working

'We should stop doing the same work over and over again with the child and look at what we can do to the abuser instead.'

'Look at the work we are doing and look at why it isn't working.'

'The child is being let down somewhere and we need to look at what is going wrong. It is our responsibility.'

'Find out why its not working. Find out why they go back and then deal with that bit.'

'We should just work harder to understand the reasons and do something about it.'

Focus more on the perpetrator and not on the child

'The professionals need to focus more on the perpetrator and build up a case for prosecution. We should be using non molestation orders, civil orders, disruption tactics.'

'Target the abuser instead, and work on trauma support for the child.'

'Responsibility here is not on the child, its on the perpetrator. Support the child and focus on stopping the perpetrators.'

'Continue to disrupt, visit and mark the abuser. Pull them over in the car. Visit their residences. Gather evidence.'

'The work should be on the perpetrator and stopping them, not raising awareness and educating the child. The victim shouldn't be doing all the work, we should be supporting them with any traumas not raising awareness of grooming etc.'

9. When the child is too traumatised to give evidence in court…

The responses to this sentence completion task revealed two schools of thought: those who would not pressure the child to give evidence if they were too traumatised and those who would continue to encourage the child to give evidence but would seek something supportive or protective for the child to enable them to attend court and to give evidence. Participants showed good knowledge of special measures that would be available for a child who was intimidated by the process, including the later pilots of the S.28 provision to have pre-recorded cross examination in addition to pre-recorded evidence in chief played to the court. However, this does show that within the participants there was a group who would have stopped the process out of their reported respect for the child

and to protect their psychological wellbeing. There was also the second group who did not discuss the wellbeing of the child as much and instead described the ways they could encourage the child to give evidence despite the trauma.

Don't make them give evidence

'Don't make them.'

'They are not required to do so and even then, we can provide this outside of a court setting.'

'Support and respect their decision. Their mental wellbeing comes first.'

'Don't try to make them. If they actually want to engage in legal proceedings, then find some supportive and creative ways for them to do so without retraumatising them for our legal agenda.'

'They need support and they should not be forced into a position that will cause them more trauma.'

'Also, children should not be expected to go to court at all if the evidence has already been established. Getting them to go to court is the way perpetrators try to get around things.'

'We will never pressure them to do this, their safety is our top priority. If the process is not good enough, the process needs to change!'

Utilise special measures or other support to help them to give evidence

'Find out if there are other ways the child can give evidence offsite, such as live link somewhere else.'

'Definitely look at alternatives to them giving evidence in court.'

'The child needs support and therapy to process what happened and how they feel before they can even contemplate giving evidence.'

'Video evidence needs to be accepted by the courts.'

'Look at alternative methods of giving evidence such as written records, videos, statements taken by social workers, using S.28 to have pre-recorded defence cross examination questions…'

10. When you find notes on the child's file using inappropriate or victim blaming language about the child and the abuse…

The responses to this sentence completion task were all very similar in nature. Participants advocated for challenging the author, reporting the notes and trying to do something to amend, remove or add a note to the comments made about the child. Some participants commented on why they thought this might have happened, which included a lack of training, time constraints and others displaying a zero-tolerance attitude and suggesting the author 'is in the wrong job and should be reprimanded.'

Challenge the author of the notes

'The professional needs to be challenged. It is not the girl's fault or responsibility if she is being abused by someone!'

'Discuss concerns with the writer of the notes and challenge their views, giving reasons and then request them to change it.'

'Support to appropriately challenge but without putting the worker down because they probably only wrote it under time constraints.'

'Challenge the author and ask them to change what they wrote.'

Report to management and discuss in supervision

'Tell my manager'

'Tell my senior and then consider telling their senior'

'Bring it up in case supervision to explore what can be done.'

'It needs to be flagged to their line manager.'

Try to get the notes amended, removed or commented on in the file

'Discover whether they can be changed, talk to a manager about changing the notes for the child'

'Ask for it to be removed or changed, one day that child might read their file and see we blamed them – then they might feel to blame for abuse and that is not acceptable.'

'It needs to be given to the system administrator to unfinalise or roll back the notes, the child should not see this.'

'Request the language is changed and explain clearly that this is not the fault of children.'

'It needs to be changed, because if the police needed those records for a criminal case…'

11. When professionals misinterpret trauma behaviours for a behavioural problem…

The answers to this question were split roughly in half. Around half of participants responded that further training was needed for professionals to understand trauma behaviours after sexual abuse, and the other half responded that the professionals need to be challenged. There were a very small number who responded that trauma does cause behavioural problems or that there was no difference between trauma and behavioural problems. However, the majority of participants approached this question from a trauma-informed perspective in which they would like to see future practice involve significant training that would teach professionals about trauma behaviours in abused children.

Train and educate professionals

'Educate them and help them to understand. They need training.'

'Further exploration and understanding, that does mean training but also more time to get a deeper understanding.'

'Further training should be available to help professional to understand and identify the difference.'

'Again, more training courses around trauma and the impact on people'

'More training and understanding around trauma'

'Educate professionals to develop their understanding'

Challenge professionals

'Challenge this view and back it up with research evidence.'

'Challenge the professionals in order to raise their awareness around such behaviours and the teenage development and how trauma impacts upon the social, physical, intellectual, cultural and emotional behaviours and development.'

'Gain evidence and keep working with each other to assess and challenge'

'Report this ... try and get the professional to understand the trauma the young person has been through.'

Section 4: Final thoughts

12. What would you say were the biggest achievements that have been made in your CSE/CSA workforce?

Participants were asked to comment on the achievements made in the workforce supporting children subjected to child sexual exploitation and abuse. The responses were diverse and ranged from participants feeling that everything they could think of had improved and changed, to participants who felt that nothing had changed or improved and that CSE was still being viewed as a special or different form of abuse that took a deficit model, reductionist approach to children.

Many participants discussed the way the understanding of CSE had changed and improved over the years and reported that the biggest achievements for the LA had included listening to the voice of the child, perceiving the child as a child rather than a promiscuous adult and being more vigilant to the signs of sexual exploitation.

Some participants talked about how much CSE practice had improved since the relationship with the police had become stronger and since children were able to access ISVAs and CHISVAs. Four participants agreed that huge improvements had been made but that CSE had become too much of specialism and that it was to the detriment of the rest of the work force to have one specialist team whilst everyone else lacked the training and insight that the CSE specialist team had developed.

13. What would you say are the biggest problems facing the CSE/CSA workforce and how would you solve them?

When asked this final question in the confidential questionnaire, the answers could be split into four main categories: a problem with the overt specialism of CSE and the CSE team, a concern about the lack of value and understanding of therapeutic support for children and families, a problem with resourcing and caseloads and a concern with victim blaming of children.

