Child sexual exploitation: support in children's residential homes

Research report

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Acknowledgements

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Executive summary

While child sexual exploitation (CSE) has attracted considerable attention in recent years and has highlighted how residential children's homes can be targeted by CSE perpetrators, little is known about the tailored support provided to children affected by CSE who are placed in residential care. This study was commissioned to start filling this evidence gap. More specifically, the study aimed to:

- identify approaches already used in children's homes to support children who have been sexually exploited or are at risk of sexual exploitation.

- explore the perceived benefits and impact of the tailored support that has been offered.

- distil what seems to work well in supporting children affected by CSE in residential care and offer conclusions on the benefits of sharing the learning more widely.

Evidence for the study was gathered through: a rapid review of the international evidence on CSE support; interviews with ten residential children's homes in England that were known for their CSE expertise and high-quality provision; and case studies in four of these homes involving eight children affected by CSE.

What are the needs of children affected by CSE

The literature we reviewed and the homes in our study showed that children affected by CSE placed in residential care were very vulnerable and had a range of complex, high-level needs. These children were typically highly traumatised due to CSE, compounded in some cases by other traumatic experiences common among children in residential care, such as neglect, and physical and domestic violence. Traumatic experiences meant that these children were very vulnerable, with substance abuse, self-harm, depression, violent behaviour, low self-esteem, and sleep and eating disorders being common.

The chaos that typically characterised these children's lives before they entered residential care was also reflected in: disengagement from education; lack of positive activities; lack of positive friendships and support networks; and health issues ranging from sexually transmitted diseases to very unhealthy lifestyles. While many children affected by CSE were reported to have been in the care system from an early age, some had entered care as adolescents.

It should be noted that our study focused primarily on girls; the extent to which boys in residential care affected by CSE may face different or additional issues would be worth exploring further.

Perceived benefits of the care and interventions offered

All the homes in our study and the literature concurred on the key purpose of interventions with children affected by CSE, that is, removing risks and building resilience. Key expected outcomes included: improved insight; a sense of self-worth; higher aspirations; positive relationships; educational achievements; positive interests; effective communication skills; and improved health and wellbeing. As well as being valuable in their own right, these outcomes were seen as contributing to teaching children to recognise and manage risks, and build resilience. Timeframes for making progress in these different areas were very individualised, and there were periods of progress as well as 'remissions', but the ultimate aim was for CSE risks to be removed or much reduced so children could 'be children' again.

There was a great deal of commonality between the expected outcomes identified in the literature and outcomes reported by the homes in our study, suggesting that these are likely to be suitable 'core' outcomes to monitor the effectiveness of CSE interventions. However, while in the literature, data on some key outcomes were often collected systematically using standardised measures (e.g. self-esteem and trauma inventories), in the homes, information on the progress children made in relation to different outcomes was based mainly on non-systematic and unstructured observations by staff. Furthermore, while the literature identified the need to collect data on long-term outcomes to assess the sustainability of the progress achieved in residential care, none of the homes collected information on children's outcomes after they left the setting. Therefore, while homes reported positive outcomes for children affected by CSE, systematic evidence to confirm these benefits and their sustainability is generally lacking.

Approaches used to support children affected by CSE

Many of our findings on what underpins effective practice in relation to CSE are in line with what was found in a recent review of residential care in England. For a residential care placement to work, it must have a clear purpose, a theoretical framework and an evidence base to guide practice, i.e. a model that shapes every aspect of residential care practice. The question is: should this model be the same as that used for all children with complex and high-level needs, or does it need to be a different model specifically developed to work with CSE?

The evidence does not indicate the need to develop a separate CSE model 'from scratch'. All the models identified in the literature and used by homes in the study were used for all children with complex and high-level needs. Refinements made for CSE work were mainly reflected in the tailored package of support provided (e.g. CSE education programmes, measures to prevent absconding), rather than the core principles underpinning the model of practice. Specific 'CSE issues' to consider in providing support to these children include the tools used to carry out CSE risk assessments and the structural features of a placement that may be more suitable for these children. However,

there is little robust evidence to assess what ways are effective in dealing with these issues:

- A range of tools has been developed to carry out CSE risk assessments, but it was not clear what evidence was used to develop these tools and the extent to which they had been tested.

- Children affected by CSE were believed to do better in very small, single-sex units, although these assumptions have not been tested and we do not know if they hold for both sexes.

- There is a widely (but not unanimously) held assumption that removing children affected by CSE from their community and placing them in very remote areas helps to keep them safe, but there is no evidence to support this.

In addition, more guidance on what homes can legally do to prevent children from running away may help in using resources more effectively. The line between ensuring children's safety and restricting their liberty was a very fine one, and a considerable amount of staff time was spent on ensuring that homes stayed on the 'right' side of the line.

The package of support provided to children affected by CSE seems to reflect the range of complex needs that these children had. To a large extent, these would be the kind of services (e.g. education, health, recreational activities, therapy) provided for those suffering from trauma. In addition, specific CSE educational programmes were being delivered. As the number of CSE tools and educational programmes is growing quickly, it would seem helpful to provide homes with advice on which of these tools and programmes have been evaluated and how effective they are in different circumstances.

What constitutes effective practice

Features of effective practice in supporting children affected by CSE identified by our study largely reflect the evidence on what underpins good residential practice more generally, although some additional dimensions and adaptations were identified as being important:

- Good residential practice is strongly dependent on staff's skills, attitudes and consistency, and on staff having sufficient time to dedicate to children and the ability to work therapeutically with them. However, the additional CSE training and input from specialist staff on CSE-related issues was seen as very important.

- Effective residential practice is also underpinned by good interagency work. Dimensions of interagency particularly relevant to CSE were joint protocols and information sharing in relation to missing children, and identifying and prosecuting CSE perpetrators. Specialist external agencies also seem to play an important role in delivering CSE educational programmes in residential settings.

- Children's meaningful involvement in decisions that affect their lives is a basic right, as well as being associated with effective residential practice. This is again highlighted by work with children affected by CSE, as the opportunity to become 'active agents' can help to support a sense of self that is apart from victimhood, and develop self-confidence and self-efficacy. As well as from a range of mechanisms used in residential care to involve children, the literature indicates that opportunities for children to provide mutual support around CSE could be very empowering. This was done through group work around CSE, and in one programme identified in the literature, CSE survivor mentors provided support to their peers who had been sexually exploited.

- Working with the families of children in residential care is an important but often neglected aspect of good residential practice. For children affected by CSE, family work needs to consider the difficulties families may be facing in accepting and understanding what has happened to their children, as well as the fact that some families may be posing or contributing to CSE risks.

- As with residential care in general, how long it took for a residential intervention to achieve the intended outcomes for children affected by CSE was largely dependent on individual circumstances. The literature pointed to the fact that, as these children were highly traumatised, there were no 'quick fixes', and CSE programmes tend to be long-term (e.g. several months or even years). The observation of the homes in the study was that the longer children had experienced CSE, the longer their recovery was likely to take. Moving children away from intense and specialist residential support before they were ready could be seen as not only counterproductive, but as a waste of the resources which had been invested.

- The sustainability of the improvements made while in residential care was also seen as being crucially dependent on the transition arrangements out of residential care. Again this aspect of effective practice is not exclusive to work with children affected by CSE. However transition planning must consider all the learning from a residential placement on how individual children can be kept safe from CSE: how risks can be removed or managed, and how a child's resilience can be supported.

Conclusion

Our study has found an increased awareness of CSE and a growing (albeit still limited) body of research on this topic, both of which are to be welcomed. Residential care delivered by those who understand the issues of CSE has a role to play in keeping children affected by CSE safe, helping them recover and become more resilient. However, it will take time and much more robust evidence to know what interventions, either in the community or in residential care, work best in terms of reducing the prevalence of CSE and increasing children's resilience to it, as well as helping children to recover.

1 Introduction

A number of cases in recent years have increased awareness of the vulnerability of children in residential care to child sexual exploitation (CSE). They have also highlighted how residential children's homes can be targeted by CSE perpetrators (Berelowitz et al 2015). These revelations have prompted new regulations, guidance, and a renewed focus on staff training and practice improvements, such as better CSE identification and co-ordination across relevant bodies (Department for Education, 2015).

The 2013 DfE census of residential children's homes in England asked managers to describe the range of children's needs that their home could accommodate, and 71% said they catered for children at risk of sexual abuse or sexual exploitation (Thornton et al 2015). However, little is known about the support provided to these children, its effectiveness, and if and how these children benefit from being in residential care. This study was commissioned to start filling this evidence gap.

1.1 Research aims

The aims of the research were to:

- identify approaches already used in children's homes to support children who have been sexually exploited or are at risk of sexual exploitation.

- explore the perceived benefits and impact of the tailored support that has been offered.

- distil what seems to work well in supporting children affected by CSE in residential care and offer conclusions on the benefits of sharing the learning more widely.

1.2 Methodology

Data for the study were gathered through: a rapid review of the evidence on CSE support; interviews with ten residential children's homes in England; and case studies in four of these homes.

1.2.1 Rapid evidence review

The review of evidence was based on literature available in the English language. The search focused on 2010-15, although through reference harvesting, older relevant references were also identified. The literature review was extended beyond the immediate focus of the study (i.e. CSE support in residential settings), as this generated very limited evidence. In addition to CSE residential programmes, we covered community-based CSE programmes, and reviews of therapeutic interventions for sexually abused children and children's residential care practice in England. The review

strategy can be found in Appendix A and a summary of the literature reviewed in Appendix B.

1.2.2 Interviews with residential homes' managers

In autumn 2015, qualitative telephone interviews were carried out with registered managers and other relevant staff (e.g. the CSE lead and psychologists) in ten English children's residential homes. In selecting homes for the research, we wanted to identify examples of good practice. Therefore, homes were selected because of their CSE expertise (including three homes which only took CSE cases), which was either highlighted in their Ofsted report or identified through soft intelligence (e.g. recommendations from experts in the field). Furthermore, all homes had been rated as 'good' or 'outstanding' at one or both of the previous two Ofsted inspections.

The sample included two secure children's homes (SCHs) and a unit that provided short-term placements (4-6 weeks) for respite and assessment. Six homes were private, one was voluntary and three were run by the local authority. They were geographically spread throughout the country and located in both urban and rural areas. Five homes were registered just for girls, while the other five were mixed. All were registered to take children aged 7-18, but in practice none took children below the age of 11, and early to mid-teens was the typical age range catered for.

The interviews explored homes' practices and the services provided to children affected by CSE, what factors influenced how they worked with these children and how their progress and outcomes were monitored. Recent Ofsted reports and relevant documentation provided by the homes were also examined.

1.2.3 Case studies

From the interviews, we selected four homes, including one secure home, to provide examples of particularly promising CSE practice. We visited these homes in January-February 2016 to analyse the cases of eight children who had been sexually exploited, to explore in more depth what support was provided and the outcomes for these children. The cases consisted of seven girls and one boy, aged 14-16. They had all been in the homes for several months, and they had had a number of residential placements; three girls had been in secure care. Data were collected from members of staff who had worked closely with these children (e.g. their key worker) and in two homes, we were also given access to the children's case files.

1.3 The evidence on CSE practice in residential care

CSE support is an emerging field of research and recently the DfE Children's Social Care Innovation Programme has allocated funding to projects with a CSE focus; for example, St Christopher's Fellowship has developed a high-supervision model of accommodation

for looked-after girls at risk of sexual exploitation and Durham County Council has opened a new unit at Aycliffe secure home to test a new model of trauma support for children who have been sexually exploited. The projects are being evaluated but the results are not yet available[1]. A number of research participants commented on the lack of robust evidence to inform their practice, and this was also highlighted in the literature we reviewed (e.g. Avinger and Jones 2007; Thomson et al 2011; Webb and Oram 2015).

None of the programmes identified in the literature review had been robustly evaluated and thus they would not be ready to be implemented.[2] Similarly, none of the homes included in the study had systematically collected data on short or longer-term outcomes for children and linked these outcomes to the support they had provided. So we cannot conclusively prove that their approaches work.

In the concluding chapter, we will return to the question of what evidence would be required to answer the question of what works in relation to CSE support in residential care.

1.4 Report outline

In Chapter 2, we consider the needs of children who have been, or are at high risk of being, sexually exploited. We then explore the intended outcomes from residential care for these children and the extent to which these outcomes are (perceived to be) achieved.

In Chapter 3, we explore models of practice used in residential settings to support children who have been or are at risk of being sexually exploited. We then discuss the process of 'matching' these children to a home to ensure that a placement meets a child's needs, and the packages of support that are provided to children affected by CSE.

Chapter 4 sets out the key ingredients of effective practice when supporting children affected by CSE, including: a clear model of practice that all practitioners could consistently apply; adequate staffing levels and staff with the relevant experience and attitudes; effective interagency work; children's involvement in decisions that affect them; and, families' engagement while children are in residential care.

In Chapter 5, we draw together the research findings to answer the key research questions set out at the start of this chapter.

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[1] http://springconsortium.com/

[2] For more information on what a 'ready to implement' programme would look like see: http://guidebook.eif.org.uk/

2 Purpose of CSE interventions in residential care

Using the findings from the literature review and the fieldwork we carried out, in this chapter we consider the range of needs of children who have been, or are at high risk of being, sexually exploited. We then explore the intended outcomes from residential care for these children and the extent to which these outcomes are (perceived to be) achieved.

2.1 The needs of children affected by CSE

The literature, from England and elsewhere, consistently highlights an interplay of factors which can increase a child's risk of sexual exploitation. Such factors include: neglect; domestic violence; physical or sexual abuse; running away; mental health issues; substance and alcohol misuse; anti-social and violent behaviour; trafficking; criminal behaviour and involvement with gangs (Hickle and Roe-Sepowitz 2014; Twill et al 2010; Webb and Oram 2015). Moreover, while being abused as a child or experiencing domestic violence at home may increase a child's vulnerability, other factors such as substance misuse or poor mental health can be both causal contributors and a onsequences of CSE (Hickle and Roe-Sepowitz 2014; Webb and Oram 2015; Twill et al 2010). In addition, supplying alcohol or drugs, and/or using the child as a dealer, is a method used by sexual exploiters to get to know a child, make them compliant and keep them in tow (Berelowitz 2013).

