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A Trauma-informed Health and Care Approach for responding to Child Sexual Abuse and Exploitation

Current knowledge report

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Prepared by

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The author takes sole responsibility for the perspectives and suggestions in this report; including any errors.

Purpose and audience

This report has been prepared to be used as a source of information for the development of trauma-informed recovery services for children and young people who have experienced trauma as a result of sexual abuse and exploitation.

The audience for this report will be commissioners and staff in all relevant statutory and voluntary and community sectors – health, social care, criminal justice; who have responsibility for commissioning and provision of services which are effective and efficient, in supporting children and young people to recover from the impact of trauma as a result of sexual abuse and exploitation.

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What the young people and their keyworkers said….

The keyworker relationship:

> *"My keyworker gives me advice, but only once she has listened to me; once she's understood the situation fully. She doesn't tell me, she makes suggestions which help me to understand what I am going through. She helps me see things from a different angle and I can say 'no'."*
>
> *"The most important part of our work is developing that relationship with the young person. I think that's fundamental, without that the young person is not going to open up to you, they are not going to trust you."*
>
> *"It's not a problem having additional people as long as I have one proper keyworker, the one person I talk to and who I know I can ask to help me."*

Young people's voices being heard:

> *"Some people don't talk to you with respect. They talk with attitude. They interrupt all the time and they don't listen to what you say. More people should respect you and listen to you."*
>
> *"I feel like Pollyanna sometimes. At some meetings, when everybody is really doing the child down, I'll pipe up and say, 'Hang on, there are quite a lot of strengths here actually' or 'She wouldn't have told us that three months ago, so it's really positive that she is now able to tell us those things.' So I do that a lot in meetings in terms of being strengths-based in my multi-agency work."*

Being understood and feeling safe:

> *"They don't understand that I am confident on the outside but I am not confident on the inside. On the inside I am scared."*
>
> *"They didn't realise that I am just going through something and my past doesn't actually mean that I'm still there."*
>
> *"Before I didn't feel safe in the sense that I used to be really sad and I used to self-harm. My keyworker helped me figure out what was causing this; she gave me options."*

A holistic approach:

> *"She doesn't immediately go into 'Oh, you've got a mental health problem' – because that diagnosis makes me feel worse in myself. She doesn't treat me like I'm an 8 year project!"*

> *"You don't want to be talking about bad stuff all the time, it's nice to talk about something good."*

Young people's strengths:

> *"I think I could help girls who have had bad experiences like myself because I am sensitive and I am a good listener. I care about what happens to people who are not fortunate. Things like honest and kind and caring – that's me."*

> *"My good qualities are only that I'm not as angry as I used to be and that I'm not as depressed. I don't really know about any other good things about myself…"*

Service pressures:

> *"I do feel there are some pressures in terms of getting that young person from A to B when sometimes that young person just wants to talk. I feel like you need an outcome."*

> *"I find it difficult to say, 'Right, been really nice working with you'. Particularly when there's still so much going on for this young person, to say, 'I've got to close your case now'. I really struggle with that."*

Adverse childhood experiences:

> *"I'd say in the majority of our cases it's never just child sexual exploitation. It's not a case of thinking 'Right, I've got six sessions with this young person and I can deliver healthy relationships, online safety, risk taking behaviour etc.' Because there'll be other things going on in the young person's life which will then come up as you get to know them. Such as violence at home or parental mental health concerns…"*

The Report

Project overview

1. Introduction

1.1 Aims, context and objectives

It appears that young people who have been harmed through sexual assault in the UK are not able to access the type of recovery services which at a minimum are most likely to help them and are consistent in terms of approach, across the country.

1.1.1 Aims

The aims of the Project were twofold:

1) The primary aim of this Project was to produce an evidence base on an effective and efficient, non-clinical trauma-informed delivery of recovery services for young people who have experienced sexual abuse and exploitation.

2) A secondary aim was to suggest that the same trauma-informed response is likely to be effective for sexually abused and exploited young people whether it is delivered via the local 'safeguarding children care pathway' or the local 'violence against women and girls (VAWG) care pathway'. In the latter case the young person may be identified as a result of intimate partner violence. For more information on this see subsection 1.4.1 Terms, below.

1.1.2 Context

Support for young people

The UK has a history of struggling to respond well in supporting young people who have been harmed through child sexual abuse and exploitation. This reflects the fact that safeguarding children policy and practice has focussed on the impact of maltreatment experienced in the early years. A consequence appears to have been a growing assumption that adolescence is a period of greater resilience to the impact of abuse (Gorin and Jobe, 2013). Yet research indicates that harm experienced by young people has a more global negative impact into adulthood than childhood-limited maltreatment (Thornberry et al, 2010). In recent years the Association of Directors of Children's Services concurred with Thornberry that 'many adolescent interventions are either downward extensions of adult programmes or upward extensions of child programmes' (examples include criminal justice (see APPGC, 2014) and domestic abuse, services)[1].

Trauma-informed care

A trauma-informed approach has been described as one which:

> *'Realizes the widespread impact of (psychological) trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in*

[1] From March 2013 the cross-government definition of domestic abuse was widened to include 16 and 17 year olds. Information for Local Areas on the change to the Definition of Domestic Violence and Abuse (HO, March 2013)

clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.'[2]

A trauma-informed approach can be implemented in any type of organisation or service setting and can be distinct from trauma-focused interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

This Project has, nevertheless, sought to focus at the same time on both the trauma-informed approach and on a service seeking specifically to address the consequences of trauma and to facilitate healing. This is because, as will be shown in this report, a service aiming to be effective in assisting an individual to recover from a 'recent incident' of sexual abuse or exploitation, needs to take into account that individual's past traumas or adverse life experiences. Recognising the whole-life impact of past and present trauma on an individual and understanding their whole lived experience is essential to working effectively with them to achieve a measure of recovery. Importantly, this will facilitate the practitioner's understanding and accommodation of the pace the survivor is able to sustain and the 'distance he or she is able to travel' towards recovery, within the period of an intervention (case length).

1.1.3 Objectives

Following from the aims, the Project objectives were:

1) To inform interested health and care commissioners in relation to the child sexual abuse and exploitation recovery services that they commission, by:

    a) Defining what trauma is in the context of child sexual abuse and exploitation and explaining why a tailored approach to trauma needs to be taken in relation to child sexual abuse and exploitation

    b) Assessing the extent to which a trauma-informed approach is being practiced in an existing child sexual abuse and exploitation service

    c) Understanding the degree to which good outcomes for the young people using the service relate to the use of a trauma-informed approach.

2) To enable interested health and care commissioners to benchmark the child sexual abuse and exploitation recovery services that they commission

    a) Identify the costs for an exemplar trauma-informed health and care recovery service to enable interested health and care commissioners to benchmark the child sexual abuse and exploitation recovery services that they commission

    b) Describe the activities for an exemplar trauma-informed recovery service to enable interested health and care commissioners to benchmark the child sexual abuse and exploitation recovery services that they commission.

1.1.4 Report structure

[2] The American Substance Abuse and Mental Illness Administration; bracketed text added by the author. Available at: https://www.samhsa.gov/nctic/trauma-interventions. Accessed on: 20 November 2017

This report begins by defining trauma in terms of its impact on an individual; section 2. Also in section 2, the report identifies and explores the evidence-base for a best-practice response to assist an individual to recover from trauma; and the needs of the practitioner supporting that individual or survivor. In section 3 the report presents the findings from fieldwork aimed at testing both the extent to which a best practice or 'exemplar', trauma-informed recovery service model is currently being implemented, and the efficacy of the model. Section 4 offers a practical description of an exemplar trauma-informed recovery service for young people following child sexual abuse and exploitation. The section identifies the activities and cost of providing such a service and the core elements of such a service. Finally section 5 offers a summary conclusion about the provision of appropriate trauma-informed recovery services for young people following child sexual abuse and exploitation.

1.2 Methodology

1.2.1 Fieldwork sites

The Project builds on the Department of Health's 'Transforming services for children who are sexually abused Project' implemented in Birmingham, London and Rotherham in 2016-17. The research partners were three local authorities in London, Enfield, Redbridge and Lewisham, and Safer London, a voluntary and community sector organisation which provides specialist child sexual exploitation services for young people in some of the boroughs.

1.2.2 Project lead

The Project lead, Christine Christie, Director of Chanon Consulting, has a track record of local multi-agency service review and design for services for children and young people who have experienced sexual abuse and exploitation.