Around 25% of the answers discussed related to a feeling that CSE had become so specialist that other professionals in the workforce were not valued. Speaking about the CSE support service team, one participant said:

> *They have been made "expert" to the detriment of the expertise of the other, I understand why given historical context but the number of young people who are potentially at risk is higher than the volume they can cope with. We need to "normalise" our attitude to CSA and give expertise equitably across the workforce at a much higher level and retain some specialism to ensure the most complicated families receive the right support.*

This view was not unique. Another participant shared very similar views:

> *'They (CSE SUPPORT SERVICE) are perceiving themselves in the LA as a specialist elite service, who say that no-one else understands risk like they do, no-one gets CSE like they do, and that they have the last word on what is and isn't CSE. (Not helpful when this comes from the HOS down). However, when cases transfer to Locality or LAC teams, those SWs manage to work with the children and young people and do not see themselves as anything other than hardworking, conscientious, safety-aware, child-focussed social workers. That is what is happening in the LA - CSE has been linked to complex abuse and by the set-up of a specialist team, the knowledge is contained within a discreet number of individuals.'*

This view is very complex and warranted further exploration and so it was incorporated into the interview and focus group question schedule to discuss.

Other participants talked about trauma therapies and counselling for families and children, arguing that some professionals still did not understand the value of counselling or support for children, or that they could not see how it might help a family. Linked to this, some participants talked about residential placements out of area were being termed 'therapeutic placements' without them having any therapeutic value. Participants reported that children often perceived the move out of area as punitive towards them and not therapeutic at all. One participant said:

> *'Not always having proper therapeutic placements for young people so if they move from family and all their connections then the young person can end up with foster carers who give up on them and reject them. This is not therapeutic.'*

Finally, participants talked about the way children were sometimes perceived as culpable, or the way professional approaches placed responsibility on children to change in order to protect them from being sexually exploited. Participants talked about the pressure on children to disclose, the focus on getting the child to change or keep themselves safe and the low conviction rates. One participant talked about the way the disagreement over the definition of CSE was still hampering practice, which included the strong stereotypes of who was a victim and who was a perpetrator of CSE.

Findings from this section and all other sections in the questionnaire were analysed to look for issues that needed further exploration and deeper conversation. Teamed with the issues that the commissioners had asked to be included, they formed the questions in Appendix D.

Interview and focus group findings

Between May and August 2018, professionals were interviewed or took part in focus groups to explore key issues related to future CSE/A practice. Questions were developed from the questionnaire findings and included directed questions as required by the commissioner who had an interest in holistic practice and the use of the CSE risk toolkit.

Is CSE a distinct form of abuse or a form of child sexual abuse?

Participants from outside of the CSE support service team or who do not work on CSE cases generally argued that CSE is CSA and that there is no real difference between the two types of abuse.

> **Professional 1:** *CSA is CSA, CSE is CSA and there are thousands of different ways it happens – they are all the same but maybe the child deals with it in different way. In my work I call it 'CSE/A' – it is exploitation and its emotional impact on child that is huge – no one would agree with me though, my view is rare here*

Some participants argued that the distinction between CSE and CSA had led to detrimental effects on practice for the wider workforce, something that was picked up in the questionnaire. Participants such as Professional 2, argued that CSE had grown into something more specialist than it is and that the whole workforce needed to be able to support children who had been sexually exploited, with CSE practice being pulled back into mainstream practice.

> **Professional 2:** *I think it had a time and a place in The LA here to trigger investigations and to look at practice – but now it needs pulling back into the mainstream. I mean, you know, with access to specialist things when you need it – but it should be in mainstream. I think people have seen it as a specialism and its grown into something more specialist than it is and I think all staff need to be able to support children. I do get a bit frustrated when I hear from 'specialists in CSE' – because I don't buy that at all and I have worked in various places and CSE has turned into an industry – I'm not saying CSE teams don't have specialist skills, but it devalues the rest of the workforce and their skills, abilities and qualifications*

A further argument was made by other participants that the decision to have a specialist team that responded to CSE but not to CSA and other forms of child abuse had positioned CSE as more important or had marginalised those children as more vulnerable than everyone else. This view was not unique and recurred across the interviews with participants.

> **Professional 15:** *For children accessing those services, it has to have some sort of marginalising effect on them where they feel they have to have this specialist person – what does that do to our children? How would that feel as a kid or other people in the family get a run of the mill family social worker, but you need a specialist? That's makes you different and that causes that narrative that CSE is different.*

> **Professional 3:** *From my experience, I used to work in another area where most cases were in cities. I've always seen it as a very separate issue and there are some links to vulnerabilities and it can be seen too separately sometimes. As long as each case is seen properly, and the familial stuff is also considered and assessed. With it being seen separately, 'oh it's in the community, its kids deciding they want to do what they want to do' – there is less of a defeatist approach in CSA that you get in CSE. People wouldn't take that view in*

intrafamilial CSA. There is a risk of normalising CSE and behaviours, workers saying 'well that's what we did as kids' and we need to stop them normalising it.

Professional 4: *It is CSA. It is child sexual abuse, I feel like, I don't really know how that could be argued against. I guess I can sort of see a benefit of having a term but not as a distinct and separate approaches. I can also see the negatives of having the separate term and then people think it is something different that only happens to certain kids by certain people. Working with NQSW, they don't feel confident with CSA or CSE cases at all, that's still an area they need more development, no matter what term they use. The older staff see a difference, they see CSA as parent to child, and they talk about that as sibling on sibling, but they see CSE as distinct. I have heard people starting to use that language and saying abuse not exploitation.*

The responses from the CSE support service team were very different in nature and tone as they were much more likely to define CSE as different from CSA. Many participants argued that CSE was distinct from CSA but without significant explanation as to why.

Professional 5: *Well it's a form of CSA, but it is distinct. There are differences in CSE, but it is a form of sexual abuse.*

Professional 6: *I would say there are more specific complexities to CSE than CSA, but it is still a form of CSA.*

Some participants argued that the crime of CSE is perpetrated differently from the crimes of CSA, and said the key difference was the 'exploitation' and 'exchange'. Some participants said that perpetrators of CSE do not commit offences for sexual gratification the way they do in CSA, which revealed a lack of knowledge about sex offenders and stereotypes about sexual offending.

Professional 7: *The way in which the crime is perpetrated is different, and the exploitation bit makes it different. The exchange. That's the exploitation in CSE. But it is a form of CSA.*

Professional 8: *CSE has got them different complexities around the exploitation and the intention is different in CSE whereas in sexual abuse the same intention isn't there, is it? Its not for their own sexual gratification is it? They don't do it for sexual gratification in CSE.*

One participant argued that CSE starts off as CSA and then changes to CSE when the exploitation and grooming begins, which positions grooming as only happening in CSE.

Professional 9: *CSE starts off initially as sexual abuse and then it separates off into exploitation and grooming. That's the distinction and that's what makes it different from CSA.*

If practice of CSE and CSA was merged, how would you feel about that?