Box 2.1 provides a checklist from the literature of the negative consequences of CSE to be considered when supporting children who have been sexually exploited.

Box 2.1 Checklist when supporting children affected by CSE (from Channon Consulting 2014)

Post-traumatic stress disorder (PTSD).

Substance abuse, e.g. to self-medicate, cope with what is happening and with symptoms of PTSD.

Self-harm can provide a way to express difficult feelings, to have some control, to communicate with others, a distraction from emotional pain and self-punishment.

Denial of abuse/defence of the abuser is explained by two psychological theories: the Stockholm Syndrome and the Betrayal Trauma theory.

Depression is one of the most common emotional and psychological reactions to CSE.

Flashbacks: children can re-experience the trauma, believing they are back at the scene of the attack/ abuse.

Sleep disorders (insomnia, nightmare, Sleep Terror Disorder) and **eating disorders** (anorexia, binge eating and bulimia). The latter can seem to offer a way to regain control.

Physical injuries associated with assault, **sexually transmitted infections** and **pregnancies/terminations**.

Somatic (body) memories when the stress of the memories of the abuse take the form

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of physical problems (e.g. migraines and disorders of the digestive system). **Borderline Personality Disorder** (BPD) and **Dissociative Identity Disorder** (DID – previously known as multiple personality disorder) are two possible long-term effects of CSE.

There is a heightened risk of **suicide attempts**.

Data collected from the homes in the study echoed these vulnerabilities, the risks associated with CSE and the complexity of children's needs. In addition to the issues listed in Box 2.1, homes observed a number of other commonalities:

- Low self-esteem and poor confidence were ubiquitous across children affected by CSE.

- A lack of insight into their vulnerability and the risks faced was apparent, although respondents could not say whether this was attributable to their youthful sense of invincibility, or a phenomenon specific to this group.

- Children tended to lack any positive friendships or support networks, and had very low expectations of a 'good friendship' or of romantic relationships.

- Emotional and communication problems were common, with feelings often communicated through aggression or self-harm.

- Personal hygiene was said to be commonly neglected and could be deliberately used as a barrier.

- Poor diet and neglected health issues were also reported to be common.

Some children affected by CSE had been in the care system from an early age, but others had entered the care system, and residential care, in adolescence, primarily because of CSE. For those children who entered care in adolescence, relationships with parents may have been strained, but on the whole these children were not in care because of parental neglect or abuse. However, the 'coming to light' of the child's sexual exploitation exacerbated any existing parent-child difficulties and could prompt the parents to reject the child, or blame them for what had happened. Respondents believed that CSE had resulted in children completely new to the care system entering residential care, as one explained: *'these are not your typical care kids'.* Diversity was also found in children's previous experience of education.

Finally, interviewees believed that although significant numbers of boys are sexually exploited, the issue is not always detected, as it could be masked by concomitant association with gangs and aggression. Half of the homes included in our study were female only, as it was believed that girls-only settings were more suitable for dealing with CSE-related issues and helped the girls feel safer. There was only one boy across the eight case studies we explored, and the programmes found in the literature only involved girls. Therefore, it is possible that our study may have missed the different and additional needs of sexually exploited boys.
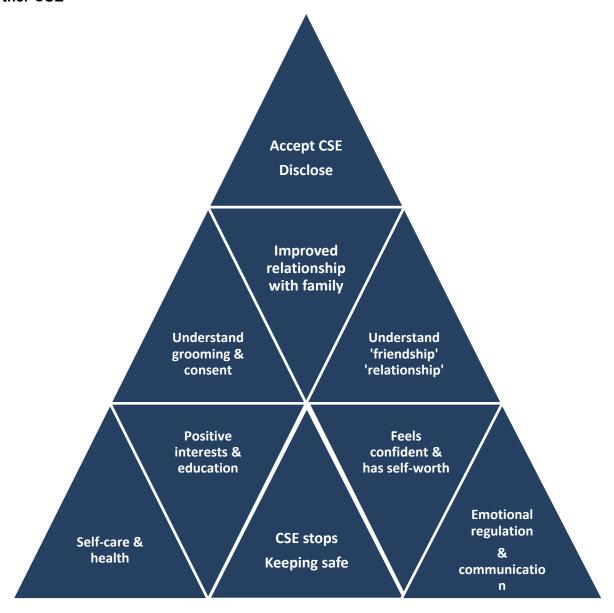
2.2 The aims of intervention

The two overarching aims of CSE programmes identified in the literature were: first, to reduce risks (e.g. deal with absconding and addiction, and prevent contact with CSE perpetrators); and second, to build a child's resilience (e.g. build self-confidence and positive relationships, have positive interests and engage with education) (Edinburgh and Saewyc 2008; Pierce 2012; Webb and Oram 2015).

These two key goals were also reflected in the settings in our study, and what homes were aiming to achieve in relation to CSE was found to broadly concur, regardless of the precise model of working or type of setting. The ultimate aim was that children recovered from CSE, the risk of CSE was eliminated or greatly reduced, and they could have a more 'normal' life going forward. To reach those aims, children needed to achieve a series of incremental steps and understand that they had been exploited. The recognition of CSE was seen as an enormous breakthrough, and achieving it relied on several factors, including: beginning to value themselves; comprehending 'consent'; appreciating the components of a healthy friendships and relationships; learning how to keep safe; and no longer desiring contact with the perpetrators.

Figure 2.1 sets out the main outcome 'stages' or building blocks that homes said were individually critical. Each of the discrete elements contributed to the overarching goals of keeping the child safe by eliminating risks and building resilience.

Interviewees stressed that this process was neither simple nor linear. Individual children had their own timeframe; 'stages' were interdependent and overlapped, and regression was common.

Figure 2.1 Matrix of desired outcomes which contribute to recovery from and prevention of further CSE

Accept CSE
Disclose

Improved relationship with family

Understand grooming & consent

Understand 'friendship' 'relationship'

Positive interests & education

Feels confident & has self-worth

Self-care & health

CSE stops
Keeping safe

Emotional regulation & communication

2.3 Children's outcomes

In this section, we look at the outcomes reported by homes in the study and the extent to which these reflect outcomes from CSE programmes identified in the literature.

The outcomes described below are those which homes aimed to achieve, and generally believed they were achieving, for children in the setting, although there were clearly individual variations. The focus of the discussion was on outcomes observed while children were in the home or at the point of leaving, as homes did not collect data on outcomes once children left the setting. Furthermore, we relied on respondents' perceptions of children's progress based on examples they decided to provide. We could not independently verify if these outcomes had been achieved.

2.3.1 Keeping the child safe

From the outset, a fundamental goal was to keep the child safe, which included:

- Stopping children from absconding, so they were safe from perpetrators and physically safe, and preventing further incidences of CSE while in the home.

- Improving children's acceptance of their own vulnerability. Children often had little appreciation of their own vulnerability to multiple dangers, such as perpetrators, including traffickers, finding and taking a child, or being attacked or taken advantage of in other ways besides CSE. When homes were in very remote areas, running away brought additional risks of physical injury or exposure.

The shift towards this outcome came when children showed that they desired to, and had some understanding of, how to keep themselves safe. Fundamental to this was reduced absconding. One manager said they judged how well their approach was working by the fact that the children were still there, as they *'could vote with their feet'*. Many examples were given of children who had absconded frequently or constantly in previous placements, but had had fewer or no missing incidents, or attempts to run away, in the current home. The children were reported as saying that this resulted from feeling safe, loved and cared for in the home, as well as becoming aware of their vulnerability. As one interviewee put it, the aim was that the '*external boundaries'* initially imposed by the home became internalised so that the child knew how to, and wanted to, keep themselves safe.

The literature (Shuker 2014;Thomson et al 2011) also identifies being safe as a significant intermediate outcome, as it is only when children feel safe and have stabilised that the 'real' work can start.

2.3.2 Improved health and self-care

Health outcomes were seen as important by homes, and while children were in the setting, they were reported to have made progress in a range of areas including:

- eliminating or reducing dependency on drugs and alcohol.

- sexual health outcomes, that is, getting treatment for sexually transmitted infections (STIs), understanding how to prevent these in the future and being able to use contraception effectively.

- achieving a healthy lifestyle, that is, eating healthily, sleeping well, '*thriving*', and being interested in their personal hygiene and general wellbeing.

Children were also reported to have developed life skills such as budgeting, shopping, cooking, laundry and other forms of practical self-care. These were seen as important achievements in themselves, as well as being instrumental in helping a child move back to the family home, or live independently.

The importance of focusing on health outcomes and life skills was also highlighted in some of the literature as a way of dealing with key risks and the consequences of CSE (Edinburgh and Saewyc 2008; Pierce 2012; Saewyc and Edinburgh 2010; Scott and Skidmore 2006; Webb and Oram 2015).

2.3.3 Positive interests and education

Many children arrived at the homes with no interests or having dropped those they used to like. Having something they enjoyed doing was seen as beneficial in itself, as well as being instrumental in developing self-confidence and creating part of their future protection mechanisms. Some children discussed in our interviews and case studies had excelled in their new activity or sport.

Regardless of their academic ability or previous attainment, the children in these homes found that applying themselves, achieving academically and getting helpful career guidance, also gave them a set of hopes and plans which they were both pleased and surprised by, as the case examples below illustrate. Succeeding educationally and having career aspirations were seen as direct protective factors and also indirectly boosted self-confidence.

Case study A
The young girl had been a star student with excellent grades, but over a three month period missed school so much that she was expelled. In that time she had started using drugs, ran away from home a lot and was exploited by a gang of older men. At this home her school attendance and application were excellent. She was predicted to get good results in her GCSEs and wanted to become a lawyer.

Case study B
This child had some cognitive impairment, had been a poor school attender and had never done well academically. She arrived with no aspirations and very low expectations. But after eight months in the home, she was expected to sit exams, was predicted to do well in these and to start at a further education college that autumn. She was surprised and really pleased with this, as she had never expected to be able to do exams or that college could be an option for her.

Many of the programmes reviewed in the literature also identified positive engagement with education as a key indicator of the success of a CSE programme (Pierce 2012; Saewyc and Edinburgh 2010; Scott and Skidmore 2008; Shuker 2014; Thomson et al 2011; Twill et al 2010).

2.3.4 Demonstrating self-confidence and appreciating their own worth

Improvements noted by homes included children demonstrating a positive sense of their own identity and self-worth; reducing or ceasing to self-harm; and expressing aspirations for their future, as one respondent said: '[to] *understand their value as an individual*'.

Self-confidence was identified in the literature as a key protective factor to be supported through CSE programmes and in some cases it was systematically monitored using established psychological assessments (e.g. the Coopersmith self-esteem inventory) (Avinger and Jones 2007; Thomson et al 2011).

2.3.5 Emotional self-regulation and communication

In the homes studied, behaviours such as self-harming or aggression were viewed as forms of communication and a learned behaviour in response to stress. The development of an understanding of their own emotions and emotional reactions was seen as a pivotal part of this change. Respondents said they knew that children were making progress in this area when they had learnt to 'self-regulate', such as to: not run away; withdraw; and/or be aggressive to oneself or others when upset. Other indicators reported included children showing less agitation, fewer extreme mood swings, being better able to regulate their moods, using 'self-soothing' techniques and being more able to communicate their feelings assertively: *'I don't need that behaviour any more'*.

Emotional regulation was another key area of focus identified in the literature, with established psychological assessments (e.g. sub-scales of the Trauma Symptom Inventory) used to monitor a child's progress and the success of a CSE programme (Avinger and Jones 2007; Deb et al 2011; Hickle and Roe-Sepowitz 2014).

2.3.6 Higher expectations of friendships and relationships

Homes reported that given the children's characteristically low starting point, having higher expectations of friendships required a significant change of mind-set, and hinged on other factors too, not least having increased self-confidence. Understanding what a 'true friend' was, was important in two ways. Firstly, this meant that they valued and developed healthy friendships when they returned home and had a yardstick by which to judge acquaintances in the future. Secondly, understanding the qualities of a good friendship helped shake the child's conviction that their exploiters had been their 'friends' or 'boyfriends', and contributed directly to the overall achievement of recognising CSE. Understanding the limitations of 'friendships' created over social media platforms was also critical.

The benefits of supporting children to develop positive relationships and to reconnect with their community in positive ways are also emphasised in the literature, especially as protective mechanisms (Scott and Skidmore 2006; Shuker 2014; Thomson et al 2011).

2.3.7 Improved family relationships

Improving family relationships was a major desired outcome and one where homes felt they made some progress with discrete targeted activities; these are described in Chapter 4. This outcome hinged on achieving improved understanding and more open and easier communication between the parent and child, combined with the parents' understanding of some of the factors which may have contributed to the CSE and feeling better able to parent the child.

These factors again reflect the literature. Many of the programmes we reviewed (Pierce 2012; Saewyc and Edinburgh 2010; Scott and Skidmore 2008; Thomson et al 2011) identified improved family relationships as a key desired outcome from a CSE programme.

2.3.8 Understanding consent and grooming

Realising what consent was and was not, and changing existing perceptions about consent, were reported to be a significant outcome which appeared to take some time to achieve. Moreover, it was believed that when children were able to discuss consent issues in various practical scenarios, it indicated that they were beginning to see how it applied to their own situations, and might challenge their previous misconceptions. For example, changes in perceptions around how much their own behaviour had contributed to their abuse was common. Residential staff helped children to understand that dressing a certain way, or accepting gifts, did not equal consent. The children were also said to have learned the legal rules around consent and age, and appreciated how much alcohol or drug consumption undermined the validity of any 'consent'.

This enabled children to understand that they had not consented to what had been done to them. A central part of that belief system was their insistence that they had been in a loving relationship, and/or that what had happened had been '*their choice'* and had been under their control. Deconstructing these beliefs was another major milestone, and included children understanding the grooming process and recognising how they had been groomed. This was pivotal to the next outcome: accepting CSE.