Recent/current relevant projects include: piloting of a core child sexual abuse and exploitation data template for the Centre of Expertise on Child Sexual Abuse; a three year project estimating the prevalence (and costing the police response) to child sexual abuse and exploitation – off and online (NPCC); literature reviews for Public Health responses to child sexual abuse and exploitation, harmful sexual behaviours and family violence (PHE and LGA); review and recommendations of current local child sexual abuse and exploitation services commissioning (Centre of Expertise for Child Sexual Abuse); expert advice to the review and recommendation of best practice Policing responses to child sexual abuse and exploitation (CPAI/KPMG); review and redesign of a Victims Services Commissioning Strategy for a Police and Crime Commissioner; design and implementation of a multi-agency Child sexual exploitation Outcomes Framework (Staffordshire); quality assurance for the DH Child sexual exploitation e-learning digital tool for health professionals (DH) and expert advice for the Public Health response to child sexual exploitation, report (NHS England); authoring the Health Working Group Report on child sexual exploitation (DH); and review and recommendation of a unitary authority's multi-agency child sexual exploitation response (Stoke-on-Trent).

1.2.3 Rapid literature review

The Project includes a rapid literature review undertaken to create a framework for understanding 'what works' in helping young people to recover following child sexual abuse and exploitation. Findings from the rapid literature review informed the fieldwork in relation to structure, stakeholders/professionals and design of the dataset. Crucially, the rapid literature review identifies the substantial body of knowledge which informed the Project methodology

and, together with the fieldwork findings, provides an evidence base for the Project recommendations.

1.2.4 Fieldwork programme

The research involved three phases:

Phase 1: the first Phase involved face-to-face, semi-structured interviews with the fifteen young people – five per local authority. The young people were not asked to share their personal experiences but were invited to share their view of the services provided to them and to other young people in similar circumstances.

The criteria for engaging the young people was that they:

- Were in receipt of support for recovery from child sexual abuse and exploitation
- Could have an allocated local authority social worker as a result of being harmed through child sexual abuse and exploitation
- Had a specialist child sexual abuse and exploitation service practitioner as a keyworker providing support to recover from being harmed through child sexual abuse and exploitation
- Were assessed to be likely to benefit from engagement in the research
- Had access to ongoing support from their current specialist service practitioner or social worker.

And

- Whose cases will have been open for a sufficient period of time for progress towards recovery to be assessed.

The sample size of young people was set at fifteen to allow for in-depth engagement with each young person in order to explore with them, their experience of receiving support to recover from experiencing child sexual abuse and exploitation.

The interviews aimed to gather information from each young person on the type of response they had received and whether it had helped to promote the young person's recovery; the extent to which the service they had received could be described as 'pedagogic' (see section 1.4 Terms for a definition of pedagogic); and whether this had been relevant to any progress the young person felt that they had made.

Phase 2: the second Phase of the research involved:

- Reviewing the young people's statutory case files using a structured audit tool, to understand each young person's circumstances and experience. This included completing an adapted Adverse Childhood Experiences questionnaire for each child (for more information see subsection 3.5.3 Adverse Childhood Experiences (ACEs)).
- Undertaking an 'activity based costing' exercise with the specialist child sexual abuse and exploitation service to establish the costs associated with the delivery of the service in the three London boroughs.

Phase 3: The third Phase of the research involved gaining the perspectives of the professionals involved with the young people in relation to the key service elements:

- Semi-structured, qualitative interviews with each young person's specialist service practitioner in the three London boroughs.

- Semi-structured, qualitative interviews with the service manager in each local authority, and the commissioner where this is a separate post; also, with the specialist child sexual abuse and exploitation service manager.

- An electronic social worker survey questionnaire to gather information similar to that in the semi-structured interviews with each young person's specialist practitioner. As with the specialist practitioner interviews, the questionnaires will seek to gain the professionals' perspectives on the key service elements.

1.3 Ethics and challenges

1.3.1 Ethics

This fieldwork for this project followed the ethical processes of the Institute of Applied Social Research Committee and the University of Bedfordshire, both of which comply with the requirements for ethical approval as outlined by *The Economic and Social Research Council* (ESRC) and *The British Sociological Association Ethical Guidelines*.

Participation by the local authorities and by individual keyworkers, social workers and managers/commissioners was voluntary. The professionals received information explaining the fieldwork aims, process and anticipated outcomes and outputs, and were asked to provide written consent to being interviewed and being recorded. All individuals were offered the option of having notes taken rather than being recorded and also had the opportunity to withdraw their contribution or elements thereof.

The ethics for working with the young people followed the ethical template developed by the University of Bedfordshire for work with young people who have experience of sexual exploitation. This included risk assessment for the young people prior to direct engagement, and the use of age appropriate information sheets and consent forms, clarity about the limits to confidentiality, the option of having notes taken rather than being recorded and also had the opportunity to withdraw their contribution or elements thereof.

The young people were interviewed alone, but with support from their keyworker or social worker immediately prior to and post their interview, to ensure that they were fully supported throughout the process.

The Local Authorities and the Project lead entered into a written Fieldwork Agreement which outlined codes of conduct e.g. in relation to confidentiality; and importantly in relation to the emergence of evidence of poor practice which could place individual young people at risk of harm.

Finally, arrangements were in place for the Project lead to be supported through regular supervision.

1.3.2 Challenges

Intimate partner violence services

The fieldwork for this Project was dependent on voluntary engagement by the organisations, practitioners, managers and young people who participated. Whilst the Local Authority areas which were identified for the fieldwork all had both child sexual abuse and exploitation and intimate partner violence services for young people, the domestic and sexual abuse organisations in all three areas were not in a position to participate. It was therefore not possible for the fieldwork to explore the effectiveness of recovery services for young people who have experienced sexual abuse and exploitation but who come to notice via a domestic abuse pathway rather than the child sexual abuse and exploitation pathway.

Young men

A second core challenge for the fieldwork related to the gender of the young people who participated. To date, research regarding the interplay between gender of survivors the effects of their experiences, the abuse process and responses by services is mixed and gaps in knowledge continue to persist (Cockbain et al., 2015). It transpired that this Project was unable to redress this position because the young people who fitted the criteria for engagement in the Project (see subsection 1.2.4 Fieldwork programme, above) were all female. In view of the fact that only girls were interviewed in this fieldwork, caution is advocated in generalising the findings to boys. However, as boys who have experienced sexual abuse and exploitation are often overlooked in the literature, they tend also to be overlooked in terms of service provision (see subsection 2.3.3 Suggested gender differences, below). There may be potential in using the findings from this Project to pilot a service for boys, monitoring it closely and refining it, to accommodate gender differences, as a means of avoiding delays in offering boys a service.

1.4 Terms and presentation

1.4.1 Terms

Child/young person: The terms 'child' or 'children' in this report includes children and young people up to their 18th birthday. The term 'young person' describes a child 13 years or older.

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

Child sexual exploitation: Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. (Department for Education 2017:5)

Child sexual exploitation (Risk) Categories: The Metropolitan Police Service Child Sexual Exploitation Operating Protocol sets out 3 categories of child sexual exploitation[3]:

- Police Category 1: A vulnerable child or young person, where there are concerns they are being targeted and groomed and where any of the child sexual exploitation warning signs have been identified. However, at this stage there is no evidence of any offences.

- Police Category 2: Evidence a child or young person is being targeted for opportunistic abuse through the exchange of sex for drugs, perceived affection, sense of belonging, accommodation (overnight stays), money and goods etc. This will also include a child or young person being sexually exploited through the use of technology and without the child or young person receiving any reward i.e: the exchange of indecent images on-line. The likelihood of coercions and control is significant.

- Police Category 3: A child or young person whose sexual exploitation is habitual, self-denied and where coercion/ control is implicit. This is often carried out by multiple perpetrators.

Note that these categories differ from those applied by Children's social care services in London who take into account a much wider range of factors, to provide a more holistic assessment of a young person's circumstances. These include a young person's: relationships, sexual health, school attendance, emotional health (self-image, self-esteem, self-harm, aggressive outbursts, threatening behaviour, offending behaviour), physical condition, peer association, isolation, online activity, use of alcohol and drugs, income/possessions and whether the young person goes missing.

Keyworker: A keyworker is a named member of staff who has responsibility for building a positive trusting relationship with a child with a view to helping the child recover from trauma. The keyworkers referred to in this report are not members of one of the psychoanalytic or psychotherapeutic professions. As a 'trusted adult' in the child's life, the keyworker provides advocacy, mentoring, counselling and advice for the child. The key worker takes a lead role sharing information from and to the child in relation to the network of family and professionals around the child.

Manager: Managers have responsibility for frontline staff, ensuring all staff are well managed, motivated and developed through line management, supervision, team reflection and learning opportunities, all aimed at enhancing their professional practice, within service aims and objectives. Oversee the allocation monitoring and audit of work ensuring that staff provide a high quality service. Promote multi-agency working to meet the needs of all children.

[3] The London sexual exploitation operating protocol 3rd edition June 2017. Child sexual exploitation. London Safeguarding Children Board, Section 7.7. Subsection Mapping the Metropolitan Police Service 'Categories 1- 3'

Commissioner: Commissioners have responsibility for commissioning services which appropriately meet the needs of children in the local population who require children's social care support. In addition the commissioners in this project all have line management responsibility for the managers of the frontline children's social care teams. The commissioners responsible for planning and letting contracts, based on care pathways; to achieve the best outcomes for the most number of children, within the financial envelope they are given.