Participants from the wider general workforce responded differently to this question than those who worked in the CSE support service team or worked on CSE cases regularly. The CSE support service team had more concerns about merging practice than the wider workforce and felt that if practice was merged, cases of CSE were likely to be missed by other practitioners.

Professional 10: *I worry that the complexities of CSE would be missed, it wouldn't be seen as separate and things would be missed, maybe it wouldn't come through as strongly*

> **Professional 11:** *We do a lot of mapping and we have massive flipcharts of how people are connected, and if it was merged into CSA, we would miss those connections. We also map the perpetrators and that wouldn't happen in CSA so…*
>
> **Professional 12:** *I wanted to add that we get a lot of referrals through where there is a lot of familial abuse, rather than actual CSE and we keep getting these referrals that when we screen them, they are familial abuse. But it is getting better now and people in locality are still adjusting. I think it would be a big loss to merge the areas of practice*

The participants from the CSE support service team also felt they were in a better position to challenge poor practice and to spend time with children, that they felt would be hindered by merging practice and may lead to children not getting the specialist time they needed with their worker.

> **Professional 13:** *I think we are in a better position to challenge people if those indicators haven't been picked up on or we do get referrals where it is the flip side and it's a 17-year-old male with a 13 year old female and they say its CSE but we look at it and say it is an inappropriate relationship.*
>
> **Professional 8:** *We have all been there, you're a social worker in the locality and you have 35 cases or more, and time is quite limited but because we have that extra time to work with children and to get more, it takes a lot to open up and you don't get those disclosures early on. A locality social worker doesn't have the capacity to do that work. We have low case loads here, we have maybe 9 or 10 I guess but we need that because a lot of the girls and boys need patience and consistency and that may take forever. If within that, you had 20 other cases, that person that needs more time.*

The discussion in the focus group turned to caseloads and whether it was fair that CSE specialist workers had very low caseloads when other workers were holding up to four times more cases and therefore not able to develop the relationship needed to work effectively.

> Professional 6: *The thing for me is that if everyone had lower caseloads then all children would get the amount of time we are able to give in the CSE team and they would all be deserving of the same amount of time and service*
>
> Professional 1: *CSE team has much lower caseloads so they can do much more intensive work, but we are sending CSA referrals to locality teams with high caseloads and they are not getting the same level of service. But the CSE team only work normal hours 9-5 – Monday to Friday so those teams need to be much more flexible.*

One participant commented that they didn't feel confident working in CSE and were reassured by having the CSE support service team to refer to and ask for support. However, they did then consider whether it is the stigma around CSE that makes her feel nervous about working with children affected by CSE rather than the fear that she was not able to do the work.

> **Professional 2:** *I feel reassured by having the CSE team and I know CSE is not one of my stronger areas because I don't have much experience of it and I would feel more comfortable working with another more experienced workers than on my own – and it's better to have two workers, they have so much more experience. I don't feel that way with CSA, I have had loads of those cases and had lots more experience and I don't think it's as overwhelming, a lot of this is stigma but also the complexities and the amount of links and mapping between children and perpetrators. There is so much stigma around CSE, especially here – I'm not sure*

if there was that stigma there, maybe workers wouldn't feel so worried and vulnerable about working with CSE. I feel I would be more uncomfortable if I had a CSE case, so I read up on it and researched it

How would you feel about practice and knowledge being merged to take into account all forms of interpersonal violence such as DA, CSA, CSE, HBV, HSB rather than seeing these issues in silos?

This follow up question also created debate and divide in the answers with many participants being concerned about caseloads and the way this would work in practice. However, this discussion also revealed that the allocated social worker in CSE cases was often being left with the difficult and more contentious tasks whilst the CSE team workers were able to build rapport, resulting in the child not trusting their social worker.

> Professional 8: *It is a disadvantage to the child to merge practice because we have more time. If they didn't have us, it would be limited to what they would have and the chances they would have, and barriers would be more evident.*
>
> Professional 9: *It helps that the social worker deals with all the other issues and we don't get dragged into the other issues like the allocated worker.*
>
> Professional 10: *For example, say you are doing a parenting assessment and your outcome is that the child needs to go into foster care that would ruin that relationship with the social worker but we don't have to deal with that which means they can come to us. Quite a lot of the young people I have at the moment do not like their allocated social worker because they see them as against them or their parents and they will openly say to me, 'I don't tell my social worker anything' and we also use that information they tell us to keep them safe, but they see that as different.* **(Researcher: In a way, does that mean because you are able to do the rapport building, the social worker ends up picking up all the difficult bits and negative news to give the family but you always appear supportive, meaning the child gets a positive view of you and negative view of their allocated social worker? But only on the basis that you don't have to do that stuff the allocated social worker has to do*?)* *I think it just places the blame on the social worker and you get to do the direct work with them.*

One participant commented that the dynamic between the CSE specialist team and the rest of the workforce caused a feeling that CSE deserved specialist one to one work, but CSA didn't.

> Professional 1: *We already sort of have that in locality teams and the caseloads are 28-30 people. It feeds into everything, it's rare that you are going to work with a family where it is just sexual abuse. And that's why the CSE team co-work cases do not hold them – it sort of says this form of sexual abuse deserves one to one work and yours doesn't and that's a bit crappy.*

This was echoed by another participant who questioned why there was a specialist team for the least referred issue but not one for neglect, as the most referred issue.

> **Professional 2***: It would be an advantage to the child if teams could be specialist in many areas – that worker knows the child inside out and rather than seeing this worker for this and one worker for this – its stops the blame being passed around social workers for things that go wrong where it is one person in localities but caseloads would need to be way down and training would need to be tenfold. It needs to be able to reflect on the child life and their*

history. Because why don't we have a specialist for neglect? It's the most common form of abuse in country and yet we don't have a neglect team. Everyone is scared – it's all media driven and political driven rather than child driven but LAs are not being child driven, CSE is the least referred issue. We have DA, EA, CSA, neglect but they don't have teams and they are much more common.

Some practitioners also talked about the need for more holistic working that looked at the whole life of the child rather than being concerned about labelling them with one form of abuse or another.

> **Professional 3:** *I think we should be working towards a much more holistic way for what that kid needs. They might have had several things happen in their life and we need to look at the whole child and try to understand everything they need. We get too stuck as professionals and say 'oh we need a domestic abuse strategy' rather than for example, a wider approach. We need to work to solve the whole problem and not just lead that person on. The more we can focus on the child and understand what their needs are and not get too hung up on the label we give them.*

> **Professional 4:** *When you have two workers alongside, that does work well. But I always assume as social workers we would link it all up and look at wider concerns. The issue is that if you have a specialism you can become blinkered.*

Finally, one participant argued that training and merging would be futile as a strategy if the cultures and value bases around CSE practice didn't shift.