Understanding of consent and grooming was at the heart of the CSE programmes we found in the literature (e.g. Pierce 2012; Saewyc and Edinburgh 2010; Scott and Skidmore 2006; Thomson et al 2011), with specific educational programmes seeing a playing a pivotal role in achieving this outcome (e.g. Hickle and Roe-Sepowitz 2014).

2.3.9 Accepting CSE and disclosing CSE

Interviewees reported that shifting a child's loyalty and mindset was no easy matter and that making a disclosure was '*a defining moment'*. Breakthroughs generally took a long time, and were dependent on trust being established with staff and achieving many of the

other outcomes outlined above. In the homes included in the study, children often had numerous disclosures to make, for example, about different incidences of rape, numerous perpetrators, or networks of perpetrators, drug dealing and other young people involved. It could take children many months or years to tell the whole story, 'bit by bit'. As further progress hinged on this, staff emphasised the need to be patient and to avoid pushing children to disclose until they were ready.

Disclosure was described as a major *'traumatic'* event for children, as they had to accept that what they had believed, or wanted to believe, was not truth. Indeed, one programme reviewed (Thomson et al 2011), did not start the intensive, CSE-specific work until a child was willing to acknowledge that they had been sexually exploited. Demolishing all the other misconceptions that went with disclosure (e.g. that this man loved them), was said to be extremely distressing for children.

Once a disclosure was made, the police had to be told and involved. However, disclosing to the police or providing evidence in criminal prosecutions were further, very demanding and potentially dangerous milestones, which many children were not immediately ready, or were too scared, to make. It was not unusual for a child to make a disclosure to staff and then try to deny it, or refuse to disclose any more information for a long period. Nonetheless, children in the study had been supported to give statements to the police as well as evidence in court, and convictions had been made. This legal aspect of CSE is shared by children who suffer other forms of sexual or physical abuse, but may also distinguish the set of desired outcomes and associated care required from other, more general, types of residential care.

Case Study A

The girl was admitted when 14. About nine months into her stay at the home she made disclosures, including being raped on numerous occasions, by the main suspect and someone else, as well as being scared of the gang leader, her 'boyfriend'. Rape had been suspected on referral, but the girl had previously denied it. The same man had since been convicted for raping another young girl as well as for other offences. Up to this point the girl had been adamant that it was a mutual and proper relationship. Even after making the disclosure, her acceptance of being exploited fluctuated from day to day and she said she was not ready to make a formal statement to the police.

Case Study C

A girl who was admitted when 13, had a history of self-harming, suicide attempts, truanting, using drugs and alcohol and running away from the family home and from previous placements. The referring social worker believed there was a high risk of CSE and some indications. After some months in this home, the girl made disclosures about having sex with older men (aged 23–30), while heavily under the influence of drugs or alcohol, losing her virginity at 13 and having had about 30 sexual partners over 6–7 months. She also disclosed two violent rapes, including one by her 16 year old

boyfriend. She believed that all this sex had been her 'choice' and that after the rape it had seemed better to go along with it, rather than get beaten up.

Case Study D
The child was originally admitted to the home at 12 for emotional and behavioural difficulties. This was not a specialist CSE home at the time. The child was very uncommunicative and withdrawn. After about two years, she developed a strong interest in a sport, which the home encouraged and assisted. A lot of success in this and self-confidence followed. At this point, disclosures started to come out, including being used for drug dealing and for sex by a gang of at least 12 men. Roughly, four years after admission, the girl testified in court and convictions were secured.

2.4 Conclusion

Our research has found that children affected by CSE placed in residential care were very vulnerable and had a range of complex, high-level needs. These children were typically highly traumatised due to CSE, often compounded by other traumatic experiences common among children in residential care, such as neglect, physical and sexual abuse, and domestic violence. Traumatic experiences meant that these children were very vulnerable, with substance abuse, self-harm, depression, violent behaviour, low self-esteem, and sleep and eating disorders being common.

The chaos that typically characterised these children's lives before they entered residential care was also reflected in: disengagement from education; lack of positive activities; lack of positive friendships and support networks; and health issues ranging from sexually transmitted diseases to very unhealthy lifestyles. While many children affected by CSE were reported to have been in the care system from an early age, some had entered care as adolescents.

It should be noted that our study focused primarily on girls; the extent to which boys in residential care affected by CSE may face different or additional issues would be worth exploring further.

All the homes in our study and the literature concurred on the key purpose of interventions with children affected by CSE, that is, removing risks and building resilience. Key expected outcomes included: improved insight; a sense of self-worth; higher aspirations; positive relationships; educational achievements; positive interests; effective communication skills; and, improved health and wellbeing. As well as being valuable in their own right, these outcomes were seen as contributing to teaching children to recognise and manage risks, and build resilience. Timeframes for making progress in these different areas were very individualised, and there were periods of progress as well

as 'remissions', but the ultimate aim was for CSE risks to be removed or much reduced so children could 'be children' again.

There was a great deal of commonality between the expected outcomes identified in the literature and the outcomes reported by the homes in our study, suggesting that these are likely to be suitable 'core' outcomes to monitor the effectiveness of CSE interventions. However, while in the literature, data on some key outcomes were often collected systematically using standardised measures (e.g. self-esteem and trauma inventories), in the homes, information on the progress that children made in relation to different outcomes was based mainly on non-systematic and unstructured observations by staff. Furthermore, while the literature identified the need to collect data on long-term outcomes to assess the sustainability of the progress achieved in residential care, none of the homes collected information on children's outcomes after they left the setting. Therefore, while homes reported positive outcomes for children affected by CSE, systematic evidence to confirm these benefits and their sustainability is generally lacking.

3 Supporting children affected by CSE

This chapter explores:

- approaches for working with children affected by CSE.
- meeting the needs of individual children.
- key areas of work prioritised to stabilise children.
- the package of services provided to children.

3.1 Framework underpinning CSE work

A number of theoretical frameworks underpinned the CSE interventions identified in the literature, but none of these had been developed from 'scratch' to work with children who had been sexually exploited. Rather, all had been developed to support children with a high level of need and had been refined to deal with CSE, alongside the other underlying vulnerabilities a child was facing.

- **Trauma-based** care was commonly reported as underpinning the development of the interventions reviewed (Avinger and Jones 2007; Deb and Mukherjee 2011; Deb et al 2011; Edinburgh and Saewyc 2008; Webb and Oram 2015). Sexual abuse experienced early in life can have profound negative effects (e.g. attachment difficulties, inability to trust adults and cognitive distortions about sexuality and relationships). These can lead to risky sexual behaviour and to re-victimisation. The shame and pain from trauma can be the root cause of many of the issues highlighted earlier (e.g. self-harm and depression). Teenagers may resort to substance abuse to deal with these issues, and the neurological changes resulting from trauma may increase susceptibility to chemical dependence (Edinburgh and Saewyc 2008).

- **A strength-based** approach (Pierce 2012; Webb and Oram 2015) and **resilience theory** (Edinburgh and Saewyc 2008; Webb and Oram 2015) were commonly mentioned as helping to identify protective factors (e.g. self-esteem, self-efficacy, positive attachments and support networks) that can provide children with the tools they need to put their lives back together.

- **Behaviour modification** programmes were also identified as potentially effective to support children who had been sexually exploited (Wilson et al 2015). These programmes typically included an initial highly structured, routinised and controlled period, with intensity gradually reduced as individuals demonstrated that they could modify their behaviour.

- **Behavioural change** theories also underpinned some approaches (Thomson et al 2011), like the one illustrated in Box 3.1.

Box 3.1 The ACT (Acknowledge, Commit and Transform) programme (Thomson et al 2011)

ACT is based on the trans-theoretical model, which outlines five stages to change problematic behaviours: 1) pre-contemplation, when there is no acknowledgment of the problem or desire to change; 2) contemplation, when some acknowledgment of the problem exists, but the individual is ambivalent about change; 3) preparation, when there are both acknowledgment and commitment to change; 4) action, when the individual is actively taking measures to bring about change; 5) maintenance, when change has been achieved and the individual is working on preventing relapse. ACT is offered to children who are at least at the second phase and are ready to adjust to life in a residential setting.

The average length of stay in the ACT programme is just over six months. Children are assigned a staff mentor (a residential counsellor), with whom they typically develop a very close relationship. Children are also connected with a survivor mentor whom they meet regularly, often for activities in the community. They also meet weekly with their individual therapist, and take part in an educational support group, My Life My Choice. ACT includes work with families, if available – family therapy and family dinner nights are offered, including in-home family therapy for parents who cannot travel to the ACT centre.

The seven goals of treatment are: 1) reconnecting children to the community in a positive, safe way; 2) education; 3) helping children find their identity; 4) building self-esteem; 5) connecting children to community resources; 6) providing a safety net to help them cope with risky behaviours; and 7) linking them with mentors who will support them after discharge.

Overall, ACT staff try to ensure that girls leave with a trail of people and services to support them as they transition to live safely in the community.

From our interviews with homes, it would seem that the above concepts and theories underpinned the work of the homes to a greater or lesser extent; in addition, attachment theory[3] was also mentioned by some. Staff in the homes were said to be working therapeutically, that is, they were trained to understand issues such as trauma and attachment and expected to identify:

> *'how trauma affects children and young people; how and why their ways of coping with this trauma might be maladaptive; how and why agencies and staff respond in the ways they do, how some of these ways are not adaptive, and how they might change'* (SCIE 2012).

Home managers said their staff had a good understanding of how trauma influenced children's behaviour and the need to identify and develop protective factors, and this was reflected in the support the homes provided. In some settings, the pattern of having a

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[3] Attachment theory is a child development theory developed by Bowlby and extensively used in social work practice.

very controlled initial phase with the intensity reduced as behaviour improved was evident. The importance of 'readiness to change' was stressed by homes' managers. They all described an initial period when children needed to stabilise and build trusting relationships with staff before they could start working in a therapeutic way and engage in the range of services provided. This period could last from a couple of weeks to many months, depending on the complexities of the issues that the children needed to work through and how traumatised they were when they arrived. It was seen as important not to push children too hard during this initial period, and allow them to decide when they were ready to engage, particularly with aspects of the programme directly dealing with traumatic CSE experiences.

While concepts such as trauma, attachment, protective factors and behavioural modification were evident when managers explained the practice in their homes, only some could describe details of a *specific* model which underpinned all the work they did. These models informed how children were assessed, the package of support provided, how a child's progress was monitored, and staff training, development and supervision. Three of the models described by the homes were said to have been specifically developed to work with sexually exploited children. However, as the example in Box 3.2 shows, the overarching approach used by homes seemed 'generic' for addressing a child's underlying vulnerabilities and could apply to any child with a high level of need, like the model in Box 3.3, which was used in another setting to work with all children, rather than being specifically used to work with children affected by CSE.

Box 3.2 Model for working with sexually exploited children

One of the homes in the study identified four main phases of the treatment programme, reflecting what a child is expected to achieve at each stage, including forming positive attachments:

Phase one – Containment and Stabilisation: establishing a sense of safety; stabilisation and containment of emotion and behaviour; increasing capacity for self-regulation; development of security/secure base, capacity to explore and engage in relationships.

Phase two – Engagement and Exploration: building self confidence; foundations for self- agency; increased self-regulation; establishing attachment bonds; engaging in treatment-related activities.

Phase three – Connection and Partnership: continued building of attachment bonds; building partnership with treatment staff; developing self-confidence, self-efficacy and self-agency; enhancing self-regulation.

Phase four – Security and Social Relatedness: cement self-confidence, self-efficacy and self-agency; demonstrate emotional and behavioural stability, recognition and understanding of others; empathy and concern for others, social connection, pro-social socially appropriate behaviours.

Box 3.3 Model for working with children who have experienced multiple and/or prolonged traumatic stress.

One of the homes operated a model developed in the US which identifies three core domains that frequently impact on traumatised children, and are relevant to future resilience: attachment, regulation and competency.

The model was about giving children choices and helping them to regulate their emotions and take control of their lives. While providing an overarching theoretical framework, guiding structure and core principles which should underpin practice, the model was applied flexibly. It was designed to be used by different professionals, and all staff who supported children in this home (e.g. teachers, key workers and nurses) were trained to use this approach, with support from the mental health team. After this model was introduced, 'critical incidents' reduced from around 70 to 15 a month, and staff injuries also declined.

Some evidence was also reported in the US that the approach led to reduction in child post-traumatic stress and general mental health symptoms, as well as increased adaptive and social skills. It was also associated with a reduction in the use of restraints, and improved permanency rates in foster care.

3.2 The secret is in the matching

Good matching of the child to the home and vice versa was said to be crucial. Homes in the study were reluctant to accept children who might not benefit from their approach, and they also had to consider if they had the capacity and skills to adequately support each individual child. The constituents of good matching were said to be:

- an accurate and detailed referral assessment.

- the home's ability to meet the child's needs.

- the child's readiness to gain from the home's approach.

- compatibility with children already in the home.

Homes needed accurate details about the child on referral, including the history of exploitation, risk factors and family relations, as well as their emotional state and needs. Openness about drug and alcohol dependency and mental health issues was essential to help the home decide if they could accept a referral. Incomplete or inaccurate information could compromise the matching process and placement stability. In one home, a placement was terminated quite quickly after a child violently attacked staff members: this history of aggression and assault had been omitted from the referral. At the other extreme, it was reported that the risk of CSE was sometimes exaggerated, to assist a

child in getting a placement in a desired home. Adequate matching could be compromised if the children had to be accommodated in an emergency. Another major challenge was the child's appreciation and openness about CSE. As children were not always ready to disclose sexual exploitation at the point of being referred to a home, social workers had to make a judgement call with an incomplete picture of a child's experience of CSE.

An accurate assessment of the home's ability to meet the child's needs was found to be equally critical. This included the home's approach to working on CSE, their capacity to keep the child safe and staff members' expertise and skill mix. Homes said they had to be clear whether they had the internal capability and/or enough access to external resources, to adequately to deal with the range of vulnerabilities that a child was facing.