Survivor: Survivor is used, predominantly in section 2. Rapid Literature review; interchangeably with the term 'victim', as a potentially more positive descriptor of an individual who has survived childhood trauma and abuse.

Pedagogy: Pedagogy is an approach to helping an individual (in this case a child) which is relationship-centred, bi-directional and focused on the 'self' of the child and encompasses the child's whole lived experience. It depends on the gradual development of trust between the practitioner and the child, which provides an opportunity for a child to practice building a relationship. (For further information about social pedagogy see subsection 2.3.6 Humanistic psychology).

Adverse Childhood Experiences: The work on Adverse Childhood Experiences (ACEs) instigated by Vincent Felliti and Robert Anda during the 1990s in San Diego has established the long-term negative impact of experiencing multiple traumas in early years and acted as a catalyst for a great deal of ongoing neuropsychological research that has given us enormous insights into the biological mechanisms that are impacted by trauma. (For further information see subsection 3.5.3 Adverse Childhood Experiences (ACEs)).

Model/approach: In the first three sections of this Report the term 'model' is used to describe a 'whole, self-contained concept' and an 'approach' describes 'an attitude or perspective'.

In section 4 Implementing trauma-informed practices, the terms are used interchangeably to describe a service or elements thereof.

Care pathway: Care pathway describes an agreed, multi-agency/disciplinary process of best practice to be followed in the treatment of a service user with particular needs. A properly functioning care pathway requires the service offered at each point of the process to be easily accessible and effective.

Relevant organisations

The language in this Report reflects the perspectives of the researchers in the literature on trauma-informed care reviewed for this project; and also the sectors in which the organisations delivering the services which have been reviewed are based. However, this Report is aimed at commissioners and staff in all relevant statutory and voluntary and community sectors – health, social care, criminal justice; who have responsibility for supporting children and young people to recover from the trauma following sexual abuse and exploitation.

Recovery

In thinking about recovery – as an outcome, Herman (1997)[4] provides the following description:

> *"The first principle of recovery is the empowerment of the survivor. She must be the author and arbiter of her own recovery. Others may offer advice, support, assistance, affection and care, but not cure. No intervention that takes power away from the survivor can possibly foster recovery, no matter how much it appears to be in the survivor's immediate best interest. Herman offers a survivor's view: 'The person who helped me did so because they validated my experience and helped me to control my behaviour, rather than trying to control me.'*
>
> *Herman describes Symonds (1982), working with hostages, identifying the aim of treatment as being to restore power to the victim, reduce isolation, diminish helplessness by increasing the victim's range of choice; and countering the dynamics of dominance in the approach to the victim."* [5]

Accordingly, the term recovery is used in this Report to describe a state reached by a young person who has received support following child sexual abuse and exploitation, in which the young person has demonstrably achieved autonomy:

- A sense of separateness
- Self-possession (including being able to regulate their emotions and manage their behaviour)
- An ability to define their goals
- The flexibility to make significant choices.

And, empowerment:

- A sense of safety (with others and in their environment)
- The ability to enter into mutual support.

Child sexual abuse and exploitation and intimate partner violence

The author contends that there is greater commonality between child sexual abuse and exploitation and intimate partner violence than might be evident in cases of intimate partner violence where sexual assault has taken place.

The commonality begins with the descriptions of intimate partner violence and child sexual abuse and exploitation given here. starting with intimate partner violence – an intimate partner is a person with whom a young woman has a close personal relationship. However, while this can be characterized as emotional connectedness, identity as a couple, ongoing physical and sexual contact, familiarity/knowledge about each other's lives, the relationship need not involve all of these dimensions and it can be very brief (one association or encounter) (Centres for Disease Control, USA). Intimate partner violence refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. These behaviours can be off- and online, and include acts of

[4] Herman J.L. *Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror* (1992 reprinted 2015) New York: Basic Books

[5] Symonds M. *Victim responses to terror: Understanding and Treatment in Victims of Terrorism*, ed. Ochberg F., Soskis D. (Boulder CO: Westview, 1982)

physical and sexual violence, and emotional (psychological) abuse, including humiliation, intimidation, coercion and stalking (WHO, 2012).

In relation to child sexual abuse and exploitation, abusive behaviours include the sexual violence and abuse, coercion and manipulation referred to in intimate partner violence. It has been usual to think of child sexual abuse and exploitation as involving the victim receiving something they need or desire (which can include intangible items such as, perceived affection, protection or a sense of value or belonging). However, child sexual exploitation can also be perpetrated through violence and aggression in which the victim complies with the abuse through fear of humiliation or of physical violence to themselves or their family. The gain for those perpetrating or facilitating the abuse can include personal gratification, financial benefit, status and/or control. As with intimate partner violence, child sexual abuse and exploitation can take place in person, or on-line and involve both contact and non-contact abusive activities, including grooming and the production and distribution of sexual images or exposure to such images (Christie 2017).[6]

The manipulation or grooming with which most sexual exploitation commences involves the young woman believing that she is in an intimate partner relationship with the perpetrator; and this belief can last throughout the relationship (Barnardo's, 2011). The commonality between intimate partner violence and child sexual abuse and exploitation extends to the impact on young people. In both intimate partner violence and child sexual abuse and exploitation young people experience physical, sexual and emotional violence and abuse. Furthermore, the circumstances in which young people become drawn into the abuse are similar in so far as the relationship with the abuser develops through peer and other social relationships. The conclusion drawn at this point is therefore that for many young people the essential experience of intimate partner violence and child sexual abuse and exploitation is conflated – and in both a key element of the harm caused is the betrayal of the trust the young person has invested in the relationship.

Other manifestations of harm resulting from both intimate partner violence and child sexual abuse and exploitation include drug and alcohol problems, self-harming and broader mental health problems, such as, severe low self-esteem, thoughts of suicide, depression, self-neglect, and emerging serious personality disorders (Children's Commissioner, 2012). All the young people interviewed for the Office of the Children's Commissioner's Inquiry following sexual abuse and exploitation, reported experiencing physical violence. Forty-eight percent of them had injuries that required them to visit Accident and Emergency; 41% had substance misuse problems, 32% were self-harming, 27% had mental health issues and 39% had sexual health problems. In terms of intimate partner violence, findings from SafeLives'[7] national dataset in 2012 were that, of the young people who had accessed (adult) domestic abuse services, 67% had experienced physical violence, threats to kill, stalking, rape, serious sexual assault, broken bones or strangulation. Thirty-two percent had attended Accident and Emergency because of injuries, 21% were suicidal, 26% had self-harmed (and 23% were experiencing financial problems, which research shows acts as a barrier to leaving the abusive relationship).

1.4.2 Presentation of quotes and reported contributions

Contributions from fieldwork participants have been anonymised in the report. When not in textboxes, direct quotes from the young people are presented in italicised text and direct quotes from keyworkers, managers and commissioners are presented in italicised text. Quotes from the literature are presented in italicised text.

[6] Christie E.C. *Online Grooming (communication with/about a child for the purposes of sexual abuse & exploitation) – What do we know?* (2017). Norfolk Constabulary

[7] Previously known as CAADA (Co-ordinated Action Against Domestic Abuse)

Project theory

2. Rapid literature review

2.1 Introduction

This section outlines the substantial and respected body of knowledge from the currently recognised schools of philosophical and psychological thought, that provide the evidence-base for 'what works' in supporting young people to recover from the trauma of child sexual abuse and exploitation. Such a body of knowledge is potentially more accurate in informing service design and delivery, than the current understanding of 'evidence', which relies on the measurement of outcomes.[8]

The section begins by developing an understanding of trauma before exploring the evidence base which has been developing internationally, over the past 150 years about 'what works' in helping an individual to recover from trauma.

2.2 Trauma defined

> *'Trauma is much more than a story about the past that explains why people are frightened, angry or out of control. Trauma is re-experienced in the present, not as a story, but as profoundly disturbing physical sensations and emotions that may not be consciously associated with memories of past trauma. Terror, rage and helplessness are manifested as bodily reactions, like a pounding heart, nausea, gut-wrenching sensations and characteristic body movements that signify collapse, rigidity or rage….*
>
> *The challenge in recovering from trauma is to learn to tolerate feeling what you feel and knowing what you know without becoming overwhelmed. There are many ways to achieve this, but all involve establishing a sense of safety and the regulation of physiological arousal.'*
>
> Bessel van der Kolk (2014)

Of all the issues facing humans in the 21st century, few have been as devastating on a personal and familial level as the experience of inter-personal trauma – and specifically trauma experienced in childhood. Childhood adversity is now known to contribute to perhaps the majority of current public health priorities. This includes many physical and mental illnesses, social difficulties and harmful behaviours such as domestic violence – in a dose-response manner i.e. greater number of traumas increase the overall negative impact.