> Professional 6: *Immediate thought of this, where do you stop? So then don't we all just need all of that knowledge? Of everything? And does everything end up being co-worked? And that's not necessarily a bad thing. I worked in a feminist org for a while and I keep thinking about DV and development around DV. We do the assessment on Dad, and how well Mum can protect the kids from Dad and there is so much victim blaming there. I don't know if it is just about skills, it's about value base. So that's why I am concerned about separate teams, because it's not the skills that are important if there is a such a different value base, it needs complete cultural shift?*

One of the things that has made CSE unique in practice is that it has a specific tool to measure risk of CSE occurring to the child that is used heavily in practice to direct decisions and interventions – how would you like to see these improve or change in future?

There were strong views communicated in the interviews and focus groups about the CSE risk toolkit, many of which were negative. However, when participants were asked if they would stop using them, they spoke of the fear of missing things. There was also some confusion about how the toolkit was used in practice, with some participants claiming the tool was narrative based and did not rely on indicators or checklists, and others claiming that was incorrect.

Some participants talked of removing them or not using them because they didn't like them, and didn't like the low, medium and high-risk language on the tool, especially to describe children who are already being harmed.

> **Professional 1:** *I don't see the point in them. If you are having the measure them on that risk scale, they have already been harmed. I can't stand ours. The high-risk kids have already been abused. Low risk children are already high. If I say that in MASH I am banging my head*

against a wall, low risk will go to early help. Med and high risk are already abused. Calling them medium or high is kicking them when they are down – you've been missing three days and you are medium. Baffles me. The meetings 5 professionals judged by them and being told they are not at risk enough

Professional 2: *I would like to remove them. They do nothing. Where to start? I have seen them develop and I have seen different strains and types of them. I would rather us to just talk to children using a validated, evidence-based tool and we could talk to them about their psychological and social and emotional wellbeing – the toolkits make you look at the wrong thing, they make professionals feel better. They fill it in and they get a score or a RAG rating. I don't like the idea of risk ratings – these are children.*

Professional 3: *Part of this is just back covering because people are under such scrutiny but there is no evidence base and they have never been validated. I am sure some staff will say they feel comfortable using them. There is a future without them and good relationship and learning the experiences and the child's voice is more important without the form, not as a form, but as a way of learning about the child. The form should not be used with children and I tell my staff to never take that form with them – the form becomes a wall between them*

One participant talked about the sexism and victim blaming in the toolkits, especially around sexualised dress. They went on to talk about the tick box exercise being ineffective if someone else can change their outcomes and decisions and called for something more evidence-based.

Professional 4: *It has always sat uncomfortably with me. The stuff around the sexualised dress and behaviour really trouble me and put the risk factors in the chid themselves and I had a referral once saying a girl was wearing a crop top and I was like 'I wore a crop top at that age!' The fact that high risk children are not high risk, they are victims. When the CSE team staff come to our meetings and we do the risk assessment and one of my students commented that it was a tick box exercise. We had a few cases where we got low and then a manager rang and said 'actually, this is medium' which shows they don't work, because as soon as there is any reflection around it, it changes but it is a tick box thing. I want something evidence based, I want something that works and has evidence – if there is no evidence base we shouldn't use it and we should just go back to our assessment, single point assessment.*

When the CSE support service colleagues were asked the same question, their use of the CSE toolkit seemed more nuanced and child-specific, but they also spoke of disliking the low, medium and high risk criteria and of changing outcomes based on their own professional judgement, rendering the indicators on the tool ineffective.

Professional 7: *It's a strange question because to me, it is just guidance and no children fit into a box and you know things are going on for those children but the indicators aren't there and you use your judgement. The narrative is the most important bit, not the indicators*.

Professional 9: *Sometimes we will get a feeling from reading something that there is something underneath it, even when the boxes aren't ticked, and you realise there is more you want to unpick*. **(Researcher: Isn't that evidence that the narrative in the referral is more important than the list of indicators?)** *No because I spoke to workers in locality who say it is useful to help them, so they don't forget.*

The focus group engaged in a debate similar the thoughts coming from the interviews in the wider workforce, focussing on what low, medium and high risk really mean.

> Professional 10: *My issues are with fitting children into high medium and low. That's my problem. You can put context in, but fitting it into medium or high and we disagree and sometimes we err on the side of caution and the way those locality workers view the child is totally different to how we view it so its almost like, how can we compare them as being the same if everyone perceives the information different? What is high? What does medium mean?*
>
> Professional 11: *I agree with you, its so open to interpretation. If there is a risk, there is a risk, why is it medium or high?*
>
> Professional 12: *I think a narrative is better – because when we say high risk, we are talking about high risk of being exploited in future but our high risk children are already being exploited so it doesn't define it enough so is the young person already being exploited, or do we suspect they might be, those two categories are much better than high, medium and low. And that also aligns it to the significant harm thresholds and categories better. If they are at low risk, they are still at risk but then they aren't open to CSE team, so why aren't they?*

Participants from the CSE support team and those who worked with CSE cases also discussed the purpose of the CSE toolkit, describing it as 'trying to assess the future' and discussing what happens when children do not hit the stereotypical indicators but are still being sexually abused.

> **Professional 13:** *Well, risk brings vulnerabilities and vulnerabilities bring risk and a child doesn't necessarily have to be vulnerable to be abused by a perpetrator and they could come from an affluent background and be going to school. You are trying to assess the future I guess.*
>
> **Professional 14:** *Well, there are also the children who are already being abused but they don't tick any of the indicators because they are still doing well at school and there are no signs and they wont even get a service.*

In individual interviews, some participants talked about the confusion between the single point assessment and the CSE risk toolkit, and why the process was being duplicated. They also disputed the claim that the CSE risk toolkit was a narrative based tool that was flexible and nuanced.

> **Professional 4:** *Single assessment is basically saying talk to us about the child, what is life like for this child, if you have concerns, write them and say this is your hypothesis and the locality teams need to explore this – we don't need tick boxes, it's quite open and you can write about whatever you want. The CSE toolkit does not work with child focussed single assessments. Even though the single assessment shows that the child is possibly being abused already the CSE toolkit doesn't pick it up and then they end up not hitting the threshold. The CSE team tell us you can write a narrative around the tick box – and I think, what's the point? Read the assessment! You don't need another tool! Writing around a tick list that doesn't work is not the same as an assessment. They come back and say it is a narrative based tool, its not.*
>
> **Professional 5:** *In our LA it was really important to get on top of it, but maybe when we get to a point where people are more confident at addressing it and identifying it, maybe we wouldn't need one? In duty, the identification happens before the toolkit, we have to identify*

its CSE in our own brains before we even fill in the toolkit otherwise why would we use the toolkit?