Homes also assessed whether a child would engage with and benefit from a home's therapeutic programme. A home's approach was commonly set out to the social worker and child, with both expected to agree to it formally before admission. Homes did not expect children to have an in-depth understanding of their model of working and package of support, but they did expect them to understand the home's basic rules and what life would be like in the setting, to ensure that children knew what to expect.

Ensuring a good fit with existing residents was a two-way deliberation: what would be best for the existing children as well as the new child. This was considered essential to support a harmonious and nurturing environment. Commonly, in our sample, homes had reduced the number of places and/or become female-only, because of CSE work. It was believed that children who had been sexually exploited tended to benefit most from being cared for in a very small group (e.g. 2-3) and that a female-only environment helped girls to feel safe and created an easier dynamic to manage. While it was recognised that more provision was needed for boys, mixing genders was seen as problematic and potentially risky, as sometimes boys who had experienced CSE, especially in gangs, may have also been perpetrators. The risk of girls grooming other children and potential for violence were also reported to be important in considering the other children's need for security and safety. Homes carefully considered the number of frequent absconders they could take on to ensure that they had the resources to cope and minimise the risk to the other children. A reluctance to take children with a high tendency to go missing was also perceived as an Ofsted induced risk aversion, as interviewees believed that a child absconding would negatively affect a home's rating.

Matching children for age, personality and behaviour was also considered important. A degree of role modelling was expected, partly on the basis of maturity, but mainly from children who had settled into the home and its routines, who could show that they trusted the staff and had already made some progress.

3.3 Building the foundation

From managers' descriptions of their practices, four key areas of work were prioritised from day one to stabilise children: a comprehensive needs assessment; building trusted relationships; keeping children safe; and, providing a 'normal' family environment. Effective work in these areas was seen as essential to prepare children to engage and benefit from the range of support that homes provided.

3.3.1 Comprehensive needs assessment

Following the initial referral, an in-depth assessment process was typically carried out, to determine a child's range and level of needs, and to tailor the support package accordingly. This study included one assessment centre, which provided short-term placements (4-12 weeks) to identify a suitable long-term placement within the company. Other homes provided an extensive assessment programme on site, involving a multi-disciplinary team (e.g. psychologists, substance misuse workers, nurses, teachers, CSE workers) and typically lasting several weeks. As well as 'off-the-shelf' tools, such as the Strengths and Difficulties Questionnaire, some homes used assessment tools that they had developed in-house, reflecting their specific therapeutic approach. Assessments in all homes included a section on known CSE risks, as well as education, health and wellbeing. In two of the homes where we did our case studies, the staff interviewed regularly referred to the assessment when describing what support and feedback were provided by different professionals.

Even in homes where the internal needs assessment process was not so extensive, staff seemed to have a good overall understanding of a child's needs based on the initial expectations agreed with the placing authority, and further needs that emerged as the child progressed through the programme. However, as local authority staff were not involved in the study, we do not really know how well the homes' assessments and packages of support reflected each child's care plan and the placing authority's expectations.

Key workers were mainly responsible for keeping written records of observations and other relevant information, but reports from other professionals were also provided. In one home children's progress and support was discussed at weekly multi-disciplinary case management meetings. Monthly case reviews in supervision and/or staff meetings were more typical elsewhere, although reviews could be arranged more frequently if needed. For example, following a missing incident, a child's risks would be formally assessed on a weekly or even daily basis.

3.3.2 Establishing relationships of trust

Building trusting relationships was considered key to the process of stabilising children to help them to engage in the range of support provided by the home, particularly therapeutic support. While the aim was for children to develop trusting relationships with

all staff (and other children), to support early engagement and continuity, children were given the opportunity to develop a closer relationship with just a few staff (e.g. 1–2).

Homes commonly identified a key worker and one other staff member (e.g. a co-key worker) who had specific responsibility for a child. For example, the key worker might take the lead in helping the child to settle, explain the home's rules and have regular sessions to discuss any issues the child was facing. The key worker system was used flexibly, and typically homes encouraged children to seek help from the member of staff they felt most comfortable with.

Key workers were also allocated according to their level of experience and expertise. For instance, in one of the case study homes, key workers with the most CSE expertise were assigned to the children at the highest risk of CSE. In other homes, personality matching was attempted. Gender matching was also considered for girls who had had very problematic relationships with men, or when it was believed important to provide a positive male role model. For example, the key worker might be a woman but the co-worker a man. Homes would consider changing the key worker if the child was struggling to develop a relationship with him/her, although generally we were told that key workers managed to establish good relationships and that children liked the idea of having a key worker and could become very attached to them.

3.3.3 Keeping children safe

A central task for the homes was to keep a group of very high-risk children safe while in their care, and to teach them to recognise and manage risks. This underpinned all the work homes did: detailed risk assessments were developed when children arrived, and were regularly monitored and reviewed. Key messages about recognising risks and keeping safe were reinforced through specific work, as well as informally through the home's everyday activities, such as discussing relevant story lines from TV programmes. When children went missing, discussions were held on their return, to explore what factors had prompted them to run away and what could have been done differently, and to get them to understand the actual and potential consequences of their actions.

Some measures, aimed at keeping children safe, were found to be common to all the homes in this study:

- providing high levels of staff supervision.
- limiting and/or monitoring access to phones, internet and money.
- locating homes in 'safe', usually remote, areas.
- reward and sanction systems.
- physically restraining children in very extreme circumstances.

The homes in the study accepted children with serious absconding behaviour linked to CSE. The main strategy to ensure their immediate safety was a high level of **supervision.** Commonly, one or even two members of staff were allocated to the child, all day and at night. Staff chaperoned children when they went out, and followed them

when they tried to leave on their own without permission. The aim was for this very high level of supervision to be gradually reduced in line with a child's progress in understanding and managing risks. Children were allowed to go out on their own for increasing amounts of time when they were considered ready to manage risks. Secure settings provided more limited 'mobility', as the assumption was that there would be 'step-down' arrangements in the next placement, where a child's ability to manage risks would be more fully tested.

Phones and internet access can represent major risks for children affected by CSE, and access to these was closely monitored and restricted, mainly to prevent children from contacting their exploiters. Practices varied. In secure and some non-secure homes, no mobile phones were allowed, supervised calls could only be made from the home's landline, and the internet could only be accessed for school work and under staff supervision. In other settings, the aim was to gradually increase unsupervised access to phones, the internet and social media, as these are currently part of every child's life and children needed to learn to use them safely. However, use was very closely supervised (e.g. staff checked call records and children's social media accounts, mobile phones were kept in the office overnight). If children put themselves at risk through access to the phone and internet, restrictions were reimposed and additional work done on using these safely. Access to money was also closely monitored. While work was done to teach children to manage budgets, staff had to ensure that this was done safely and money was not used to put themselves at risk, for example by buying a mobile phone.

From this and another DfE study on 'welfare' secure placements (Hart and La Valle, forthcoming) there seems to be a widespread belief that placing children **outside their community**, often in a remote location, can help to keep them safe. Some of the homes included in this study were deliberately sited in remote locations that were difficult to reach. They catered mainly for children from other areas, some of whom had been placed away from their community because it was believed that this would help to keep them safe. However, this assumption is untested. In the 'welfare' secure placements study (Hart and La Valle, forthcoming) we found local authorities that were increasingly reluctant to place children out of the area because of the disruption this caused. Moreover, they could point to examples of children who had been placed out of area, in very remote areas, and still managed to run away. A local authority home included in this study also said they had a policy of keeping children affected by CSE in the area to ensure continuity of care and avoid disruption, and because ultimately they needed to learn to keep safe in their community.

A system that **rewarded children for compliance** with rules (including rules around safety) was common in homes, although the extent to which this was formalised varied. For example, in one home children were marked through the day for effort, attitude and behaviour and at the end of the week an overall 'score' determined what 'treats' they were entitled to (e.g. TV, sweets, going out and recreational activities). In other homes the rewards system seemed less structured and linked to specific issues, particularly

demonstrating the capacity to keep safe when they went out on their own, which resulted in children being given increasing freedom to go out unsupervised. In one home there was concern that a system of rewards for certain behaviour could be associated with grooming (a child is given something in return for pleasing staff). Instead they were careful to emphasise that rewards (beads or charms for a bracelet) were mainly reminders for the child that they had overcome a major hurdle.

There was uncertainty about what residential staff could legally do to restrict children's liberty in order to keep them safe. While the DfE has issued guidance recently on **restraining** children, there was uncertainty about the interpretation of this guidance, e.g. what counted as an immediate danger that would justify physically restraining a child. Homes had alarms and CCTV on external doors and some on internal doors at night, but they emphasised that these were to alert staff to incoming intruders, but were not there to prevent children from going out. There was uncertainty about what homes could do to ensure that they knew when a child was trying to leave without permission. One new manager decided to keep the front door locked to control a high absconder seen to be at risk, so if the child wanted to go out they had to ask staff to unlock the door (and they could therefore follow him). Staff thought this approach helped but did not think it was permitted until the new manager arrived.

3.3.4 A 'normal' family life

From the literature (Hart et al 2015; Thomson et al 2011), and data collected from homes in the study, it was evident that alongside all the therapeutic and specialist support, it was vital for settings to provide some sense of normality. As one of the home managers explained:

> '…*professionals should never forget that … while sexually exploited children may have experienced a pseudo-adult type behaviour, they just want to be children'*.

Allowing children to be children was achieved primarily by:

- Providing a **loving and caring family environment.** As one manager explained: '*Whether young people like it or not we throw at them love, respect, honesty, courtesy*'. He aimed to provide the kind of family life he would expect for his own children. There were several examples of 'normal' family activities, including celebrating birthdays, inviting the family for Sunday lunch, going on holiday, personalising bedrooms, going on outings and children cooking and deciding menus. Even within the constraints of a secure setting, efforts were made to provide a sense of normality. Respondents also talked about meeting children's most basic needs (e.g. providing food and shelter, a clean bed and clean clothes), as in the very chaotic period that preceded some of the placements, children's basic care had often been seriously neglected.

- Creating **predictability and routines.** These were seen as essential for this group of children. As a manager explained:

'these young people can't deal with any form of unpredictability … if you have been in the back of a car being trafficked around, you don't know if you are going to be killed, or how many men you have to have sex with that night. When you come to a place like this everything needs to be chopped down to ten minute chunks of predictability'.

Ofsted also reported this in respect of one of the homes:
'Young people know exactly what is happening and who works when. The rota is simple and is never altered. Each day, two young people, two staff and the manager together comprise a unit that feels like a real family.'

- Enabling children to do the kind of **things children enjoy doing**, with homes providing a range of opportunities for children to get involved in, such as sports, recreational activities and hobbies. As well as on-site facilities, open settings encouraged children to engage in community activities, such as youth clubs, even when this had considerable resource implications because of the level of supervision required.

- Living a normal 'home' life was also seen as essential to assist children to **develop life skills** (e.g. budgeting and cooking), and homes said they ensured that children were regularly involved in relevant activities (e.g. going shopping, cooking, cleaning their room and doing their own laundry). A secure unit, where it was not possible to engage children in such activities within the home, used a domestic science facility in a nearby school to help the children practise these skills.

3.4 Package of services

As well as providing access to universal services (i.e. education and health), children were also given access to: education on sex, relationships and CSE; therapy; and, when required, support with giving evidence in court.

3.4.1 Education

Education was seen as a key protective factor and was supported by the homes in the study in a range of flexible ways, in line with children's needs and safety risks. As noted earlier, children's previous engagement in education and academic achievements varied considerably. However even those who had generally attended and done well in school often had a period of disruption and non-attendance prior to entering the care system. Thus the return to full-time education and academic demands was typically gradual and individual, with attendance increased over time as a child was considered ready to cope and benefit from a longer school day. Therefore, according to the child's readiness and a home's facilities, some children received one-to-one tuition at the setting, while others attended on-site schools, nearby facilities provided by the same company, community mainstream schools or specialist units, such as pupil referral units.

3.4.2 Health

Typically, the most pressing health needs of children who had been sexually exploited related to alcohol and drug abuse, and sexual health, and these were very much reflected in the package of support provided. Work around drug and alcohol misuse tended to be delivered by independent specialist agencies. Local sexual health workers normally provided screening for sexually transmitted diseases, taught children about safe sex and contraception, and provided condoms and other forms of contraception.

In the chaotic period that frequently preceded admission to the home, children's health was often seriously neglected and the looked after children's nurse and home staff also provided care and advice on more general health issues (e.g. health checks, healthy diets and exercise), as well as personal hygiene.

While much of this input was provided by external agencies, managers stressed that their residential staff were familiar with the programmes and topics covered and the work done with specific children, and they were therefore able to reinforce and build on this work.

3.4.3 Sex, relationships and CSE

Homes provided 'generic' education on sex and relationships, as well as more specific work on sexual exploitation. Essential topics were consent, grooming, body image, shame and stigma. External agencies were often contracted to deliver programmes on sex education, relationships, grooming and CSE. This work commonly consisted of a combination of group work where issues were discussed in a general way and which prepared children for more intensive individual work on their CSE experiences and their effects. A range of tools (e.g. vignettes and DVDs) were used to cover relevant topics in formal sessions, with messages reinforced informally during everyday activities.

Box 3.4 Putting the Pieces Back Together (Hickle and Roe-Sepowitz 2014)

This is a 12-week group intervention delivered in residential care, adapted from a programme originally developed for adult women with a history of sex trading, who had been sex trafficked, or had sexual abuse history. Two key features of the programme are: 1) attention to self-understanding and self-care, which are important first steps in trauma-reduction work; 2) development of a safe group environment, as safety is a key element of trauma-focused treatment. The four components of the programme are:

Education about sexual exploitation
Victims are often unaware or unwilling to acknowledge the exploitation they have experienced, so the group started by defining terms such as 'pimp', 'trick/customer' and 'escort' and clearly stated the expectation that topics related to sex work, often avoided in other treatment settings, would be discussed by the group. Games, crafts, stories and scenarios were used to cover taboo subjects and stigmatisation. For example, a number of scenarios were used to discuss how group members felt about different recruitment

techniques (e.g. scared, confused), and possible sources of help (e.g. police, protection, a friend who understands). This allowed girls who had not previously considered that their victimisation was a form of exploitation to be given a new framework for thinking about their experiences.