The work on Adverse Childhood Experiences (Felliti and Anda, 1990's)[9] (see subsection 3.5.3 Adverse Childhood Experiences (ACEs)), has established the long-term negative

[8] The lack of effective outcomes measures for recovery and other personal/care services is testament to the difficulty in developing and implementing these with any consistency (reflecting, above all, the individuality of victims' experience and the internal/external resources they are able to draw on). The consequence of such failure being that there is no reliable 'evidence-base' and commissioners are reluctant to commission services without one.

[9] Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P., Marks J.S., 1998. *Relationship of childhood abuse and household dysfunction to many of the leading causes*

impact of experiencing multiple traumas in early years and has catalysed a great deal of ongoing neuro-psychological research that offers enormous insights into the biological mechanisms that are impacted by trauma. The nervous, endocrine and physiological systems of children who have experienced trauma run on a constant 'high-alert' because they have been biologically conditioned to constantly anticipate further danger. As a result their bodies are flooded with 'fight, flight or freeze' hormones such as cortisol (Linares et al., 2008[10], Cozolino, 2002[11]) that are adaptive for short-term survival (e.g. running from immediate threat or danger) rather than long-term hypervigilance. This state of chronic 'hyper-arousal' persists for many survivors throughout their adult years.

van der Kolk[12]:

> '*We know that the impact of trauma is upon the survival or animal part of the brain. That means that our automatic danger signals are disturbed, and we become hyper- or hypo-active: aroused or numbed out. We become like frightened animals. We cannot reason ourselves out of being frightened or upset.*
>
> *In the long term the largest problem of being traumatized is that it's hard to feel that anything that's going on around you really matters. It is difficult to love and take care of people and get involved in pleasure and engagements because your brain has been re-organized to deal with danger….*'

2.2.1 Impact of chronic toxic stress

Chronic toxic stress where the body is in a constant state of high alert for danger (the 'fight, flight, freeze' response) cause stress hormones such as cortisol and adrenaline to continually release keeping blood pressure high and sympathetic/parasympathetic nervous system responses activated – weakening the heart, circulatory and immunological systems over time[13]. Constant exposure to these stress hormones has the cumulative impact of 'wearing out' the body's neurological and immune systems and directly impacting on major organs and overall mortality. Eventually the adrenal glands will become compromised producing cortisol to keep up with the demand (cortisol is also required to reduce the stress response through the parasympathetic system) leading to increased risk of auto-immune disorders. A (weak) analogy is driving a car at high speeds whilst remaining in second gear – the car may look fine externally but the engine is going to quickly wear out. The impact has been associated with increased risk and early appearance of cancers, heart disease, osteoporosis, arthritis, gastrointestinal disease, depression, anorexia nervosa, lupus, hyperthyroidism and a general compromised immune system unable to ward off infections. Glucose is also continually released to provide energy for muscles to act quickly leading to risk of diabetes. Sensitivity to normal daily stressful events becomes compromised – and the

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of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine, 14(4), pp.245-258

[10] Linares L.O., Stovall-McClough K.C., Li, M., Morin N., Silva R., Albert A., Cloitre, M., 2008. *Salivary cortisol in foster children: A pilot study*. *Child abuse & neglect*, *32*(6), pp.665-670

[11] Cozolino L. (2002). *The neuroscience of psychotherapy: Building and rebuilding the human brain*. New York, NY: W.W. Norton

[12] van der Kolk on Trauma, Development and Healing by David Bullard https://www.psychotherapy.net/interview/bessel-van-der-kolk-trauma

[13] McEwen B.S., Gianaros P.J., 2010. *Central role of the brain in stress and adaptation: links to socioeconomic status, health, and disease*. Annals of the New York Academy of Sciences, 1186(1), pp.190-222

balance of the bodies internal systems remains out of kilter with an increased allostatic load (Danese & McEwen, 2012)[14].

This chronic wear and tear on the individual's biological systems is thought to be a major factor for why the lifespan of people with six or more adverse childhood experiences (ACEs) is likely to be shortened by an average of 20 years. Children's neurological development can be disrupted when they are chronically exposed to stressful events such as physical, emotional, or sexual abuse, physical or emotional neglect, witnessing violence in the household, or a parent being incarcerated or suffering from a mental illness. As a result, the child's cognitive functioning or ability to cope with negative or disruptive emotions may be impaired.

2.2.2 Defining the impact of childhood trauma

Herman (1992)[15] is credited with being one of the first to build the case for a complex post-traumatic syndrome in survivors of prolonged, repeated victimisation 'characterised by enduring personality changes, and high risk for repeated harm, either self-inflicted or at the hands of others' (Herman 1992 p 387) . Importantly, Herman also raised the issue of misdiagnosis as personality disorder (defined as pervasive, enduring, inflexible and distressing patterns of thought and behaviour that deviate from social norms).

Revisers of psychiatric diagnostic systems such as the International Classification of Diseases[16] have been considering the issue of whether to categorise a specific 'complex' posttraumatic stress disorder (C-PTSD) for some time[17] as current PTSD diagnostic categorisation, whilst helpful for those who have experienced social upheavals such as war, disasters such as earthquakes or accidents, does not fully capture the impact of childhood abuse. Currently this population of patients may end up with a series of diagnoses ranging from PTSD, 'Disorder of Extreme Stress, not otherwise specified' (DESNOS), or 'personality change due to classifications found elsewhere'. All of these diagnoses can accommodate C-PTSD presentation. (see subsection 3.5.2 Treatment Implications for further discussion on this).

Previously a large group of experts including Bessel van der Kolk – Medical Director of the Trauma Center in Brookline, Massachusetts – had campaigned unsuccessfully for inclusion of a new category of 'Developmental Trauma Disorder' to be listed in the DSM-5 in 2009 which was rejected[18]. In 2013 the director of the United States National Institute of Mental Health proposed moving away from using the DSM-5's classification of mental disorders to a less categorical approach and this alongside the difficulty in harnessing collective agreement on definitions of trauma is one of the reasons many clinicians and researchers now feel that the American diagnostic system has become discredited.

Methodological problems, including those of definition, mean that estimates of the incidence and prevalence of child sexual abuse vary considerably. Child sexual abuse refers 'not to a disease or medical condition but to an event, or series of events, in a child's life'. Some

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[14] Danese A., McEwen, B.S., 2012. *Adverse childhood experiences, allostasis, allostatic load, and age-related disease*. *Physiology & behavior*, *106*(1), pp.29-39

[15] Herman J.L. (1992). *Trauma and recovery*. [New York, N.Y.] : BasicBooks

[16] International Classification of Diseases 10 – World Health Organisation http://apps.who.int/classifications/icd10/browse/2016/en

[17] Matheson C. (2016) *A new diagnosis of complex Post-traumatic Stress Disorder, PTSD – a window of opportunity for the treatment of patients in the NHS?* Psychoanalytic Psychotherapy, 30:4, 329-344

[18] van der Kolk B.A., Pynoos R.S., Cicchetti D., Cloitre M., D'Andrea W., Ford J.D., Lieberman A.F., Putnam F.W., Saxe, G., Spinazzola J., Stolbach B.C., 2009. *Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V*. Unpublished manuscript. Verfügbar unter: http://www. cathymalchiodi. com/dtd_nctsn. pdf (Zugriff: 20.5. 2011)

children are victimised on a single occasion, but more often sexual abuse occurs over a period of time, sometimes years. Girls are more likely to be victims than boys, with estimates of prevalence rates ranging between 20% and 32% for females and between 4% and 8% for males (Finkelhor 1994[19]; Andrews 2004[20]; Pereda 2009[21]) and the global prevalence of child sexual abuse at 19.7% for females and 7.9% for males. Over 90% of sexually abused children were abused by someone they knew[22]. Research and crime statistics suggest that anywhere from one-fifth to two-thirds of sexual abuse is committed by other children and young people.[23]

Experience of child sexual abuse and exploitation is associated with the development of PTSD (Wolfe, Sas & Wekerle, 1994)[24] and other symptoms including anxiety, anger, depression, revictimization, self-mutilation, sexual problems, substance abuse, suicidality, impairment of self-concept, interpersonal problems, obsessions and compulsions, dissociation, posttraumatic stress responses, and somatization all yielded significant associations with sexual abuse[25]. Similar problems have been identified in long-term functioning with men (Lisak, 1994)[26].