Professional 7: *They say 'We don't need everything!' and then other times 'Woah why didn't this come through to us?' and people are a bit confused about what is needed to go through and what isn't – especially where it is two teenagers together like a 15 and 17 year old or two 14 year olds and a bit scared of being shouted at for not sending things through. Some people haven't had good experiences at the CSE panel and the attitude has been really negative and been shouted down for bringing cases and been told it's not a risk of CSE, thinking its low or medium, being asked 'Why have you come here? Its low risk!' And then come away from it thinking 'I will be more careful next time of what I put through' and then I have seen the opposite where dip samples happening, and they have said 'Why haven't you put this through?' so they are scared to get it wrong.*

Are there any interventions or responses to CSE that you would like to see improved in the future?

Many of the responses to this question focussed on improving practice for the wellbeing of children, including comments about trauma informed practice, the removal of CSE films, the use of the screening toolkit and much better legal processes for children.

Professional 1: *Everything really. Identification. Thresholds needs to completely change. High risk is already sat in secure units or being raped and abused – they are victims. Most of the high-risk kids are in care, what's that about? From that, it's quite clear that CSE is not a underlying issue so why are we treating it in silos and do work in healthy relationships when they've seen their mum get kicked the shit out of for ten years so how does that help? We don't do that in domestic abuse.*

Professional 3: *The solution is child focussed work, let the child tell you where they are and what they need with support from us. If a child was gonna fill in that CSE screening tool it would all go to pot. It has to be around the child – go find them, where are they? They need to feel the SW gives a shit. Why aren't we there to find them? Standing in hotspots? Getting to know the whole family? You can't stop the problem if it's in the home unless you have serious evidence so it's all about building relationships and determination. The child will remember that someone tried rather than thinking 'they were that person who moved me into that shit place where I couldn't go out or see my friends anymore'.*

Professional 2: *Some of the stuff we are doing nationally around CSE was just made up and has no evidence because we needed a response. It might not need to be specialist to CSE- it doesn't need it. Trauma based work is very important. Parents and children need trauma-based therapy. I am more concerned about CSE programmes and interventions that are anecdotally being told to work but no evidence.*

One participant talked of the dynamic in which children who were being flagged for CSE were getting a better offer of service than other children and asked how that had been decided.

Professional 12: *So, what about children who don't get CSE team and they don't get an equitable offer? Some children are not getting the same service as others. Some children are getting a strong relationship and lots of time with their worker – so yes of course that would evaluate better, that child is getting a better service than the others. Who says this person there needs more time than this person here whose mum just died?*

A participant discussed the use of CSE films and the response their new student social worker on placement had, when she was shown the films.

> **Professional 8:** *The CSE videos. My student came to a talk and she came away really upset and she never knew any different, the racism aspect of it and that as well, the trauma and racism in the CSE films really bothered her and she was really upset that she had shown them.*

The CSE support service team colleagues unanimously agreed that their improvement would be the legal processes that the child would engage in and this was then discussed in much further detail later on in the focus group.

> **Professional 7:** *Speedier legal processes, getting CPS decisions and getting that child to the position where they may be going to court and they are really provoking anxiety and then they get told its another 9 months until they are going to court and for young people, that needs to be streamlined and quicker. You can lose a young child in that process because at any time, they have the right to say they don't want to do it anymore and we respect that completely but it is too long, the whole thing is way too long.*

One of the common themes in the survey answers was reference to therapy – can you tell me why you feel there is a gap there and how you think therapy should be used with children who have been sexually exploited?

The discussion around therapy for children was nuanced and contained complex views about why therapy was not being utilised, how to access it and whether children were ready for it. Some participants felt that social workers were not seeing that they were already doing basic counselling and support work with children as part of their jobs.

There was discussion about the role of CAMHS workers with children subjected to CSE, but the messages were mixed. Some were confused about criteria and when children could access the service, and some spoke of interventions that were provided without seeing the young person.

> **Professional 1:** *The therapy gap is around funding I'm guessing and lack of availability – I know we have CAMHS and there is a specialist in CSE and people who suffered sexual abuse but she often doesn't start work until the abuse has stopped which is a bit baffling cos in that child's head, once they've been abused once, it will never stop affecting them – it's just as traumatic whether it is ongoing or not and I don't understand why it has to hit a criteria. There is not a lot of therapy in this area.*
>
> **Professional 16***: Services are just not there and the screening process for therapy, I don't understand it, we just get told they don't fit the criteria, but what is the criteria?*
>
> **Professional 17:** *For CAMHS it's all about diagnosis for them and they will look and say 'oh they have a diagnosis of say, ADHD' and then they will just focus on that when actually, a lot of the stuff is from the abuse and trauma to deal with some of their experiences*
>
> **Professional 23:** *We do have a designated CAMHS worker who can provide us with the therapeutic intervention without seeing the young person directly* **(Researcher: is that effective, if they don't see them?)** *I suppose I have had mixed responses, sometimes I*

haven't got what I wanted, and I went to the consultation and the psychotherapist pointed out that we needed to tackle the deprivation and poverty and safety so that was really helpful because she was right.

Some participants argued that there were not the services or the resources to support therapeutic intervention with children subjected to CSE or CSA.

> **Professional 3:** *We have more specialist services and the LA has a really long waiting list; we find it hard to get anyone into CAMHS unless it's extremely serious. One service I found really good is the ISVA, but they seem to only get involved where its seen more CSA not CSE, I don't know why that is, but when it is CSE they don't get involved as much. Therapy is not about what happened to them, it's about how they are and so they don't have to keep retelling it because it won't help.*

> **Professional 2:** *Cuts to resources. I don't think there are as many specialist teams that can respond to the things that have happened, all of the services and therapeutic needs there are waiting lists and sometimes children who experience CSE are not ready to engage with therapy yet, it's the same in domestic abuse, it's a really big step for them.*

Other participants from the CSE support service team echoed the view that some children were not ready for therapy or would not find it useful at all. These discussions included conversations about the flexibility and generalisability of therapy for children affected by CSE and CSA.

> **Professional 10:** *You can't generalise how children use therapy and it's all very specific. Some children will find it really helpful, for some they are not ready, and we need to back off and respect that. We can give them information but it's about when they are ready to talk.*

> **Professional 11:** *For some young people, they don't wanna do it and might not wanna do it til they were adults. I would love it if there was a service where young people could access therapy but in reality, there is no service which is flexible therapy based and when they are going through the court process, they have no chance anyway.*

> **Professional 22:** *Some schools of thought say therapy for these children is not helpful at all and what they need is a good support network and a normal day and normal life again rather than talking about it again and having to wait 9 months for a CAMHS service that is probably rubbish who then ask you to talk about the abuse and it sets them right back.*

> **Professional 21:** *Some people need different therapy for different times and needs and it needs to be flexible but our services are just not that flexible and they might not even hit the criteria then.*

One final theme to emerge from this question was a number of participants who argued that social workers including the CSE team were already using basic counselling skills, or should be using those skills with children to provide basic therapeutic intervention. Some participants felt that children who had already built a good bond with a social worker or professional would not benefit from accessing counselling with a new professional they did not know, as it would mean retelling traumas to another new adult.