Mutual aid
Mutual aid enabled group members with commonalities to express their needs, and to recognise and respond to the needs of others in the group, and through this recognition of commonalities, group members became a source of support for each other.

Reducing shame, addressing stigma
Throughout the group, girls discussed how they were recruited, coerced and forced to sell sex, and the authors report that these discussions and support from peers served to reinforce efforts to address stigma through education, activity, mutual aid and reframing, so that they could then consider their experiences from a new perspective, without shame. Discussions about specifically stigmatized topics (e.g. parents pimping their children, trading sex to get basic needs met) were prompted in an effort to normalize the situations that are common to victims of sexual exploitation so that group members would no longer feel isolated by their experiences.

Managing strong emotions
Sharing experiences of sexual exploitation often for the first time, could elicit very strong emotions and these emotions were processed through a range of activities; these provided a 'buffering effect' and were unique to the group format, where emotions surrounding abusive experiences could be addressed without requiring high levels of self-disclosure that could be distressing, especially when group members had not achieved a sense of safety following their traumatic experiences. During these activities, members had the opportunity to share strong emotions and then allow the group to help them identify ways to cope with their feelings.

While it was recognised that the more intensive work on CSE experiences had to be done in a one-to-one setting, the value of group work was recognised by the literature (e.g. Hickle and Roe-Sepowitz 2014; Thomson et al 2011; Wilson et al 2015) and our interviewees. As illustrated in the educational programme described in Box 3.4, shared experiences could help children deal with the shame and stigma associated with CSE. Knowing that they were not '*the only one in the world'* helped them to recognise that what had happened to them was wrong and that the mutual support provided through the group could be empowering. As well as group work, one CSE residential programme reviewed (Thomson et al 2011 – see Box 3.1), included the allocation of survivor mentors, i.e. sexually exploited girls who had been through the CSE programme and supported participants throughout and after the programme. The evaluation concluded that the combination of input from professionals and the survivor mentors, who shared

their own personal stories, had been an effective way to engage girls in the treatment and provide continuing support (Thomson et al 2011).

3.4.4 Therapy

Both the literature (Allnock and Hynes 2012; Avinger and Jones 2007; Thomson et al 2011; Webb and Oram 2015) and the homes' managers identified therapy as a crucial part of the support package provided to children affected by CSE.

Therapy was typically provided through a combination of key/care worker sessions and mental health staff, with the latter providing support and advice to residential staff as well as working directly with children. Psychologists seemed particularly likely to work directly with children when they had complex psychological needs, and when they were part of the home's team and played a key role in designing, as well as delivering, psychological services.

Challenges were reported in getting children to engage with therapy, and they might refuse to talk and open up to mental health staff when they believed they did not need therapy or distrusted the process. Engaging local mental health workers, e.g. from CAMHS rather than having their own psychologists or therapists, presented additional challenges, as the children were not familiar with them. Furthermore, some children were reported to find one-to-one talking therapy too intense, and seemed to cope better and opened up more in less-intense conversations with the care staff while undertaking everyday activities.

It was considered important to work at a child's pace. In one home a child asked for monthly instead of weekly therapy sessions. This was agreed, as it was recognised that work with this particular child had to be done in 'baby steps', and that otherwise the child might have been overwhelmed. In the same home, children were encouraged to ask for more therapy, and one child was receiving therapy up to three times a week with sessions provided at times that suited her.

In the homes included in the study and in the literature, talking therapies (e.g. cognitive behaviour therapy, psychodynamic psychotherapy and counselling) seemed most widely used. Other types of therapies were also mentioned but seemed less common; these included: creative therapies (e.g. play, art, drama and animal therapy); body therapies (e.g. massage); and occupational therapy. The most evaluated type of therapy is cognitive behavioural therapy (CBT), which is recommended by the National Institute for Health and Care Excellence (NICE) as a first-line treatment for symptoms associated with sexual abuse (Allnock and Hynes 2012). Other types of talking and creative therapies have received less attention and so less is known about their effectiveness. However, homes valued creative therapies as they proved helpful to engage children who otherwise struggled to open up or express themselves. For example, it was reported in the case file of a girl who was very creative and was therefore offered art therapy:

'Expressing herself through art was much easier than talking through her trauma and she liked it because it helped her to refocus on something that was meaningful to her and helped to control her emotions.'

Avinger and Jones (2007) found that psychodrama group therapy resulted in considerable reductions in depression scores in a programme for sexually exploited girls. Wilson et al (2015) argue that it is particularly important to offer alternatives to traditional talking therapies to children from ethnic minority backgrounds, for whom these may be more culturally inappropriate and who may feel more comfortable with complementary therapies closer to their culture. Acupuncture, massage and meditation were given as examples.

3.4.5 Support with police and judicial processes

Homes in our study supported children to disclose CSE to the police and to give evidence in court trials relating to sexual abuse and sexual exploitation. For some homes this was reported to be common, with one setting having had six CSE court cases on at one time, and with one child alone having been involved in three separate CSE court cases.

This aspect of the work around CSE required considerable patience and sensitivity and was an extremely unsettling time for children, who had to relive traumatic experiences. Post-traumatic stress symptoms (e.g. self-harm or aggressive behaviour) could become more acute and previous progress could stall, requiring intensive support from care staff and the clinical team. Additional resources were also needed, as the children could unsettle the rest of the group in the home and because staff had to spend considerable time in court with the children.

3.5 Conclusion

Many of our findings on what underpins effective practice in relation to CSE are in line with what was found in a recent review of residential care in England (Hart et al 2015). For a residential care placement to work, it must have a clear purpose, a theoretical framework and an evidence base to guide practice, i.e. a model that shapes every aspect of residential care practice. The question is: should this model be the same as that used for all children with complex and high-level needs, or does it need to be a different model specifically developed to work with CSE?

The evidence does not indicate the need to develop a separate CSE model 'from scratch'. All the models identified in the literature and used by homes in the study were models used for all children with complex and high-level needs. Refinements made for CSE work were mainly reflected in the tailored package of support provided (e.g. CSE education programmes, measures to prevent absconding), rather than the core principles underpinning the model of practice.

The evidence from this study, as well as the more general literature on residential care, shows that effective residential practice requires: children to be in a placement that can meet their specific needs; comprehensive needs assessments; and ongoing monitoring of their progress. Within these processes, specific 'CSE issues' to consider include the tools used to carry out CSE risk assessments, and the structural features of a placement that may be more suitable for these children. However, there is little robust evidence to assess effective ways of dealing with these issues:

- A range of tools have been developed to carry out CSE risk assessments, but it was not clear what evidence was used to develop these tools and the extent to which they had been tested.

- Children affected by CSE were believed to do better in very small, single-sex units, although these assumptions have not been tested and we do not know if they hold for both sexes.

- There is a widely (but not unanimously) held assumption that removing children affected by CSE from their community and placing them in very remote areas helps to keep them safe, but there is no evidence to support this.

In addition, more guidance on what homes can legally do to prevent children from running away may help in using resources more effectively. The line between ensuring children's safety and restricting their liberty was a very fine one, and a considerable amount of staff time was spent on ensuring that homes stayed on the 'right' side of the line.

The package of support provided to children affected by CSE seems to reflect the range of complex needs these children had. To a large extent, these would be the kind of services (e.g. education, health, recreational activities, therapy) provided for those suffering from trauma. In addition, specific CSE educational programmes were being delivered. As the number of CSE tools and educational programmes is growing quickly, it would seem helpful to provide homes with advice on which of these tools and programmes have been evaluated and how effective they are in different circumstances.

4 What homes found to be effective

This chapter sets out what homes in our study described as effective practice when working with children who had experienced or were at high risk of CSE, as well as some of the challenges they faced. The main areas that emerged were:

1. the importance of a clear framework.
2. staffing.
3. interagency work.
4. children's involvement.
5. working with families.
6. time frames.
7. transition.

4.1 A clear framework

Approaches for residential care practice were outlined in Chapter 3. Regardless of which approach was followed, interviewees appreciated having a clear model to work within. This area of work was reported to be very demanding, even compared to specialist residential care for children with high needs. A framework, along with the support and input that went with it, helped care staff place the children's complex needs in a context and understand certain behaviours, such as denial or wanting to make contact with the people who had exploited them.

4.2 Staffing

Critical aspects of staffing included: having high staff ratios, and a stable and experienced team; the ability to deliver the home's approach; and building strong relationships with the children.

4.2.1 Staff ratios, stability and expertise

Ensuring high staff ratios enabled staff to spend large amounts of one-to-one time with the children. Waking staff at night were also central to providing care and reassurance to children who could not sleep or woke distressed, and many disclosures were said to be made at night. Homes found it more beneficial to employ their own staff to provide the night-time cover than to use agency staff.

Maintaining a stable staff body and ensuring that staff rotas were on display helped children feel reassured and safe, and reduced their anxiety about when staff would be around. The children's need for this information seemed to reflect the lack of control they had experienced previously.

Formal staff qualification levels were not examined as part of this study. However, there was an emphasis on employing staff who were quite experienced in residential care and working with children, as well as showing a particular aptitude for working with children who had experienced CSE. Desired qualities included consistency, resilience, perseverance, dedication, motivation and responsiveness to changing needs. While staff undertook the basic mandatory training on CSE, additional CSE training that the homes provided was said to be vital. Such training followed from the home's particular model of working and was often provided by the clinical psychology team and/ or, in the larger companies, by a specialist trainer.

4.2.2 Ability to deliver the home's approach

All staff who provided day-to-day care, including managers, key staff and education staff, were expected to apply the home's agreed model of practice. Consistency across all the clinical, care and education staff was said to be critical so that messages and approaches were reinforced and information shared. Staff needed to understand the practice model used, how their work and what other professionals did fitted in to that framework, and how to work in a 'therapeutic way' with the children. This helped staff to analyse and interpret what children were doing or saying, and to identify what was important to share with colleagues. Staff relied heavily on managers and the psychologists to provide the contextual framework and support. As well as benefiting from the clinician's formal assessment, planning and supervision, it helped staff greatly to be able to contact the psychologist at any time to recount an incident, or something a child had said, and get advice on what to do and how to contextualise this information.

While practice had to be grounded in the broad approach used by the home, staff also needed the ability to apply the framework flexibly and informally, and to weave awareness raising in an apparently casual way into everyday activities to help change perceptions. For instance, staff found storylines in television soap operas useful for discussing topics such as consent, choosing suitable partners, good friendships and domestic violence. As one manager said:

> *'The added benefit comes from the informal part of the care.'*

As well as working individually with the children, teamwork was central. Staff meetings, handovers and debriefs at the end of shifts and at team meetings were used to share information, for example relaying any comments the child had made and any observations. Honest communication as well as '*robust challenging'* among the team were seen as essential to help deepen the understanding of a child's behaviour and needs.

4.2.3 Ability to build strong relationships

A key requirement for all staff was the ability to establish strong, trusting relationships with children. Children's readiness to engage with a range of support was often

dependent on this relationship. Staff needed to be able to nurture children and *'hold them emotionally'* so that children felt valued. They also had to prove how much they cared and that they were trustworthy and resilient, regardless of what the child said or did, and especially in the face of any regressions or transgressions, such as running away, self-harm or aggression. As one respondent said:

> *'[She] responds to you showing you care, even though she does not want you to care.'*

Honesty was said to be key to building trust, as many of these children had been given so many *'false promises'*.

4.3 Interagency work

Homes generally perceived their work to be one part of a much bigger and longer-term picture, reflecting the literature which stressed the need for a multi-agency approach to effectively support children affected by CSE (Webb and Oram 2015) and that a residential placement should be seen as part of a care continuum (Hart et al 2015). In some homes (e.g. secure units) children were on short-term placements, and placed there primarily for assessment and stabilisation. As noted in Chapter 3, work around sex education or substance misuse was done primarily by external agencies, which were seen to have valuable expertise to complement the work of the home. Good interagency working was reported to rely on getting to know the professionals in the other agencies personally and establishing reliable working practices with them. Recent improved attitudes and awareness of CSE across the board were said to have helped greatly. While in the past these children may have been labelled as 'promiscuous', there was now wider recognition of how they had been systematically targeted and abused.

4.3.1 Developing interagency strategies

Working with local safeguarding boards and other multi-agency hubs proved very useful, but the extent to which homes did so was found to vary. Local authority homes were usually already part of multi-agency fora. The larger companies were in a better position to devote more time to attending meetings or developing joint policies and protocols than smaller enterprises. One local council was reported to have set up a multi-agency team just for children's homes, in recognition of the number of homes in the area and the particular interagency issues this generated, not least the need for a local multi-agency CSE and 'missing' policy.

Multi-agency groups enabled information sharing, for example of police intelligence of local points of interest. Jointly drafting protocols was another significant area of work, covering the expected responsibilities for home staff, police and other agencies to take on if a child went missing. This included jointly identifying the main local risks and giving

police and local transport hubs a picture of each new resident when they were admitted. If working as desired, such 'trigger plans' would be put into operation the minute a child tried to run away, and helped to locate the child, for example, if s/he turned up at the bus station. Homes felt it was crucial that police treated a child as 'missing' rather than 'absent' as quickly as possible, including if the child went back to the family home and was known to be at risk there.

4.3.2 Information sharing

Information sharing across agencies was found to help greatly, so that everyone working with the child knew all the information available about the child and their experience of CSE, or at least knew which pieces of information were shared or not. Shortcomings in transmitting information were also reported. For example, homes sometimes found it necessary to chase a social worker to find out if the piece of information provided by a child had been passed on to the police or other parties.

Information sharing with schools and colleges presented some additional challenges, for example, considering how much should be divulged about a child to a school. In one inspection report, Ofsted had pointed to a need to share more information about known risks of CSE in the area with the local colleges, as well as more background on individual children. Conversely, getting information from schools and colleges as well as other agencies such as CAMHS helped the home build a more holistic picture of the child's needs.