2.2.3 Biology and neurological impact

The body of research on the biological / neurological impacts of abuse has been building for over 20 years, and although there appears to be general agreement on the overall role of long-term 'toxic' stress on a number of biological systems (see subsection 2.2.4 Toxic stress and neuro-endocrine alterations, below) – differences in outcomes and impact of differing type of trauma (e.g. sexual abuse) appear to include a large range of individual and developmental factors including the emotional impact on personal meaning systems (e.g. Andrews & Hunter,1997)[27] and how the long-term effects of maltreatment are influenced by the quality of subsequent caregiving or familial/genetic factors, amongst other issues (e.g. Jackowski et al., 2009[20])[28].

Although the majority of sexually abused children do not go on to offend, there is some support for the hypothesis that the experience of sexual abuse in childhood is associated with an increased risk for sexual offending in adulthood (Jespersen et al., 2009)[29], and that

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[19] Finkelhor D., 1994. *Current information on the scope and nature of child sexual abuse.* The future of children, pp.31-53

[20] Andrews G., Corry, J., Slade T., Issakidis C., Swanston, H. *Comparative quantification of health risks: Global and regional burden of disease attributable to selected major risk factors* (2004). Child sexual abuse. *2*, pp.1851-940

[21] Pereda N., Guilera G., Forns, M., Gómez-Benito J., 2009. *The prevalence of child sexual abuse in community and student samples: A meta-analysis*. Clinical psychology review, 29(4), pp.328-338

[22] Radford, L. Corral S., Bradley C., Fisher H., Bassett C., Howat N., Collishaw S. (2011) *Child abuse and neglect in the UK today*. London: NSPCC

[23] Hackett, S. *Children and young people with harmful sexual behaviours* Research in Practice; 1 edition (2014)

[24] Wolfe D.A., Sas L., Wekerle C., 1994. *Factors associated with the development of posttraumatic stress disorder among child victims of sexual abuse.* Child Abuse & Neglect, 18(1), pp.37-50

[25] Neumann D.A., Houskamp B.M., Pollock V.E., Briere J. *The Long-Term Sequelae of Childhood Sexual Abuse in Women: A Meta-Analytic Review* (1996). February 1, 1996 Research Article

[26] Lisak, D., 1994. *The psychological impact of sexual abuse: Content analysis of interviews with male survivors.* Journal of traumatic stress, 7(4), pp.525-548

[27] Andrews, B. and Hunter, E., 1997. *Shame, early abuse, and course of depression in a clinical sample: A preliminary study.* Cognition & Emotion, 11(4), pp.373-381

[28] Jackowski, A.P., De Araújo, C.M., De Lacerda, A.L.T., De Jesus Mari, J. and Kaufman, J., 2009. *Neurostructural imaging findings in children with post-traumatic stress disorder: brief review*. Psychiatry and Clinical Neurosciences, 63(1), pp.1-8

[29] Jespersen, A.F., Lalumière, M.L., Seto, M.C. (2009). *Sexual abuse history among adult sex offenders and non-sex offenders: A meta-analysis*. Child abuse & neglect, 33(3), pp.179-192

child sexual abuse, like other forms of maltreatment, may increase the risk of delinquency and adult offending more generally (Thornberry et al., 2010)[30].

2.2.4 Toxic stress and neuro-endocrine alterations

Toxic stress refers to emotionally unhealthy environments driven by a range of negative experiences and situations that include abuse, neglect, violence, unsafe or unpredictable home conditions – many of which are exacerbated within the context of poverty and deprivation. A child in an acute or chronic environment of toxic stress will experience prolonged activation of their normal stress response (which is adapted to respond to short-term situations of threat or risk), leading to a reduced ability of the stress response to regulate and inability for the body to recover fully.

The ongoing stress response includes stimulation of the sympathetic nervous system leading to a high activation of neuro-endocrine responses destabilising the ability of the hypothalamus to maintain homeostasis with responses including an increase in heart-rate, blood pressure and prolonged cortisol release. In turn this reduces the efficacy of the immune system and increases the risk of infection and illness in children; and if it is ongoing it impacts on allostasis (see *Allostasis and toxic stress*, below) and potential for organ dysfunction. The negative impact may be increased if there is also an insufficient parental / support network and response to help the child buffer the impact of stress. Implications for long-term health and development are understood to include increased risk for stress-related diseases (Kendall-Tackett, 2001)[31].

After exposure to toxic stress, even though the environment may be safe, the physiological and neuro-endocrine responses such as heightened cortisol levels may still be activated and adult trauma survivors may still perceive the environment as threatening or dangerous, leading to ongoing anxiety and fear (Giarratano, 2004)[32]. In this situation, even innocuous situations or stimuli are often misinterpreted as threatening and the 'fight, flight or freeze' response is activated often leading to inappropriate responses by the individual which in themselves can put them at further risk of harm.

The toxic stress response for these individuals can be described as a 'hair-trigger' reaction, one that is not easy to reduce because their bodies are in a constant state of 'high-alert'. Children and adults who have experienced chronic/acute trauma impacting their neuro-endocrine stress-response system may also experience reduced frontal lobe functioning. Thus when children feel under threat, the fast track of the limbic system is likely to be activated before the slower prefrontal cortex has a chance to evaluate the stimulus. This increase in limbic system/amygdala sensitivity has significant implications for their ability to thrive in education/learn and problem solve – as well as having implications for their impulsivity and risk-taking (Streeck-Fischer & van der Kolk, 2000)[33].

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[30] Thornberry T.P., Henry, K.L., Ireland, T.O., Smith, C.A., 2010. *The causal impact of childhood-limited maltreatment and adolescent maltreatment on early adult adjustment*. Journal of Adolescent Health, 46(4), pp.359-365

[31] Kendall-Tackett, K. (2001). *Chronic pain: The next frontier in child maltreatment research.* Child abuse & neglect, 25(8), 997-1000.

[32] Giarratano, L. (2004). *Clinical skills for Managing PTSD; Proven practical techniques for treating posttraumatic stress disorder*. Mascot Australia: Talomin Books

[33] Streeck-Fischer, A., & van der Kolk, B. A. (2000). Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development. *Australian & New Zealand Journal of Psychiatry*, *34*(6), 903-918

Diagram 1: Neuro-endocrine trauma responses

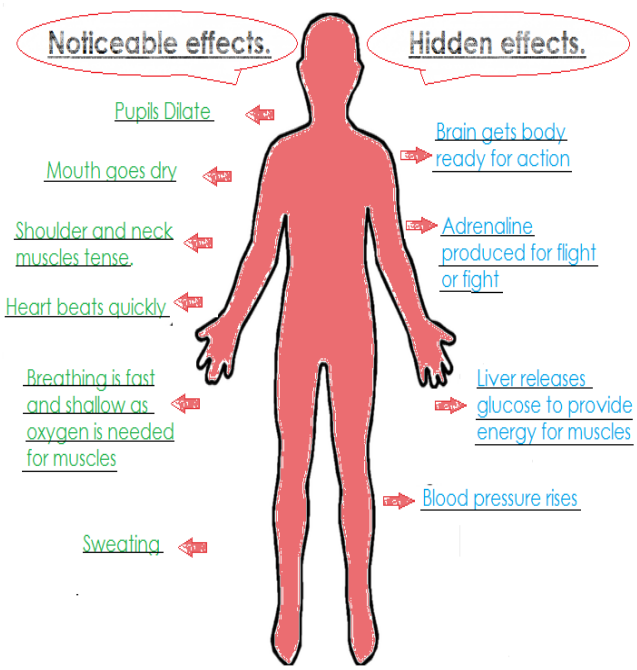
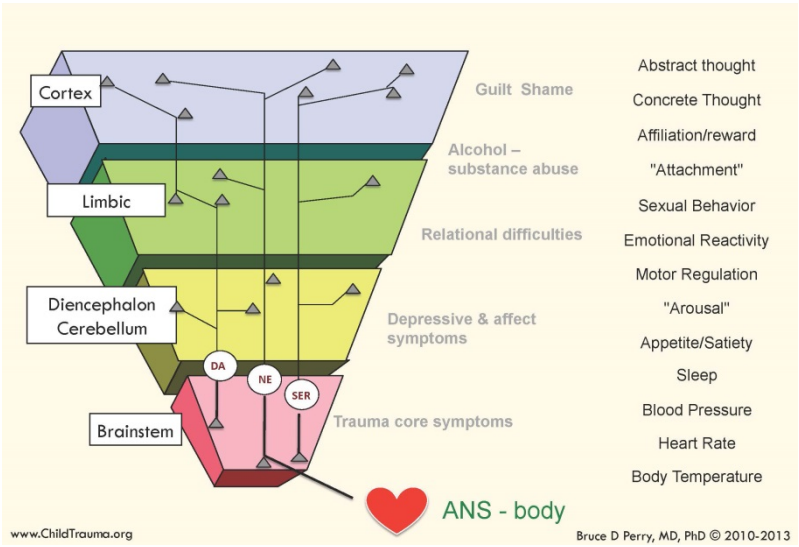


Diagram 2: Neuro-biological trauma responses



2.2.5 Adverse childhood experiences (ACEs), allostasis, epigenetics and toxic stress

ACEs and epigenetics

The growing evidence base from ACE's research over the past 20 years has robustly established that adverse childhood experiences such as domestic violence and s exual / physical abuse are directly contributing to adult mental illness and additionally to almost every major current education and publ ic health concern. This understanding is of great

relevance to public health approaches to population health and is already being explored in many areas of the UK (e.g. see Bellis et al 2014)[34]. It is becoming one of the more universal elements of the rationale for a prevention model.