> **Professional 7:** *I don't want to pressure anyone to keep pressuring children to tell us something and I don't think we should do that, it's like saying 'we can't protect you from harm unless you are willing to disclose everything' and that's a problem with the system, why isn't it just enough to say you are unsafe and something is happening? Some of that is like,*

social workers should have basic counselling skills and seeing ourselves as the intervention, we are doing it anyway, we already do that, we are the intervention, this is what we do, we just need basic counselling, we should be doing that.

Professional 1: *People don't value that approach. They don't understand the value of it – referrals don't go in unless we have a disclosure or something is happening and social workers need basic skills to do those discussions themselves – because for a child who has been abused to be told to go talk to someone about abuse would shit themselves. Social Workers could do this. Talking about abuse to someone they have never met before – its daunting. Children are declining it because they are terrified and have no one to talk to about what it means and what it will be like – we don't think about why they declined it we just say they did.*

Professional 20: *I think there is a difference between therapy and therapeutic interventions. And we can all take a therapeutic approach in our own work, but that can often be very different to clinical therapy and I think the gap for me is the clinical therapy and the young people who need it, for me, there is still barriers to accessing it. It's a gap for all forms of abuse.*

Children 'putting themselves at risk of CSE' is a common phrase used in the field. Do you think it would be possible for future practice to change the way they think about risk and how would we achieve that?

Participants saw this prospect as difficult and time consuming and talked about how embedded victim blaming narratives which position the child as 'putting themselves at risk' were in practice.

Professional 2: *That would be a very long and slow process. I would like to say yes. Getting that across every social worker and local authority is too difficult. Its personal preference and personal belief. I think there has been a shift in thinking about this but there is a massive way to go. I dealt with a case where they kept calling a girl a perpetrator and saying she was putting other girls at risk. There has to be challenge about this and people agree with it but it is a massive shift to achieve.*

Professional 3: *When I have heard that, I have seen it being challenged. I have recently heard people say, 'I know we are not supposed to say this any more but she is putting herself at risk'. Do you change the thinking first or the language or the language or the thinking? Can the language change before the thinking? Does the thinking need to change before the language will change? Because if we have a whole new cohort of newly qualified ones, and they were all thinking that new way, maybe they wouldn't victim blame?*

One participant talked about how to change the narrative with training, workshops – but ultimately felt confused how practice had come so far but victim blaming had remained so prevalent. This was echoed by other participants who stated that they didn't understand how victim blaming narratives had become so common in CSE, but were not present in CSA practice.

Professional 1: *Constant workshops and training – the difficult thing is, that should have been wiped out years ago, no child puts themselves at risk of sexual abuse and when I see it, I challenge it and people get really offended and I just think that's on a child's file and you have written that they have put themselves at risk of CSE and I don't know what more people can do without putting out emails every week, doing frequent workshops and its getting*

embedded into newly qualified social worker practice – it gets passed to files, police, court reports.. I don't know how we got to this point. It is still prevalent but not on purpose.

Professional 4: *I don't get why we say these things in CSE but not in CSA. Why do we say they put themselves at risk but we don't say that about CSA?*

In the focus group, some of the CSE team and CSE workers discussed the active role they play in challenging victim blaming and the way it made them feel, as it had become a large part of their daily role to correct or challenge the narrative that children put themselves at risk of CSE.

Professional 6: *I think we found that a large part of our job is challenging victim blaming and that statement of 'they put themselves at risk' is being challenged on a daily basis. Trying to get people to rethink that because that statement can be really really damaging in case notes. You know, you can apply it to any scenario, me walking across a park cos its quicker, I don't understand why people don't get it, that risk was there regardless.*

Professional 8: *When we are on duty and we are screening and we get it on them we are all just like so mad! It's the biggest bug bear.*

Professional 15: *I very rarely say risk to young people, I say I am worried about them. Its infuriating that professionals use this language, these are not people from the street, these are professionals. Its not going away, professionals are still using it. Its all professionals across the board, not just one type. It's a common term that has always been used, it's a phrase to go back to.*

One participant gave examples to the group of children they had worked with who had been expressly told by professionals that the reason they were being referred to the CSE team was because they were putting themselves at risk of CSE and they needed to change.

Professional 11: *I have found too that quite often that the message the young person has been given too, that they put themselves at risk, and when I talk to them about why I am there on the first appointment and they say 'Yeah I know, it's because I put myself at risk and you are here to tell me how not to do.' And the message is that we are there to tell them not to.*

There is concern that our CJS retraumatises children who have been abused and that prosecution is not in the best interests of the child and sometimes should not be pursued – how do you feel about that finding?

Participants discussed their feelings about this view and reluctantly admitted that having spent time working on cases that had either gone to court or had been dropped and the child had been let down, they were now beginning to question whether it was in the best interests of children to encourage them to prosecute.

Professional 17: *I can see the angle why and sadly I can see it.*

Professional 10: *It's not a view I ever used to have but my experience of a few cases, I now think, 'Was that the right thing to pursue? Was it the right thing for the child?'*

> **Professional 15:** *I supported some children who really wanted to prosecute but even I had not realised what it was gonna be like, and how bad it was gonna be for them to go through that, we hadn't actually realised how bad it was.*

A common theme to emerge in the answers to this question was the waiting time and the anxiety caused by the unknown. These views were more often shared by professionals who had experience of supporting children through a criminal trial and therefore had first hand knowledge of the distress the process had caused to the child.

> **Professional 8:** *That waiting time is not helping their recovery at all, all that time they are waiting, they are anxious and scared and waiting and they are not getting any recovery time, we leave that trauma with the young person a lot longer*

The discussion around waiting times and trauma led to a longer conversation about whether children were being told the reality of a court case before they made an informed decision. Some CSE team staff explained that they had started telling children the truth about court, interviews and cross examination so that they didn't feel uninformed or set up to fail.

> **Professional 19:** *It is like they do the ABEs and we wait and wait and then the CPS don't go for it after 12 months and the child thinks, 'well why didn't they believe me?' and we are left with a child who believes no one believed them and they had been waiting and waiting all that time you know why are they not taking it to court?* **(Researcher: Do you give people an informed view that they have a very low chance of guilty outcome or prosecution when they choose to report to police or press charges so they have that informed decision right from the beginning?)** *Yeah, I have worked with a few young people where I have told them the truth from the beginning and that's because it is not okay to give them false promises.*

> **Professional 8:** *I have worked with children throughout court and you do have to be realistic and to set them up that they will get a conviction is not going to work in their favour, and also the interviews, there is no point in telling them that its going to be okay and the officers will be lovely and its all going to be alright, its not fair because sometimes its not like that and we set them up to fail. We say to the children that they will be asked some really difficult questions, they might make you feel like they are saying you are a liar or they might be pulling your story apart and the young person needs to know what that will be like before they do it.*

Participants in interviews and in the focus group also considered whether they would decide not to encourage the child to prosecute and there seemed to be two main approaches, one in which the participant argued that they would respect the decision of the child not to prosecute and leave the process, and one in which the participant said that children should be able to prosecute if the systems changed and children were supported adequately.