4.3.3 Interagency practice

The external professionals most frequently mentioned and with whom the homes valued a close working relationship were social workers, the police and some specialist agencies:

- **Social workers**

An effective working relationship with the child's social worker was considered vital. This relied on several two-way factors: accurate referral information; frequent communication and updates; and regular visits to see the child. However, geographical distances and social workers' heavy caseloads could make it difficult for them to visit as often as desired, including after missing incidents. Understanding and supporting the home's ethos and approach were also seen as fundamental. Examples were given where this was undermined by social workers, for example, by giving children new mobile phones. Besides going against the home's rules, this could enable the child to contact their exploiters.

- **Police**

Homes valued and benefited greatly from a good working relationship with their local police. Typically police visited the homes informally to get to know staff and residents,

with the clear aim of establishing trust with the children. Often police updated managers on local CSE 'hot-spots', to steer children away from. As well as exchanging information about approaches and practice, some joint training was undertaken, and in one home, the police provided self-defence classes for the children.

The process of criminal investigations following a disclosure often proved challenging to the children. Although they had disclosed to staff, children could be reluctant to tell their story again to the police. However, without direct disclosure, the police were unable to take action against perpetrators. When children disclosed to the police, they could be asked to repeat the same details numerous times, for example, first to the investigating officer, and then again to a video camera. Interviewees felt that police procedures needed to be improved in recognition of how traumatic and momentous this process was for the child, echoing research findings from young people made by Beckett and Warrington (2015). Children also complained about not feeling that they were updated enough about the progress of an investigation, or that new information they provided did not seem to be taken seriously by the police, as when, for example, they passed on information to the police about the whereabouts of a perpetrator who was being investigated.

- **Specialist agencies**

Homes commonly relied on local NHS sexual health nurses and advisers to check the children's health and advise them on consent, safe sex, sexually transmitted diseases and contraception. Homes valued the training they received from contracted or in-house therapeutic psychological teams where they had one. Specialist training and resources, on topics such as positive relationships, consent and keeping safe online, were found to be useful; these were provided by national and local external agencies with particular expertise, such as Barnardo's, the Health Working Group on CSE, the NSPCC and the YMCA. In addition, individual mentoring and advocacy provided to children by Barnardo's was said to be very helpful.

Guidance from the Health Working Group on CSE (Department of Health 2014) was found to be useful in helping homes develop their own frameworks, training programmes and safety measures to ensure that the home was as safe as possible and to minimise the risk of further CSE.

4.4 Children's involvement

The literature review found that children's participation in decisions that affect their lives can be particularly important for children who had been sexually exploited. Children's participation could support their personal resilience and confidence, which are critical to the child's formation of a sense of self, that is apart from victimhood, and the development of self-efficacy (Edinburgh and Saewyc 2008; Webb and Oram 2015; Thomson et al 2011).

Children were not involved in the study, therefore we could not really ascertain how much they had a voice in the running of the home or their care plans, or how effective their involvement was. The most common mechanisms for involving children described by the homes' managers included:

- giving children a say over whether or not they wanted to live in a particular home, as a formal part of the admission process.

- regular residents' meetings and encouraging children to contribute to and chair their own case review meetings.

- having a say over the frequency and type of therapy or activities undertaken.

In terms of their inclusion in the assessment and admission process, homes said they commonly sent information to the children via the referring social workers, sometimes in a more 'child-friendly' format. They invited children to visit the home to meet the other children and the staff, and in some cases, home staff visited children in their current placements. When staff visited children they would talk about and show them pictures of the home and describe what to expect.

In some homes, children were also reported to be able to choose the food they ate and the activities they undertook. Any spark of interest was encouraged by staff, often resulting in the child not just finding enjoyment, but also excelling in that activity. In homes where children had regular group meetings, future activities were discussed (see Box 4.1). Otherwise activity planning was agreed on an individual basis with each child.

High amounts of one-to-one time with staff was seen as facilitating children to voice their opinions and enabling their involvement. A great deal of emphasis was put on the high staffing ratios, key working and managers having an '*open door policy'* to hear children's concerns and views. In some homes, independent advocacy and mentoring were also provided by external agencies.

Box 4.1 What happens in children's meeting – an example from one of the homes

A children's group meeting takes place each week and home staff are also present. Children do their weekly plans as well as any long-term planning in the meetings, and meetings are also used to iron out issues and to discuss good and bad points about the past week. It is an opportunity to talk about anything that has been going on in the home over the previous week. The children are not expected to share everything, but they like to talk and get reassurance about things that had been happening, such as a child going missing.

4.5 Working effectively with families

The importance of involving families has been highlighted in the literature relating to residential care, with positive outcomes clearly linked to families' participation in residential programmes (Hart et al 2015). The role of families was also noted in the CSE literature in relation to community support (Edinburgh and Saewyc 2008; Scott and Skidmore 2006; Webb and Oram 2015), and one US programme reviewed provided family therapy and family dinners (Thomson et al 2011). A review of therapies for sexually abused children also highlighted the potential benefit for children in involving non-abusive parents in the therapeutic process (Allnock and Hynes 2012).

The homes interviewed recognised the importance of working with the whole family, while simultaneously identifying considerable challenges. On top of the breakdown of parent-child relationships and the distance from the family, the additional challenges encountered included: parental shock; negative views about the child, including blaming them for the CSE or accusing them of being 'prostitutes'; and parents potentially posing a risk to the child, if they had encouraged or been part of the CSE. Despite the challenges, families were seen to provide valuable background information, including around the child's emotional state and behaviour, such as self-harming. Even if problematic, families and family dynamics were critical to the child's future, as the family would be '*there for the rest of [the child's] lives'*. Interviewees recognised that relationships with parents can be complicated, that children will normally want them to be involved regardless of any negative history and that improving familial dynamics is crucial:

> '*we can't work in isolation. At end of the day they are still their mum and still their dad ... even in an abusive situation that child will still have feelings'*

> '*Parents are crucial. Once they've gotten over the guilt that they could have or should have kept their daughter safe, the important things are: Have they changed? How will they recognise and do things differently now?'*

The work with families was found to range from providing information and facilitating contact to the provision of family therapy.

4.5.1 Providing families with information

All homes in the study said they had explained the home's policies and approaches to parents and asked them to comply with certain rules, such as not letting others know the home's address or not giving their child a mobile phone. It was reported that the latter was not always understood or respected.

Homes said they provided parents with regular updates about the child's progress and they tried to help parents understand their child's emotional states and behaviour. Supporting a change in attitudes and improving relationships was felt to rely on the parents beginning to understand why their child had angry or emotional outbursts or self-

harmed. Success was said to include a parent demonstrating that they understood what had happened and were willing to help the child through the various stages.

4.5.2 Supporting contact

Unless there were dangers involved, children were encouraged and helped to maintain contact with their parents. This ranged from supervised telephone and/or personal contact to unsupervised personal contact. Phone contact was seen as an important form of communication, as a build up to, or in addition to, seeing the family. Periods of face-to-face contact were increased gradually if safe, such as staying with the family for increasing lengths of time, starting from a few hours, growing to overnight visits and then weekends, and increasing again on approach to transition. Parents were encouraged to attend planning and other meetings about their child and sometimes were invited to the home for meals and special occasions.

Staff support was fundamental to all types of contact. Whether in person or over the phone, children often needed guidance and encouragement to be open and honest with their parents, to express their views and needs assertively, but not aggressively, and to apply what they had learnt in their own counselling. Contact could be distressing for the child, necessitating even more emotional support afterwards. Facilitating contact could also include driving the child long distances to the family home. Where contact broke down, or was not feasible because of the danger to the child, the child needed additional support to help process and come to terms with this.

4.5.3 Work to change family dynamics

One home in our study provided what was described as '*standard*' family therapy – see Case study E. Another home was planning to provide family therapy and in another, the psychologists provided some telephone consultation with parents. However, work with families was mostly seen as the responsibility of the referring local authority.

Case study E
This child was admitted under a Section 20 placement, initiated by her family, after the use of drugs, being used for drug dealing and possible CSE all by gangs of older men came to light. The family were very involved from the start, which on the whole helped greatly, apart from the final decision to remove the child from care, a few months earlier than the home felt was ideal.

Both parents bought into the home's approach. On top of supporting increasing contact, individual and family therapy was provided. At the start, the therapists worked with the child and parents separately and then all together. The plan had been to also include the siblings, but this had not started by the time of departure. After returning home, CAMHS had agreed to continue the family therapy.

It took time for the family to come to terms with what had been happening. The home

suggested that they change their parenting approach. For example, the child was said to have had too much control over family dynamics and relationships, including through the use or threat of aggression. Communication between the mother and child was prioritised and improved, and the mother reported feeling more 'empowered' to parent. Staff reported that 'walking into the home was now completely different', the young person was 'calmer' at home and had better relationships with all members of the family.

Case study B

This 15 year old had been involved in CSE since the age of 11, was totally estranged from her mother and siblings on admission and had a strange relationship with her father, who gave money but there was said to be 'no love about'. The mother blamed the child for the CSE and could not understand it. After some months, the child had weekly supervised contact with the mother, which involved driving her approximately 200 miles there and back. The home helped the child to voice her feelings and she became better able to have more assertive conversations with her father on the phone, with less shouting and storming off. Family members were invited to the home for meals and special occasions. The home offered family therapy to the father, but up to the time of these interviews he had refused this.

4.6 Effective time frames

Time and timing emerged as important themes:

- Homes observed a direct relationship between the length of the children's experience of CSE and the speediness of their recovery. Children whose CSE was recognised early, and who were referred for specialist intervention quicker, required less input overall. Conversely, those with a longer history of CSE and/or many unsuccessful previous placements, were the most challenging to turn around.

- The road to a 'successful outcome' was individual, bumpy and prone to obstructions. It was therefore necessary for children to have enough time to make progress. Respecting the individual pace needed by children to both recover and regain some control over their lives was important. Funding considerations could undermine this. For example, if placement budgets were decided on a three-monthly basis this undermined a home's ability to plan far in advance, or to offer security to the child.

- It was said that each child had an optimum time for moving on and that moving too soon or too late were both detrimental. Cost considerations were sometimes felt to have played a part in local authorities wanting to move children on sooner than the home considered optimal. At the same time, difficulties in finding suitable placements could mean that children were not moved on from a placement when they were ready to do so. For example, a delay in finding a placement for a child who had made a huge amount of progress but who was still considered high risk

(and was turned down by five homes) had a very negative effective on confidence and trauma levels.

4.7 Effective transition planning

In some homes, especially those providing short-term placements (e.g. secure homes and assessment placements) transition planning commonly started from the first day of admission and was kept in focus throughout the child's stay. In other homes, formal transition work was more likely to start in the last three to six months. Such transition work could cover helping the child to move to another care setting, or into independent or semi-independent living, or back to the family.

Home managers said children were supported to develop independent living skills which would apply to all care leavers, such as budgeting shopping and cooking. However, all the risk anxieties relevant to CSE became more heightened when a move to a less-intensive setting or back to the family home was expected. For example, how far were the children able to appreciate risk, use social media safely and avoid cultures and situations which could re-expose them to risk? How likely were they to recontact, or be contacted by, the perpetrators?

If moving to another care setting, homes tended to try to ensure that this was a good fit for the child, which was said to often necessitate '*challenging conversations'* with social workers. One of the main anxieties was whether the new placement would sufficiently appreciate the psychology behind CSE, be able to understand and respond appropriately to the child's trauma and stress reactions, and be capable of providing the necessary input and have enough staff to do so. Interviewees said that in their current home, the children were accustomed to *'always having someone there to talk about things, process what has happened'.* Children might find it hard to handle a sudden reduction in day-to-day contact with an understanding adult.

Family-focused interventions, explored above, were said to be effective in helping a child to be able to live with the family again and enhance the family's ability to look after them. Independent or semi-independent housing could be in a new area, to protect the child from known perpetrators and help them create a new life. To help make the move as easy as possible, staff helped children to decorate their new flats, and in one home, the key workers initially stayed with them. Ideally, homes tried to keep a bed available for some weeks after the move, in case the new placement did not work out. However, this had cost implications and did not appear to be common practice. Staying in touch was considered important, for example by sending birthday cards or making occasional phone calls. But on the whole, homes tended to give the children the option to stay in touch if they wanted to, and ensured that they had the home's contact details. Children were said to vary in the extent to which they maintained contact: some came back for a chat or advice, or if they had problems. Others preferred a clean break and to put this part of their life behind them.

Case Study F

The girl was in an SCH and her mental health report recommended several suitable placement options. Of those, the young person said she would prefer foster care. Unfortunately, a suitable foster placement could not be found despite the efforts of the local authority. This was felt to be at least partly because foster carers are reluctant to take on children who have experienced CSE, and are worried about their ability to keep them safe and the potential impact on other children.

At first the young person was very disappointed and angry. However, eventually she was happy with the alternative: a two-bed unit, specifically catering for CSE and close to the girl's family. The new home agreed that the girl could move and settle in, before the other resident arrived.

In preparation for the move, the manager and key worker of the new home visited the girl four times in the secure unit and also phoned regularly. By the time the girl first visited the new placement they had already established a good relationship. She visited the new placement six times before moving in. The first time, two SCH staff took her there and stayed with her; this was followed by two visits when SCH staff took her to the placement and went away for couple of hours so that she had time alone with the new staff; there then followed one overnight and one weekend visit. Over this period, a place in college was also set up.

4.8 Conclusion

Features of effective practice in supporting children affected by CSE identified by our study largely reflect the evidence on what underpins good residential practice more generally, although some additional dimensions and adaptations were identified as being important:

- Good residential practice is strongly dependent on staff's skills, attitudes and consistency, and on staff having sufficient time to dedicate to children and the ability to work therapeutically with them. However, the additional CSE training and input from specialist staff on CSE-related issues was seen as very important.

- Effective residential practice is also underpinned by good interagency work. Dimensions of interagency particularly relevant to CSE are joint protocols and information sharing in relation to missing children, and identifying and prosecuting CSE perpetrators. Specialist external agencies also seem to play an important role in delivering CSE educational programmes in residential settings.