ACE's research describes a body of work on the relationship of childhood exposure to different types of adversity that developed from a public health programme for obesity initiated by Vincent Felliti in the 1980's in San Diego USA. In 1998 Fellitti and Robert Anda carried out the ACEs study, which for over 15 years followed and monitored 17,400 participants for a series of health harming behaviours and disease in adulthood and compared these to ten categories of adverse childhood experiences[35]. These ten ACEs are:

Physical abuse, Sexual abuse, Emotional abuse, Physical neglect, Emotional neglect, Mother treated violently, Household substance abuse, Household mental illness, Parental separation or divorce, Incarcerated household member

The study found a significant dose-response correlation between the number of ACEs experienced and the amount of health harming behaviours and disease participants experienced in adulthood. For example, participants with four or more ACEs compared to those with no ACEs had a 4 to 12-fold increased risk for alcoholism, drug abuse, smoking, depression, and suicide attempts; as well as a 240 percent greater risk of hepatitis, 390 percent greater risk of chronic obstructive pulmonary disease (emphysema or chronic bronchitis), and a 240 percent higher risk of a sexually-transmitted disease. They also had a 1.4- to 1.6-fold increased risk of being physically inactive and severely obese.

This study has been further replicated across America and Europe robustly establishing the connection between ACEs and negative behaviour and health outcomes[36]. Replication studies have been commissioned in England and Wales including in Blackburn, Hertfordshire, Luton and Northamptonshire. Bellis and colleagues[37] were the first to carry out this study in England with almost half (47%) of the participants experiencing at least one ACE and 9% (rising up to 12.7% for those in the most deprived areas) experiencing four or more ACEs. It is important to note the dose-response of cumulative ACEs associated with long term negative outcomes even in individuals who display otherwise healthy lifestyle behaviours. It is thought that this is related to the impact of early acute and chronic stress responses on the DNA telomeres (the protective caps at the end of each strand of DNA which guard against immunological damage), alongside an epigenetic[38] failure on the coding of the allostatic system.

The biology of adversity suggests that children who experience toxic stress may be less able to benefit from good quality early childhood programmes because of impairments in their developing brain circuitry. This proposition is supported by extensive evidence (from both animal and human studies) of the vulnerability of the amygdala, hippocampus, and prefrontal cortex (PFC) to the disruptive effects of excessively activated stress response systems, beginning in the prenatal period and early infancy and, in the case of the PFC, extending well into the adult years. Children with adverse childhood experiences and adults who have

[34] Bellis, M. A., Hughes, K., Lekenby, N. & Lowey, H. (2014) Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. Journal of Public Health, 36, 81-91

[35] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., et al. (1998) The relationship of adult health status to childhood abuse and household dysfunction. American Journal of Preventive Medicine, 14, 245-258.

[36] Anda R. F., Felitti V. J., Bremner J. D., Walker J. D., Whitfield C., Perry B. D., . . .Giles W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. European Archives of Psychiatry & Clinical Neuroscience, 256, 174-186

[37] Ibid.

[38] Epigenetic – non-genetic influences on gene expression.

experienced childhood trauma may respond more quickly and strongly to events or conversations that would not affect those with no ACEs, and have higher levels of indicators for inflammation than those who have not suffered childhood trauma.

Allostasis and toxic stress

Allostasis refers to changes in the balance of biological systems responsible for maintaining internal, physiological equilibrium. These systems work by detecting environmental and physiological changes in order to activate adaptive responses which ensure internal regulation. There are three highly integrated systems involved with this specialised response, the nervous, the endocrine, and the immune systems. When under stress, the brain signals the hypothalamus and pituitary gland to stimulate the adrenal gland to produce adrenaline and cortisol. These hormones stimulate alertness and attention to the environment, and induce the activation of the sympathetic nervous system 'fight, flight or freeze' response.

When active, psycho-social stress triggers inflammation[39] an immune system response to prevent infections in case any tissue damage should occur during fight, or freeze and also activates the neuro-endocrine system by increasing metabolic demands and mobilising stored energy to further support the fight, flight or freeze response. This process involves highly integrated and adaptive systems which promote short-term adaptation in the face of environmental challenges. Chronic or repeated exposure to psychological stressors, such as adverse childhood experiences, has been linked to a prolonged activation of the allostatic systems causing allostatic overload or toxic stress.

Physiological effects of chronic stress exposure can be genetically transferred through epigenetic changes – modifying genetic programming and changes in gene function without changing genetic sequences. McGorry, et al. (2014)[40] argue that identifying epigenetic differences that cause pathological behaviour is of utmost importance in generating therapeutic and preventative approaches to potentially reverse epigenetic changes. The Adverse Childhood Experiences (ACEs) checklist has provided a unique opportunity for us to detect children that are being exposed to chronic stress and interrupt the trajectory leading to mental illness.

2.3 The impact of child sexual abuse and exploitation

The impact of child sexual abuse and exploitation is captured by Lev-Wiesel (2008)[41]:

> *'What then, are the specific issues that need to be addressed for recovery, in the light of the unique trauma of childhood sexual abuse? I suggest two core issues:*
>
> - *The body no longer serves as a 'safe place' – meaning the soul is homeless, and*
> - *The self and body are perceived to be worthless and helpless – meaning there is no hope for a better future.'*

[39] Danese A., McEwen B. S. (2012) Adverse childhood experiences, allostasis, allostatic load, and age-related disease. Physiology & Behaviour, 106, 29-39.
[40] McGorry P., Keshavan M., Goldstone S., Amminger, P., Allott K., Berk, M. Hickie I. (2014). *Biomarkers and clinical staging in psychiatry*. World Psychiatry, 13(3), 211–223
[41] Lev-Wiesel R. *Child sexual abuse: A critical review of intervention and treatment modalities* (2008). School of Social Work, University of Haifa. Children and Youth Services Review 30 (2008) P665–673

This is supported by Leask (2013)[42] who offers a description by Jean Améry, a Jewish refugee, of his experience of humiliation by the Gestapo:

> *'What is lost is 'an element of trust in the world' and the certainty that by reason of written or unwritten social contracts the other person will spare me – more precisely stated, that he will respect my physical, and with it also my metaphysical being. The boundaries of my body are also the boundaries of my self. (p28. Such an experience 'blocks the view into a world in which the principle of hope rules' and makes the victim of humiliation a 'defenceless prisoner of fear' (p40).*

Finkelhor and Browne's (1985) [43] developed a systematic understanding of the effects of child sexual abuse which identifies four trauma dynamics as forming the core of the psychological injury inflicted by abuse. These are:

- Traumatic sexualization
- Betrayal
- Stigmatisation, and
- Powerlessness.

See also references to shame in subsection 3.2.1.1 Young people's and keyworkers' responses, below; and the recognition of the importance of humiliation in Table 3.5.2 Adverse Childhood Experiences in order of prevalence amongst the young people in this Project

The rest of this subsection summarises the 2017 report[44] by the Independent Inquiry into Child Sexual Abuse[45] on the impact of child sexual abuse.

2.3.1 Physical health

The experience of CSA has been linked to a wide range of adverse physical health problems, from acute physical injuries sustained from abuse to longer term illnesses and disabilities. A number of studies have highlighted poor physical health among victims and survivors (Kamiya et al., 2016; Delahanty, 2010), and the increased risk of developing physical health problems following CSA has been described as "small to moderate" (Fergusson et al., 2013). The impact of CSA on physical health can have long lasting effects - in one study, one in four CSA victims/survivors reported a long-standing illness or disability, compared to one in five individuals in the general population (Allnock et al., 2015). The consequences of such problems can be significant – one study of older patients found that a history of CSA was associated with a higher burden of medical illness, which was estimated

[42] Leask P. *Losing trust in the world: Humiliation and its consequences*. Psychodynamic Practice Vol. 19 , Iss. 2, 2013. P129-142

[43] Finkelhor D, Browne A. (1985) The traumatic impact of child sexual abuse: a conceptualization. (1985)*The American Journal of Orthopsychiatry* 55(4); P530-41.