> **Professional 9:** *It depends on the individual child, we have the listen to the child and if they don't want to do it at all we need to stop, and I think we are good at that and we do already do that*

> **Professional 11:** *Yeah but that's down to the system and the courts, I don't think we should ever get to a position where we just don't go for prosecution, we don't try to take action, this needs to be changed so it doesn't traumatise children.*

> **Professional 5:** *Tough one because if it is going to retraumatise the child, we wouldn't advocate it. We wouldn't want them to go through that for no impact. The other side is*

accountability of the person who took the action – but I would never want to retraumatise a child. Prison doesn't always help the offender either. There is a big appetite and its seen as an achievement – some people have 115 years between them but if its gonna traumatise the child we shouldn't be doing it. There needs to be another way, I don't know what that is. Maybe the system needs to change.

Participants talked about the way children were being encouraged to prosecute, even when it was not in their best interests, with some talking about the way language is used to present prosecution as an empowering opportunity, some talking about work being focussed on getting disclosures from children and others worrying that practice was mimicking the grooming process.

Professional 6: *I don't think we should ever put pressure on children to be involved in prosecution, some of the language we use is supposed to be empowering and we call it an opportunity and it ends up putting the responsibility on them. It really shocked me when I found out children were being cross examined and I know there are some special measures, but it shouldn't be up to the child of what is in their best interests, should we be thinking, 'is this really in their best interests? Is this going to harm them or retraumatise them?'*

Professional 3: *The CSE team say it's for the child, why is it so disclosure driven? They say it's not. The direct work they are doing is about telling them what happened and who they were with and what they were doing – it needs to move to support and looking forward not going back to something all the time – it's all based around prosecutions and the child gets lost in it- cos adults can say they don't want to make a complaint but children get forced into it because they have no voice and we are supposed to be their voice and we are also pushing for prosecution so where is their voice? We will say they are not disclosure and prosecution led but they are. The CSE tool is a good example because you won't meet threshold if you have no disclosures.*

Professional 24: *It sounds horrible but I don't mean it to sound this way but it is grooming the child for prosecution gain – the child has already experiencing grooming and now a social worker is coming in to get that information for professional gain which is grooming – if the child was harmed, the child was harmed – they might not tell anyone, they might tell their best mate, they might tell in adulthood. They shouldn't be forced to tell us stuff.*

In your opinion, is there anything specific to The LA that you feel you would like to say about CSE or CSA practice?

Professional 1: *Make this more child driven, stop hunting for disclosures, get rid of the screening tool, the list goes on. Change it all together. Get people that understand it. If you don't understand it, you are fighting a losing battle and that's when you have to use tools. I've always worked in CSA, but I refuse to work in CSE because I don't agree with the way they work.*

Professional 6: *I really appreciate that The LA is trying to do something more evidence based and shifts the culture of victim blaming, anything we do must be the children best interest above anything else.*

Key themes for innovation and moving forwards

All qualitative data from the questionnaire, interviews and focus groups was analysed together to consider the key themes that emerged from the data, that could provide innovation and examples of how the workforce felt that CSE practice could move forward. This section discusses the key themes:

1. Tackle the narrative around risk taking behaviours and victim blaming of children
2. Develop a comprehensive, strengths-based, informal, flexible support service
3. Increase of victimless prosecutions and innovative prosecutions in which the child is either not present or is protected sufficiently from the process
4. Focus more on disrupting and understanding perpetrators rather than changing children
5. Critical training and healthy challenge culture
6. Explore the use and value of the CSE toolkit in practice
7. Explore whether the CSE/CSA split is detrimental to practice and to children

Tackle the narrative around 'risk taking behaviours' and victim blaming of children
Evidence from this project suggests that CSE is still being considered a 'risk taking behaviour' by some professionals and working with children who are actively being sexually abused to 'reduce their risk taking' is often a priority. Participants questioned how the narrative was still so prevalent and suggested critical challenge, training, supervision and culture shifts that may tackle the harmful narratives that children are to blame for CSE.

Develop a comprehensive, strengths-based, informal and flexible support service
When participants were asked to describe the ideal response to CSE and CSA, they repeatedly described the same future service. Their answers described the service to be informal in nature, able to work with children who engage and disengage and able to work with children on a range of issues without it being structured direct work. They often described this as a 'youth work type service' that could support children whilst focussing on the future and their strengths, that could continue to support them post-18 so they did not lose vital services as they turn 18 years old.

Increase of innovative victimless prosecutions in which the child is either not present or is protected sufficiently from the process
A large number of participants called for children's choices to be centred in the criminal justice process so they could choose not to press charges and not to give evidence if they did not want to. However, there were valid points made about the way more innovative prosecutions and victimless prosecutions could be achieved without the participation of the child. With the recent successful roll out of the Section 28 pilot, it may be a good time to look at more innovative ways to disrupt and prosecute offenders without traumatising or relying on the children.

Focus more on disrupting and understanding perpetrators rather than changing children

Evidence from this project presented the views of large number of participants who were concerned that much of CSE practice is aimed at changing or improving something about the child (risk, risk taking, vulnerabilities, characteristics etc.) whilst not achieving much with the perpetrator. Participants felt this was leading to more children being placed out of area instead of disrupting the perpetrator, and more direct work being focussed on what the child can do differently instead of taking action against perpetrators. Some participants also suggested that when harmful sexual behaviours or sexual exploitation were being perpetrated by under 18 years, there needed to be more work done with that child and less emphasis on the victim to stop or escape the abuse.

Critical training and healthy challenge culture

Throughout the questionnaire, interview and focus group data, participants called for more challenge of each other around victim blaming and the lack of understanding of trauma. There were frequent suggestions of more critical training to reduce victim blaming, increase knowledge of CSE across the whole workforce and to improve trauma-informed approaches to children. Supervision and line management was discussed frequently as part of having a healthy challenge culture and participants were particularly worried about case notes of children being subjected to CSE containing victim blaming and inappropriate materials. A number of participants asked whether there was a way to delete, amend or take action against case records that were problematic or harmful to the person.

Explore the use and value of the CSE toolkit

Feedback and views about the use and value of the CSE toolkit was one of the commissioner's aims for this project, and the data did clearly show that there were considerable issues with the toolkit, how it was being used, how children were being categorised and how language was being used to describe children who were already being harmed as 'low, medium and high risk' when the child was not at risk, but was already a victim of serious crime. Participants had serious concerns about the CSE toolkit and this requires further exploration and action.