- Children's meaningful involvement in decisions that affect their lives is a basic right, as well as being associated with effective residential practice. This is again highlighted by work with children affected by CSE, as the opportunity to become 'active agents' can help to support a sense of self that is apart from victimhood, and to develop self-confidence and self-efficacy. Apart from a range of mechanisms used in

residential care to involve children, the literature indicates that opportunities for children to provide mutual support around CSE could be very empowering. This was done through group work around CSE, and in one programme identified in the literature, CSE survivor mentors provided support to their peers who had been sexually exploited.

- Working with the families of children in residential care is an important but often neglected aspect of good residential practice. For children affected by CSE, family work needs to take into account the difficulties families may be facing in accepting and understanding what has happened to their children, as well as the fact that some families may be posing or contributing to CSE risks.

- As with residential care in general, how long it takes for a residential intervention to achieve the intended outcomes for children affected by CSE is largely dependent on individual circumstances. The literature points to the fact that, as these children are highly traumatised, there are no 'quick fixes', and CSE programmes tend to be long-term. The observation of the homes in the study was that the longer children had experienced CSE, the longer their recovery seemed to be. Moving children away from intense and specialist residential support before they were ready could be seen as not only counterproductive, but as a waste of the resources which had been invested.

- The sustainability of the improvements made while in residential care was also seen as being crucially dependent on the transition arrangements. Again, this aspect of effective practice is not exclusive to work with children affected by CSE. However, transition planning must consider all the learning from a residential placement on how individual children can be kept safe from CSE: how risks can be removed or managed, and how a child's resilience can be supported.

5 Conclusion

In this chapter, we draw together the research findings to answer the key research questions identified in Chapter 1:

- What approaches are used in children's homes to support children who experience, or are at risk of, sexual exploitation?

- What are the perceived benefits and impacts of the support these children receive in residential settings?

- What seems to work well in supporting children affected by CSE in residential care and can this evidence and learning be shared more widely?

5.1 Approaches to supporting children affected by CSE

We found no evidence that the overarching model underpinning residential practice should be different for children affected by CSE. The core foundations of effective practice with these children were based on established models (e.g. attachment theory, strength-based or behaviour modification approaches), developed to support children with high levels of complex needs, and in particular, to support highly traumatised children. Similarly, evidence on the factors supporting effective residential practice with children affected by CSE (e.g. staff with relevant experience and skills, good interagency working, meaningful involvement of children and their families, effective transition) are in line with what has been found for residential care in general (Hart et al 2015).

Established models of practice were found to provide an overall theoretical framework and a structure to guide practitioners, but they were applied flexibly and the package of support that children received was tailored to meet specific individual needs. The evidence from our study shows that it is these adaptations of the model that are key to meeting the needs of children affected by CSE. They are discussed in the rest of this section.

5.1.1 Strategies for keeping children safe

All homes in the study had developed strategies for dealing with serious absconding behaviours. However, much of this practice does not appear to have been evaluated, and further evidence and guidance in these areas of work could be beneficial.

- There is an assumption that removing children from their community contributes to keeping them safe, but this is untested. Given the disruption and negative effects that placing children away from their communities can have, it would seem important to test this assumption, and in particular, to assess the relative effectiveness of temporarily removing children from their community (e.g. for a few weeks to deal with an immediate crisis), versus long-term placements away from their communities.

- The internet and mobile phones can represent serious risks, as they provide routes for exploiters to befriend and abuse children, or for children to maintain contact with exploiters. However, these are now an essential part of a child's life and children must learn to use them safely. There may be some value in reviewing the range of strategies being used by homes to establish what seems to work well and less well, e.g. what different levels of access would involve and how one knows when a child is ready to move to the 'next level'.

- A large amount of resources was spent on providing a very high level of supervision for absconders and on closely supervising children when they went out of the home. There was some uncertainty about what else residential staff could do to prevent children from running away. Residential homes said they would welcome more guidance on this crucially important aspect of their work. A range of scenarios and practical examples would be particularly helpful. We have also suggested elsewhere (Hart and La Valle forthcoming) that semi-secure options could be explored for children who do not need secure accommodation, and the possibility of being able to restrict their liberty in a more responsive and flexible way than is allowed under current legislation and DfE guidance.

5.1.2 CSE educational programmes

A growing number of CSE tools and programmes are being developed. Information about these approaches and resources (e.g. how they were developed, if/how they have been evaluated) does not seem to be in the public domain. Our review identified only one CSE educational programme that had been tested in the US (Hickle and Roe-Sepowitz 2014) with plans to introduce it in England (more information about this programme is provided in Chapter 3). Discussions would be required with organisations providing these programmes to see if they would be willing to share course materials, the evidence used to develop these materials, any evaluations done, and if they would agree to (further) testing, if required.

5.1.3 Therapeutic programmes

The evidence also indicates that effective support for children affected by CSE should include some psychological input and treatment. There are a range of therapies available. However, there is no consensus on which one(s) would be most suitable for these children. Cognitive Behavioural Therapy (CBT) is the only one recommended by NICE as a first-line treatment for symptoms associated with sexual abuse (Allnock and Hynes 2012). However, this does not mean that other therapies would not work; they just have not been as extensively tested as CBT.

5.2 Benefits of residential care

Homes in the study identified a range of desired outcomes for children in their care. Progress in meeting these outcomes was monitored through various processes (e.g. looked-after children reviews, case management meetings, supervision and psychological assessment tools), and the package of support adapted depended on progress and what seemed to work well and less well for a particular child. The outcomes monitored reflected a range of risk factors to be reduced/eliminated (e.g. running away, drug use, CSE) and protective factors to be nurtured (e.g. educational achievement, caring friendships, engagement with positive activities). Most outcomes were those one would expect from residential care for children with complex needs (Hart et al 2015), but some were specifically related to children who had been sexually exploited (e.g. to learn to recognise and manage CSE risks).

Overall this provides a good model for ensuring that homes deliver effective support and improved outcomes for children who have been sexually exploited. However, there are areas where practice could benefit from greater transparency and from being more specifically and consistently based on what is already known to work. These are:

- **Assessments**: a range of assessment tools was found. Placing local authorities carry out an assessment, using their own assessment tools which provide the basis for the search for a suitable placement in accordance with the child's care plan. This would be followed by the residential unit's own referral assessment to decide if a child was a 'good' match, followed by a more comprehensive needs assessment to identify a suitable support package if the child was admitted, which would, ideally at least, be reflected in the placement plan. However, it is not clear how much consistency there was between these different assessments and the extent to which they were duplicating work. There may be scope for streamlining the range of assessments carried out, including those conducted while children are in residential care. Furthermore, it would seem important to have greater clarity and transparency about the effectiveness of the range of psychological, health, educational and other tools used to identify needs and monitor progress. Many tools exist, but only some have been rigorously tested, and given that tools to monitor CSE risks are relatively new, they would benefit from testing. It may be helpful to look at the work done in Scotland on this, as they are rolling out a single CSE assessment checklist as part of the Scottish Action Plan for CSE.[4]

- **Longer-term outcomes**: homes focused on the outcomes children achieved while in the home and at the point of leaving. However, information about longer-term outcomes is needed to establish if a residential programme worked for children who had been sexually exploited (Saewyc and Edinburgh 2010; Twill et al 2010). This

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[4] http://www.gov.scot/resource/0046/00463120.pdf

study did not include local authorities, so we do not know whether outcome data was collected by local authorities to monitor the longer-term effects of residential programmes, and if so, what kinds. However, we are aware that generally, the evidence base on this is very poor (Hart et al 2015). It would seem important for both local authorities and children's homes to have information on children's progress after leaving a residential setting, to try to assess the effectiveness of the setting and identify possible areas for improvement.

- **Children's voices and experiences**: homes stressed that children had a say in decisions affecting them and Ofsted inspections gave positive assessments of children's participation in the homes we visited. However, the range of ways in which homes said they involved children and reported children's views made it difficult to build an overall picture of children's involvement. There is scope for more transparency and clarity about children's involvement, for example, about the processes that support this involvement and what children say about their experiences. As with assessments, it could help to develop some standardisation in collecting this information, based on evidence on what supports meaningful participation and what this 'looks' like from the perspective of children. While again this is important for all children in residential care, as we have seen for children who have been sexually exploited, meaningful participation could be an important protective factor.

5.3 What works well?

This study has helped to build the evidence base on CSE support in residential care, but it cannot provide definitive answers on what works in supporting children affected by CSE, because none of the programmes identified in the literature have been robustly evaluated and none are ready to be implemented.[5] Similarly, none of the homes included in the study had systematically collected data on short and long-term child outcomes and linked these to the support children had received. And, as we have seen there were also elements specific to CSE practice (e.g. the CSE risk assessments used, the CSE educational programmes) which have not been tested.

Homes' perceptions of what helps to support effective practice when working with children affected by CSE were largely in line with what we know underpins effective residential practice more generally:

- A clear theoretical model to guide practice underpinned by an evidence base to provide consistency and enable staff to feel confident that they are 'on the right track'.

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[5] For more information on what a 'ready to implement' programme would look like see: http://guidebook.eif.org.uk/

- Sufficient time, training and support to deal with children's complex needs, including needs specifically linked to CSE.

- Effective interagency work. Working closely with the police and external specialist agencies providing CSE educational programmes was particularly important in relation to CSE.

- Children's involvement in providing a child-centred and individually tailored package of support. Mechanisms that enable children to support each other (e.g. via group work) were potentially effective in relation to CSE.

- Working with families, particularly when families may have difficulties dealing with their child's CSE experiences.

- Ensuring that the length of the residential placement is determined by a child's needs and progress made, and that the post-residential arrangements are adequate to build on what a child has achieved in the residential setting.

5.4 In conclusion

Our study has found an increased awareness of CSE and a growing (albeit still limited) body of research on this topic, both of which are to be welcomed. Residential care, delivered by those who understand issues relating to CSE, has a role to play in keeping children affected by CSE safe, helping them recover and become more resilient.

Our research has identified some key components of practice and some specific intervention tools which homes believe lend positive support. However, it will take time and much more robust evidence to know what interventions, either in the community or in residential care, work best in terms of reducing the prevalence of CSE, increasing children's resilience to it, and helping children recover.

References

References quoted in the text

Allnock D, Hynes P (2012) *Therapeutic services for sexually abused children and young people: scoping the evidence base.* London: NSPCC.
www.nspcc.org.uk/globalassets/documents/research-reports/therapeutic-services-sexually-abused-children-evidence-review.pdf

Avinger KA, Jones RA (2007) Group treatment of sexually abused adolescent girls: a review of outcome studies, *American Journal of Family Therapy*, 35 (4): 315-326.

Beckett H, Warrington C (2015) *Making justice work: experiences of criminal justice for children and young people affected by sexual exploitation as victims and witnesses. Bedford:* University of Bedfordshire.
http://www.beds.ac.uk/__data/assets/pdf_file/0011/461639/MakingJusticeWorkFullReport.pdf

Berelowitz S, Clifton J, Firimin C, Gulyurtlu SSC, Edwards G (2013) '*If only someone had listened': Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups*. London: Office of the Children's Commissioner.

Berelowitz S, Ritchie G, Edwards G, Gulyurtlu, Clifton J (2015) *'If it's not better, it's not the end': Inquiry into Child Sexual Exploitation in Gangs and Groups: one year on.* London: Office of the Children's Commissioner.
http://www.childrenscommissioner.gov.uk/sites/default/files/publications/If%20its%20not%20better%20its%20not%20the%20end_web%20copy.pdf

Blazey L (2011) *Reducing the risk, cutting the cost: an assessment of the potential savings from Barnardo's interventions for young people who have been sexually exploited.* Barkingside: Barnardo's.
http://www.barnardos.org.uk/reducing_the_risk_cutting_the_cost__final_.pdf

Brodie I, Melrose M, Pearce JJ, Warrington C (2011) *Providing safe and supported accommodation for young people who are in the care system and who are at risk of, or experiencing, sexual exploitation or trafficking for sexual exploitation.* Luton: University of Bedfordshire.
http://www.beds.ac.uk/__data/assets/pdf_file/0008/120788/SafeAccommodationreport_finalOct2011IB_1.pdf

Channon Consulting (2014) *The range of health impacts which can result from child sexual exploitation.* Barkingside: Barnardo's.
http://www.barnardos.org.uk/health_impacts_of_child_sexual_exploitation.pdf

Deb S, Mukherjee A (2011) Background and adjustment capacity of sexually abused girls and their perceptions of intervention, *Child Abuse Review*, 20 (3): 213-230.

Deb S, Mukherjee A, Mathews B (2011) Aggression in sexually abused trafficked girls and efficacy of intervention, *Journal of Interpersonal Violence*, 26 (4): 745-768.

Department for Education (2015) *Guide to the Children's Homes Regulations including the quality standards*. London: DfE. https://www.gov.uk/government/publications/training-and-developing-staff-in-childrens-homes; https://www.gov.uk/government/publications/childrens-homes-regulations-including-quality-standards-guide

Department of Health (2014) *Health Working Group report on child sexual exploitation.* London: DoH. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279189/Child_Sexual_Exploitation_accessible_version.pdf

Edinburgh LD, Saewyc EM (2008) A novel, intensive home-visiting intervention for runaway, sexually exploited girls, *Journal for Specialists in Paediatric Nursing*, 14 (1): 41-48.

Hart D, La Valle I (forthcoming) *Local authorities' use of secure placements*. London: DfE.

Hart D, La Valle I with Holmes L (2015) *The place of residential care in the English welfare system*. London: DfE.https://www.gov.uk/government/publications/residential-care-in-the-english-child-welfare-system

Hickle KE, Roe-Sepowitz DE (2014) Putting the pieces back together: a group intervention for sexually exploited adolescent girls, *Social Work with Groups*, 37 (2): 99-113.

Pierce A (2012) American Indian adolescents girls: vulnerability to sex trafficking, intervention strategies, *American Indian and Alaska Native Mental Health Research*, 19 (1): 37-56. http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2019/19(1)_Pierce_American_Indian_Adolescent_Girls_37-56.pdf.

Saewyc EM, Edinburgh LD (2010) Restoring healthy developmental trajectories for sexually exploited young runaway girls: fostering protective factors and reducing risk behaviors, *Journal of Adolescent Health*, 46: 180-188.