[44] Fisher C, Goldsmith A, Hurcombe R, Soares C. IICSA Research Team. July 2017. *The impacts of child sexual abuse: A rapid evidence assessment*. Available at: https://www.iicsa.org.uk/document/iicsa-impacts-child-sexual-abuse-rapid-evidence-assessment-full-report-english

[45] The Independent Inquiry into Child Sexual Abuse (IICSA) in England and Wales was established in 2014 (after investigations in 2012 and 2013 into the Jimmy Savile sexual abuse scandal) to examine how the country's institutions handled their duty of care to protect children from sexual abuse.

as comparable to adding eight years to a person's age (Talbot et al., 2009). Specific health conditions that have been associated with CSA include: acute trauma/injuries; STIs, including HIV; migraines; heart and lung problems; obesity; diabetes; problems with the reproductive system; and chronic pain (Fisher et al., 2017). The relationship between CSA and physical health problems may not be directly causal – CSA is significantly associated with an increased risk of mental health and substance use problems, both of which have been demonstrated to be independently associated with poor physical health outcomes. However, emerging evidence into the effects of early trauma such as CSA on brain structure and neurodevelopment may shed light on the biological mechanisms through which CSA may lead to certain physical health outcomes. This line of research, which is still in its infancy, explores the ways in which extreme stressors may impact an individual's nervous systems, making them more sensitive to future stress (De Bellis et al., 2011).

2.3.2 Emotional wellbeing and presentation

CSA victimisation has been consistently linked to poor mental health outcomes, including general emotional distress, disorders such as PTSD, depression and anxiety, as well as self-harm and suicidal behaviours. The psychological impact of CSA does not always meet the threshold of mental health disorder diagnoses – CSA is associated with the development of negative feelings such as low self-esteem, powerlessness, and self-blame (Perez-Gonzalez et al., 2015), and the persistence of such emotions can have a significant impact on survivors' quality of life (for more information about low self-esteem, see section 3.5.1 The young people's emotional and behavioural challenges). The literature exploring the impact of CSA on mental health conditions is robust, however the measures and definitions of such disorders often vary between studies, resulting in significant variation in effects. Mental health conditions linked with CSA vary, and include psychosis, personality disorders, dissociation, and eating disorders (Fisher et al., 2017).

The strength of the association between CSA and adult depression is small to medium statistically, and remains significant even when other confounding factors (e.g. sociodemographic characteristics) are taken into account (Coles et al., 2015); (for more information about depression, see section 3.5.1 The young people's emotional and behavioural challenges). There is even some suggestion from the literature that the relationship between CSA and depression is directly causal (Perez-Gonzalez et al., 2015). Evidence suggesting gender differences in terms of risk of developing depression following CSA is mixed – some studies highlight higher rates of depression amongst female victims compared to males, while others have found no significant differences in depression severity between male and female victims and survivors (Schlachter et al., 2009; Zeglin et al., 2015).

Anxiety disorders, and Post traumatic Stress Disorder in particular, feature prominently in the literature examining the link between CSA and the development of poor mental health outcomes. PTSD, an anxiety disorder characterized by symptoms including the re-experiencing of the traumatic event through intrusive memories and images, hyper-arousal, and avoidance of trauma-related stimuli or triggers, has been found to be significantly more associated with CSA compared to other anxiety disorders (Maniglio et al., 2013). This association, identified as small to medium in terms of statistical strength, remains after controlling for other forms of child maltreatment (such as physical abuse), and numerous other clinical/socio-demographic variables (Maniglio et al., 2013). The likelihood of developing PTSD has also been shown to increase with the degree of abuse experienced; in one study, experiencing physical and sexual abuse in both childhood and adulthood was related to a considerably higher risk of PTSD than the experience of abuse in childhood or adulthood only (Wosu et al., 2015). The particular effects of chronic and/or repeated abuse during early childhood on development and functioning have been termed 'complex trauma' or 'complex PTSD', and include disorders of affect regulation, dissociation, and difficulties in self-concept and inter-personal relationships (Kisiel et al., 2014).

For many trauma survivors, the distress of post-traumatic stress disorder (PTSD) is compounded by the destructive effects that anger, hostility, and aggression have on interpersonal relationships and daily functioning. Research evidence suggests that anger, and other strong post-traumatic emotional reactions arise from appraisals related to the violation of safety rules, frustration and unfairness of the incident (Ehlers & Clark, 2000[46]; Berkowitz & Harmon-Jones, 2004[47]).There is also considerable research to suggest that there is a strong association between anger and higher frequency and severity of daily hassles in non-clinical populations (Thomas & Donnellan, 1991). Whiting and Bryant (2007)[48] found that anger expression did not depend on whether an individual was suffering from PTSD or not (although this was not consistent with previous research (Chemtob et al., 1994; Riggs et al., 1992). For more information about anger, see section 3.5.1 The young people's emotional and behavioural challenges).

Gender differences in the prevalence of mental health conditions amongst CSA survivors are noted within the literature. It has been suggested that females are more likely to exhibit internalising behaviours (including depression, anxiety, and other mental health problems), and males are more likely to demonstrate externalising behaviours in response to CSA (such as substance misuse, aggression, or antisocial behaviour) (Fisher et al., 2017).

Self-harm and suicidal behaviour are also reliably found to be associated with CSA. Rates of self-harm (including self-injuries such as cutting or hitting oneself with fists) have been shown to be high amongst samples of CSA survivors (Fisher et al., 2017). Although these rates vary based on methodology and samples used, studies have reported rates as high as 49% among adult survivors in treatment (Bolen et al., 2013). Numerous studies have reported links between CSA and suicidal ideation and attempted suicide (Perez-Gonzalez and Pereda, 2015). The Adult Psychiatric Morbidity Survey reported that ten per cent of adults with a history of CSA had attempted suicide (Scott et al., 2015), and individuals who have experienced CSA can be up to six times more likely to attempt suicide than comparison groups with no abuse history (McCarthy-Jones, 2014). Although the strength of the relationship between CSA and attempted or completed suicides has been demonstrated to vary considerably between studies, there is some suggestion from the literature that CSA may act as a predictive factor for suicidal behaviour (Maniglio, 2013). In one study of youth residing in juvenile detention centres, CSA independently predicted suicidal ideation and non-fatal suicidal behaviour; CSA was similarly identified as an independent predictor of suicide amongst homeless youth (O'Riordan, Arensman, 2007; Esposito & Clum, 2002). Gender differences in suicidal behaviour amongst victims of survivors have also been identified in a number of studies, such that the association is stronger amongst females than males (Cashmore & Shackel, 2014; Rhodes et al., 2011). However, this evidence is inconclusive, as other studies have reported an increased risk for male victims and survivors, or equal risk for both genders (Fergusson et al., 2013; Dube et al., 2005).

2.3.3 Suggested gender differences

The majority of prevailing literature, discourse and intervention around CSE has focused overwhelmingly on female survivors (Cockbain, Ashby & Brayley, 2015; Lillywhite & Skidmore, 2006). However, within the limited research conducted on child sexual abuse and

[46] Ehlers, A., Clark, D. M. (2000). *A cognitive model of posttraumatic stress disorder. Behaviour Research and Therapy*, 38, P319–345

[47] Berkowitz L., Harmon-Jones E. (2004). *Toward an understanding of the determinants of anger. Emotion*, 4, P107–130

[48] Whiting D., Bryant R.A. *Role of appraisals in expressed anger after trauma*. School of Psychology, University of New South Wales, Sydney, New South Wales, Australia. Clinical Psychologist, Vol. 11, No. 1, March 2007, P33–36

exploitation and gender, differences have been reported across factors (Feiring, Taska and Lewis, 1999; Smallbone and Wortley 2000).

In a meta-analysis of global prevalence, Stoltenborgh et al. (2011) reported child sexual abuse prevalence rates in Europe at 5.6% for males and 13.5% for females, a rate that remained higher in girls across continents, except South America. Research continues to corroborate the finding that girls constitute the majority of child sexual abuse victims, which has led to some conclusions that boys are therefore at less risk (Cashmore, Shackel, 2014). However, other research has suggested that the abuse of boys may involve increased physical violence and harm, and that adolescent boys, in comparison to girls, were more likely to be exploited by multiple perpetrators (Fogler et al., 2008; Steever, Follette, Naugle, 2001); factors which have been linked to increased psychological distress and poorer mental health outcomes (Easton, 2014). In Garnefski and Diekstra's (1997) research, boys who had experienced sexual abuse had greater behavioural and emotional problems, including suicidality, in comparison to girls in the study. However, in contrast, in a recent review of 1,250 cases of abuse, results demonstrated no differences in PTSD, mental health or conduct disorders according to gender (Soylu et al., 2016).

Further research has found that boys were more likely to experience extra-familial abuse than intra-familial (e.g. Romano, De Luca, 2001). However, such statistics may have changed with the growing awareness of child sexual abuse and exploitation in recent years, particularly knowledge pertaining to disclosure rates, which are deemed to be considerably lower in boys than girls, discussed below. Evidently, this could have a huge impact on prevalence statistics in boys, amongst other factors.