Explore whether the CSE/CSA split is detrimental to practice and children

A strong theme in the data from interviews, focus groups and the questionnaire was the way CSE and CSA had become distinct and separate areas of practice despite most participants disagreeing with this view of abuse. Participants reported feeling that the wider workforce was not valued, resourced or skilled to the same level as the CSE team, leaving questions about how the split was helpful to general practice and why children who were sexually exploited were getting a more comprehensive services than children who were sexually abused.

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Appendix A - Questions used in the questionnaire for LA staff & partners

Section 1: Action taken with children suspected of or known to be sexually exploited and abused

1. How are you involved in work relating to child sexual exploitation or abuse, or in the work of the CSE SUPPORT SERVICE team?
2. How long have you been working with children subjected to child sexual abuse or exploitation?
3. When we *suspect* that a child is being sexually exploited, what do you think the main priorities should be? (Please select up to six tasks that you would prioritise out of the available 14 tasks)
4. 3a. Could you please explain why you chose those six priorities and whether there are any options here that you felt were missing or that you would not do at all?
5. When we know that the child is already being sexually exploited, what do you think the main priorities should be then? (Please select up to six tasks that you would prioritise out of the available 14 tasks)
6. 4a. Could you please explain why you chose those six priorities and whether there are any options here that you felt were missing or that you would not do at all?
7. **Section 2: Scenarios**
8. **Mikel**
9. Mikel is 14 years old and fancies himself as a bit of a gangster. He has lots of friends and is generally confident and happy. Teachers complain that he smells of weed sometimes after lunch break. He is from a wealthy family and has three older brothers. He has all of the latest tech and has set up a chatroom on his favourite Xbox game online. Him and his mates play on there for hours on a weekend with some other guys from around the world. A teacher overhears Mikel and his mates laughing about some guy who keeps sending them links to porn and pictures of himself naked. They are all calling him Mikel's 'boyfriend', but Mikel laughs it off and says it's hilarious. The teacher has rung through to the MASH to talk to someone as they don't know what to do.
10. **Jaimie**
11. Jaimie is a 17-year-old girl who has been sexually exploited and trafficked a number of times since she was 12 years old. Before that, she experienced familial sexual abuse as a child that was not picked up and she didn't disclose until recently. Jaimie has had significant support from CSE specialist workers and appears to understand what they are saying but a few months later, she goes back to the perpetrators and the abuse happens all over again. The police have been supportive and managed to convict a man and a woman a few years back but even that didn't seem to stop the exploitation of Jaimie. Yesterday, she told you that she was raped, and someone filmed it. She tells you she needs to escape, wants to report them all to the police and this time she will never go back. Her file says that she is implicit in her own abuse and often says that she won't go back but then retracts all of her statements and goes back to the abusers. Someone has written on her file that she is selling sex for drugs which means she keeps going back to them when she needs more of the drug - and that is why the support isn't working.
12. **Deona**
13. Deona is a 13-year-old girl who says she has a 17-year-old boyfriend, Marcus. Her parents are comfortable with the 'relationship' and say they have known the boy and his family their whole lives. You are still very concerned and feel the 'relationship' is exploitative. Deona has started taking selfies (some nude) and sending them to Marcus. She hangs around with him

all of the time and rarely sees her friends anymore. Her mum says its 'young love' and that she met Deona's Dad when they were a similar age. You speak to your colleague about your concerns and they say that teenage boys are driven by sex, that Deona is bringing this on herself and you should teach her more about sexting and grooming. You agree to teach her more about sexting and grooming the next time you see her, but you can't help but feel something else needs to be done here.

14. If this scenario happened in the LA now, what would be the current response and approach to (name)? How do you think CSE SUPPORT SERVICE and others would work with this child?
15. If this scenario happened in the LA in the future and you had all of the resources, knowledge and approaches you would need, what do you think the best possible response and approach to (name) is?

16. Section 3: Exploring your solutions to common CSE/CSA problems in practice

17. This final section asks you for your opinions on the solutions to common issues and problems in CSE/A practice and procedure. This is your opinion and your ideas that can be used to move the field forward. For each problem or issue, how would YOU solve it, if it was up to you?

Please finish the sentences:

18. When children don't want to press charges against the people sexually abusing them…
19. When professionals blame the child's behaviours or vulnerabilities for being sexually exploited…
20. When the CSE toolkit says 'low risk' but you just know something is happening to the child…
21. When the child keeps going back to the abusers even after lots of work has been done with the child…
22. When the child is too traumatised to give evidence in court…
23. When you find notes on the child's file using inappropriate or victim blaming language about the child and the abuse…
24. When professionals misinterpret trauma behaviours for a behavioural problem…
25. When the child tells you that they are not being exploited, but they are in control and are exploiting the abusers to get what they want out of them…
26. When the child is not ready to disclose yet but you really need a disclosure so you can take action or get further support for the child…

Section 4: Final thoughts

27. What would you say were the biggest achievements that have been made in your CSE/CSA workforce?
28. What would you say are the biggest problems facing the CSE/CSA workforce and how would you solve them?

Appendix D: Interview/Focus Group Questions for Participants

This project is about innovation, change and improvement moving forwards. Therefore, I will be asking you questions about how you see CSE practice could change in the future and why it might need to change.

1	Can you tell me how you feel about the proposal that CSE is CSA, rather than being a distinct form of abuse? - What is your opinion of merging the two specialist areas in practice and policy?
2	If we were to take that further, how would you feel about our practice and knowledge being merged to take into account DA, CSA, CSE, HBV, HSB rather than seeing these issues in silos? - If we did merge practice to see the whole spectrum of issues/whole life of child, how would this change the way we worked? - Would it convey a disadvantage or advantage to the child?
3	One of the things that has made CSE unique in practice is that it has a specific tool to measure risk of CSE occurring to the child that is used heavily in practice to direct decisions and interventions – how would you like to see these improve or change in future? - Is there a future without CSE toolkits or will we always need them? - Do we therefore need them for all issues or do we need one assessment that covers all possibilities and needs?
4	Are there any interventions or responses to CSE that you would like to see improved in the future? - If you were able to direct that improvement, what would need to happen?
5	One of the common themes in the survey answers was reference to therapy – can you tell me why you feel there is a gap there and how you think therapy should be used with children who have been sexually exploited? - What do you think would happen if you did have access to therapy?
6	Children 'putting themselves at risk of CSE' is a common phrase used in the field. Do you think it would be possible for future practice to change the way they think about risk and how would we achieve that?
7	There is mounting concern that our CJS retraumatises children who have been abused and that prosecution is often not in the best interests of the child and sometimes should not be pursued – how do you feel about that finding?
8	In your opinion, is there anything specific to The LA that you feel could be improved in future practice or policy in CSE?