SCIE (2012) *Therapeutic approaches to social work in residential child care settings*. Report 58. London: SCIE. http://www.scie.org.uk/publications/reports/report58/index.asp

Scott S, Skidmore P (2006) *Reducing the risk: Barnardo's support for sexually exploited young people.* Barkingside: Barnardo's. http://www.barnardos.org.uk/reducing_the_risk_report.pdf

Shuker L (2014) *Evaluation of Barnardo's Safe Accommodation Project for sexually exploited and trafficked young people.* Luton: University of Bedfordshire. http://www.barnardos.org.uk/barnardo27s-sa-project-evaluation-full-report__3_.pdf

Thomson S, Hirshberg D, Corbett A, Valila N, Howley D (2011) Residential treatment for sexually exploited adolescent girls: Acknowledge, Commit, Transform (ACT), *Children*

and Youth Services Review, 33 (11): 2290-2296.

Thornton A, Hingley S, Mortimer E (2015) *A census of the children's homes workforce.* London: DfE. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/391529/RR 437_-_Children_s_homes_workforce_census_.pdf

Twill SE, Green DM, Traylor A (2010) A descriptive study on sexually exploited children in residential treatment, *Child Youth Care Forum*, 39: 187-199.

Webb J, Oram C (2015) *Working effectively to address child sexual exploitation: an evidence scope*, Totnes: Research in Practice. http://www.rip.org.uk/resources/publications/evidence-scopes/working-effectively-to-address-child-sexual-exploitation-evidence-scope/

Wilson B, Critelli FM, Rittner BA (2015) Transnational responses to commercial sexual exploitation: a comprehensive review of interventions, *Women's Studies International Forum*, 48: 71-80.

Other relevant references

Cabinet Office (2015) *Sexual Violence and Children and Vulnerable People National Group: progress report and action plan 2015.* London: Home Office. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412420/Sexual_Abuse_Action_plan_5th.pdf Casey L (2015) *Reflections on child sexual exploitation: a report by Louise Casey CB.* London: DCLG. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418394/Louise_Casey_report_into_CSE_template_format__4_.pdf

Child Protection All Party Parliamentary Group (2014) *Recommendations for the prevention of child sexual abuse and better support for victims: seminar series on child sexual abuse.* London: NSPCC. http://cdn.basw.co.uk/upload/basw_13644-2.pdf

D'Arcy K, Dhaliwal S, Thomas R, Brodie I, Pearce J (2015) *Families and Communities Against Child Sexual Exploitation (FCASE): final evaluation report.* Barkingside: Barnardo's. http://www.barnardos.org.uk/university_of_bedfordshire_FCASE_report.pdf

Department for Education (2009) *Safeguarding children and young people from sexual exploitation.* London: DfE.

HM Government (2015) *Tackling child sexual exploitation.* London: Cabinet Office. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408604/2903652_RotherhamResponse_acc2.pdf

Jones DN, Florek A (eds) (2015) *Child sexual exploitation: a study of international comparisons.* Nottingham: Virtual Staff College.

Pearce JJ (2014) 'What's going on' to safeguard children and young people from child sexual exploitation: a review of local safeguarding children boards' work to protect children from sexual exploitation, *Child Abuse Review*, 23 (3): 159-170.

Ward A, Roe-Sepowitz DE (2009) Assessing the effectiveness of a trauma-oriented approach to treating prostituted women in a prison and a community exiting program, *The Journal of Aggression, Maltreatment & Trauma*, 18 (3): 293-313.

Web links accessed in October 2015

Appendix A Search strategy

Terms
1. sexual exploitation
prostitution
trafficking
grooming
organized abuse
AND
Terms for children

2. Rent boys

Date range: initially 2011-2015

Databases
PsycINFO
Medline
Social Policy and Practice
IBSS
Web of Science (Social Science Citation Index)
OpenGrey

Inclusion criteria
Relates to the sexual exploitation of children
Relates to a developed country
Describes or assesses an intervention for children who have been exploited
Last 5 years
In English, Spanish or Italian

Search strategies
PsycINFO (EBSCO)
TI/AB/MJ
Sex* W3 exploit* or Prostitut* or Organi?ed W3 abuse
Or
(sex or sexual) and (Traffick* or Groom* or slave* or slavery or smuggl* or gang*)
Or
"Rent boy" or "rent boys"
Or
CSEC (TI/AB only)
Limit: childhood (birth to 12); school age (6-12); adolescence (13-17); young adulthood (18-29)
650 hits, of which 50 selected

Medline (Ovid)
TI/AB/MJ
Sex* adj3 exploit* or Prostitut* or Organi?ed adj3 abuse
Or
(sex or sexual) and (Traffick* or Groom* or slave* or slavery or smuggl* or gang*1)
Or
Rent adj1 boy* Or CSEC
AND

child*3 or adolescen* or teenage* or teen$1 or juvenile* or schoolchild* or boy$1 or girl*1 or minor$1 or youth$1 or young adj1 adult*
241 hits, 18 selected

Social Policy and Practice
(Contains the following catalogues/databases:
AgeInfo- Centre for Policy on Ageing
ChildData – National Children's Bureau (NCB)
NSPCC – National Society for the Prevention of Cruelty to Children
Planex – IDOX Information Service
Social Care Online – Social Care Institute for Excellence (SCIE))

Sex* adj3 exploit* or Prostitut* or Organi?ed adj3 abuse
Or
(sex or sexual) and (Traffick* or Groom* or slave* or slavery or smuggl* or gang*1)
Or
Rent adj1 boy* Or CSEC
AND
child*3 or adolescen* or teenage* or teen$1 or juvenile* or schoolchild* or boy$1 or girl*1 or minor$1 or youth$1 or young adj1 adult*
562 hits (with a lot of duplicates); 56 selected

IBSS (Proquest)
Sex* N/3 exploit* or Prostitut* or Organi?ed N/3 abuse Or Rent N/1 boy* Or CSEC
Or
(sex or sexual) and (Traffick* or Groom* or slave* or slavery or smuggl* or gang*1)
AND
child*3 or adolescen* or teenage* or teen$1 or juvenile* or schoolchild* or boy$1 or girl*1 or minor$1 or youth$1 or young N/1 adult*
232 hits, 4 selected

Web of Science (excluding Arts & Humanities)
Topic:
(Sex* NEAR/3 exploit*) or Prostitut* or (Organi?ed NEAR/3 abuse) Or Rent-boy* Or CSEC
Or
(sex or sexual) and (Traffick* or Groom* or slave* or slavery or smuggl* or gang or gangs)
AND
Child or children or adolescen* or teenage* or teen or teens or juvenile* or schoolchild* or boy or boys or girl or girls or minor or minors or youth or youths or young-adult*

Exclude research topics: zoology; microbiology; fisheries
540 hits; 32 selected

All databases merged: 141 items

OpenGrey
Terms: child sexual exploitation; sex trafficking; rent boys; child prostitution; organized abuse; organised abuse; csec; child slaves; child slavery; sex slavery; sex slaves
No items selected

Websites searched
(NCB, NSPCC, SCIE are in Social Policy and Practice)
Barnardo's: 2 items
CEOP: 1 item
Children's Commissioner: 3
Save the Children: 6
4Children: 0
UK Human Trafficking Centre: 1

Appendix B Summary of evidence reviewed

Programmes		
Reference	**Description**	**Methodology**
Blazey 2011	An assessment of the potential savings from Barnardo's community-based services for young people who have been sexually exploited. The services support young people to exit and recover from exploitative situations, whilst also working to increase the range of protective factors in their lives.	Data collected from 539 service users on key outcomes which were highly correlated with risk of sexual exploitation and which could be assigned a monetary value. A 'synthetic' control group was created using data from the initial assessment of young people of different ages to build up a picture of the progression of risk over time in the absence of any intervention. See also Scott and Skidmore (2006) for a formative evaluation.
Deb and Mukherjee 2011; Deb et al 2011	The study focused on sexually abused trafficked children who were further used for commercial sexual exploitation, and explored the impact of counselling on their aggression. The study, involving girls aged 13 to 18, was carried out in Kolkata (India).	Four shelters were selected randomly from all child welfare shelters in and around Kolkata. From these, 120 sexually abused trafficked girls were purposively selected to participate in the study. A comparison group of 120 non-sexually abused girls matched for age was included, selected randomly from four schools situated in close proximity to the shelters.
Edinburgh and Saewyc 2008; Saewyc and Edinburgh 2010	A home-visiting programme for sexually assaulted runaways: the Runaways Intervention Programme (RIP). All participants were girls from Chinese, Native American or Latino communities; 75% had been involved in prostitution or survival sex, or had been gang raped. The intervention was delivered by an	The outcomes for 84 girls were assessed at entry and then 6 and 12 months later; outcomes were based on RIP goals. The evaluation included a comparison group drawn from a state-wide census of 9th grade pupils (n=12,775) with sub-groups within this: abused (11%) and non-abused girls. The former was not a perfect match for RIP participants. RIP did better on

	advanced practitioner nurse (i.e. qualified at Master level).	some baseline measures (e.g. running away) and worse on others (e.g. protection factors, emotional distress).
Hickle and Roe-Sepowitz 2014	Putting the Pieces Back Together: a CSE group intervention offered at a residential treatment programme for high-risk girls in a large city in the southwestern US. The curriculum/group format consists of 2 hours for 12 consecutive weeks facilitated by a social worker or similarly qualified person. The programme is currently being developed for delivery in the UK.	This particular group programme has not been evaluated for high-risk girls, but the curriculum has been used and evaluated for incarcerated women and prostitutes.
Pierce 2012	This outreach programme to support CSE victims was developed as part of a wider programme, the Minnesota Indian Women's Resource Center (MIWRC), which provides strength-based, culturally centred support services to American Indian and Alaskan Native women, adolescent girls and their families.	Collection of baseline data and then follow-up data every 6 months for 35 participants.
Scott and Skidmore 2006	Evaluation of Barnardo's community-based services for young people who have been sexually exploited. The services support young people to exit and recover from exploitative situations, whilst also working to increase the range of protective factors in their lives.	The outcomes are based on a sub-sample of 226 children and young people aged under 18 with whom the service had a sustained relationship. The analysis was based on entry data and data collected when the intervention was terminated. Case study histories were collected for sub-sample of 42 young people. A total of 50 interviews were completed with practitioners and managers from the 10 services and 26 stakeholders (e.g. police, youth offending teams, social services, education, health). See also Blazey (2011) for an

		economic assessment.
Shuker 2014	This describes a pilot of specialist foster placements (the Safe Accommodation Project) for young people at risk, or victims, of sexual exploitation and/or trafficking. The project was run by Barnardo's, and consisted of: • 44 two-day training courses for foster carers and associated professionals. • direct work with 88 looked-after young people who were at risk, or victims, of CSE and/or trafficking. • 16 specialist foster placements for young people at risk, or victims, of CSE and/or trafficking.	This was a formative evaluation aimed at providing learning to refine the programme. The training was evaluated via survey of attendees (n=663). The evaluation of the other two components of the programme relied mainly on qualitative data to identify the key mechanisms and contexts of change that underpinned the outcomes achieved within and across placements. Data were collected via interviews with young people, specialist foster carers, project workers, the local authority and Barnardo's social workers, as well as weekly monitoring logs.
Thomson et al 2011	This group home programme for sexually exploited adolescent girls is known as ACT (Acknowledge, Commit, Transform); it was run by Germaine Lawrence and operated in a residential treatment facility for adolescent girls in Massachusetts. Of the thirteen young people admitted to ACT in the period covered by the research, nine came from the G Lawrence home programme and four from living with their families.	The evaluation primarily aimed to understand how the intervention worked and used a case study approach. The study was based on very small sample, i.e. interviews with three staff, five former residents, three parents and eight guardians, plus administrative data on thirteen young people who were discharged from the ACT programme in 2009-10.
Twill et al 2010	This programme, delivered in a large city in a southern US state, was developed in 2001 in recognition that juvenile detention centres were not equipped to meet the specific needs of young girls involved in prostitution.	The analysis was based on entry and post-entry data from case files for 22 girls admitted to the programme in 2001-03. Data analysed included juvenile court records, and data collected by programme staff (e.g. about after-treatment

		arrangements collected 3 months after discharge). Post-discharge data were partial.

	Reviews	
Allnock and Hynes 2013	A review of effectiveness of therapeutic interventions for sexually abused children.	No information on the parameters of the review.
Avinger and Jones 2007	A review of 10 outcome studies evaluating group therapy for female adolescent victims of CSA to assess the effectiveness of group modality in the treatment of CSA.	The studies reviewed were published between 1985 and 2005; it seems (but is not specified) that they were all from US. Four of the ten studies provided the treatment in a residential facility, while in the other six, treatment was provided on an outpatient basis. They involved young people aged 11 to 18.
Brodie et al 2011	A scoping study funded by the NSPCC, looking at the provision of safe and supported accommodation for young people in care who are at risk of, or experiencing, sexual exploitation or trafficking for sexual exploitation.	The review focused on the UK.
Hart et al 2015	A review of the place of residential care in the English welfare system which looked at: the use of residential care in England and other relevant countries; evidence on children's outcomes from residential care; the quality of the evidence; and gaps in the evidence base.	A review of the international academic and grey literature published between January 2004 and December 2014.
Webb and Oram 2015	A scoping study of evidence on working effectively to address CSE, produced as part of the Greater Manchester project on CSE, funded by the DfE Children's Social Care Innovation Programme.	The review focused on: definitions and interpretation of CSE within the UK; contextual factors that inform understanding of, recognition and response to CSE; and what is important when working with sexually exploited young people, or those at risk

		of CSE. It largely draws on peer-reviewed and usually published research; this supports the findings of the review and offers assurance regarding the quality of the research. Sources related to CSE policy and practice in the UK were prioritised, although global sources were also considered for context or to supplement a lack of UK-based resources in particular areas.
Wilson et al 2015	A comprehensive review of different models of interventions used to address the issue of CSE in the US and India.	The review methodology was not provided.

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