Lack of research

Despite some research highlighting certain factors which differ in the exploitation of boys, other findings indicate few, if any, differences (Cashmore, Shackel, 2014). Such inconsistencies may reflect the view that there is still 'limited research that specifically compares the experiences of male and female victims' (Cashmore, Shackel, 2014, p. 76) whilst most research purely looks at girls. This lack of research might simply reflect the underdevelopment and infancy in understanding of child sexual abuse and exploitation. However, other opportunities to explore gender differences have been systematically missed, despite national research conducted in the United Kingdom that involved both male and female participants (Child Exploitation and Online Protection Centre, 2011). Large-scale analysis of data from 9,042 users of CSE services in the UK (Cockbain et al., 2015) highlighted gaps in understanding, gender differences in detection and reporting of CSE and the impact this has on delayed disclosure in boys.

Disclosure and responses for boys

Cockbain et al. found that, children rarely came forward completely independently to disclose sexual exploitation. However, there was also a significant gender disparity within this, with girls being four times more likely to disclose than boys. Cockbain et al. (2015) argue that this continues to emphasise the importance of professionals' ability to identify risk and signs of child sexual abuse and exploitation in the absence of child-disclosure. This position appears not to have improved over the years as almost ten years previously Lillywhite and Skidmore (2006) had reported that both child sexual abuse and exploitation disclosure and detection rates were consistently lower for boys than girls. In recent research conducted in partnership with Barnardo's around the exploitation of boys and young men, Barnardo's practitioners stated that referring agencies were more aware of vulnerability and early indicators of abuse in girls than in boys. Consequently, in their experience, this meant that child sexual abuse and exploitation-related concerns for boys tended to be reported at a

much later stage, meaning boys' situations were typically more severe and required more immediate intervention (McNaughton-Nicholls, Harvey, Paskell, 2014).

In a study by Lowe and Pearce (2006) girls were three times more likely, in comparison to boys, to be referred because of concerns specifically centred around suspected child sexual abuse and exploitation; this has been supported by subsequent studies (McNaughton-Nicholls et al., 2014; Smeaton, 2013). The findings correlate with recent research in the UK which reported that child sexual exploitation risk assessment tools were 'female-centric'. This is important because the tools often facilitate a pathway of action for workers or indicate a level of intervention dependent on the identified risk indicators (Brown et al., 2016). The conclusion drawn in the research was that child sexual exploitation assessment toolkits are: 'targeted towards young women rather than young men', and boys' needs may be 'overlooked and under-served' (Lowe, Pearce, 2006, p. 289).

Cockbain and Brayley (2012) provide examples of gender differences, citing a sample of child sexual exploitation service users in which males were 1.6 times more likely than females (55% vs. 35%) to have a criminal record. This was corroborated by Cockbain et al's (2015) findings that 'significantly more male (48%) than female service users (28%) were known to have a criminal record' – proportions which exceed that of the general youth population. Consequently, boys were more likely to be referred through the criminal justice system/youth offending route or because of concerns around being 'missing' rather than a safeguarding route for child sexual exploitation.

2.3.4 Social wellbeing and behaviours

Victims and survivors of CSA exhibit externalising behaviours in response to the abuse they have experienced, understood as maladaptive coping strategies adopted as ways to manage or provide relief from distress. Such behaviours include substance misuse, inappropriate or "risky" sexual behaviours, anti-social behaviours, anger or aggression, and offending (Beckett et al., 2017; One in Four, 2015). Research examining such outcomes has typically focused on behaviour in youth and adult samples, as opposed to early childhood, and has highlighted how behaviours exhibited in adolescence can persist into adulthood (Lown et al., 2011; Nelson, 2009). Such behavioural impacts are dynamic over time, and may also occur in response to other outcomes of CSA (e.g. substance misuse) (Warrington et al., 2017).

The link between CSA and substance misuse is particularly evident within the literature (Fisher et al., 2017). Research has found CSA to be strongly associated with increased use of nicotine, alcohol, and illegal drugs (particularly cannabis and amphetamines) (Fergusson et al., 2013; Beckett et al., 2017; Fisher et al., 2017). In one US study, females who had experienced CSA were significantly more likely than those without an abuse history to have higher levels of 'past year' and 'lifetime' alcohol misuse (Lown et al., 2011); a higher prevalence of alcohol misuse amongst survivors of CSA compared to those who had experienced childhood physical abuse was also found. However, when considering substance misuse as an outcome, it should be noted that definitions and measures of substance use, misuse, and dependency are inconsistent across studies. In the context of child sexual exploitation, it is also important to acknowledge the role of substance misuse in the committing of abuse, for instance in relation to the grooming processes undertaken by perpetrators (Jay, 2014). Research highlights that substance misuse, in turn, can lead to further negative outcomes including physical health problems, poor educational and employment opportunities, or create vulnerabilities for certain sexual behaviours or re-victimisation (Pittenger et al., 2016; One in Four, 2015).

The emergence of 'risky sexual behaviours' in adolescent victims and survivors was a recurring theme throughout the literature, referring to examples of negative sexual conduct,

early pregnancy, sexually transmitted infections, or having multiple sexual partners (Fisher et al., 2017). Of particular note was the link between CSA and adolescent pregnancy – one study examining this relationship highlighted that the experience of CSA, particularly if abuse was experienced both in childhood and adolescence, greatly increased the risk of adolescent pregnancy amongst female victims and survivors (Young et al., 2011). Findings from a longitudinal study suggested that CSA was a risk factor for risky sexual behaviours that extended into adulthood (Fergusson et al., 2013). However, as with most research on risky sexual behaviours, the role of substance misuse in this behavioural outcome is of particular importance. Additionally, further research incorporating relatively new online risky sexual behaviours (i.e. 'sexting', online imagery) is needed (Fisher et al., 2017).

Anti-social behaviour and offending outcomes are also highlighted in research on outcomes associated with CSA, among both adolescent and adult samples. Conduct disorder, a condition characterised by disruptive and socially inappropriate behaviour diagnosed in childhood and adolescence, was found to be associated with CSA after controlling for several other factors (Maniglio et al., 2015). Offending behaviour has been consistently linked to CSA, and offending outcomes vary, including general aggression, arson, shoplifting and violent offences. One detailed longitudinal analysis conducted in Australia reported that those who had experienced CSA were 1.4 times more likely to have contact with the police, and approximately five times more likely than comparison groups to be charged with a criminal offence (Ogloff et al., 2012). While rates of offending were greater for both males and females, compared to respective comparison groups, male victims and survivors were noted to commit a broader range of offences compared to female victims (Ogloff et al., 2012). When interpreting research examining the link between CSA and offending outcomes, it should be noted that the majority of victims and survivors do not offend; the confounding role of substance use must also be considered (Fisher et al., 2017). Although a particular interest in the link between CSA and sexual offending has been noted within the literature, this effect is still comparatively small, and are most strongly associated with male victims and survivors (Ogloff et al., 2012).

2.3.5 Inter-personal relationships

The impact of CSA on victims and survivors' relationships can also be profound. Two main areas of inter-personal relationships explored in the literature are the impact of CSA on:

a) Intimate and sexual relationships, including issues relating to sexual identity/orientation, and sexual dysfunction; and

b) The parenting skills and approaches of victims and survivors.

In terms of intimate relationships, CSA has been linked to lower relationship satisfaction and stability, and difficulties with intimacy and sexual intimacy in adult relationships (Senn et al., 2012; Kia-Keating et al., 2010). Particularly among male victims and survivors, CSA can cause confusion around sexual identity and orientation (Nelson, 2009).

Research on the impact of CSA on parent-child relationships is complex and multifaceted. Although having children can be a positive experience for victims and survivors, and can promote recovery, experiences of CSA may initiate emotions or parenting practices that may negatively impact the parent-child relationships. A number of themes emerged from this body of research, such as parenting styles, a lack of energy or confidence in navigating parenthood, or a fear of inflicting harm. Notable findings include evidence of an increased risk of overprotective or controlling parenting styles, as well as more detached or disengaged styles – both of which can negatively affect attachment and parent-child interactions (Allbaugh et al., 2014; Sneddon et al., 2016; Testa et al., 2011). One important area of research relating to parent-child relationships is the impact and effect of pregnancy and

childbirth on female victims and survivors of CSA. These findings indicate that the physical experiences of pregnancy and giving birth, in conjunction with certain medical examinations and feelings of a lack of control, can together serve as significant triggers of sexual trauma, causing emotional distress, dissociation, and peri-natal and post-natal difficulties (Fisher et al., 2017). Studies examining the impact of CSA on inter-personal relationships, and parenthood in particular, primarily focus on females with a clear gap in current research on the experience of male victims and survivors (Fisher et al., 2017).

2.3.6 Socio-economic outcomes

A small proportion of studies have explored socio-economic outcomes of CSA, and many of these are of variable quality (Fisher et al., 2017). Some higher quality research has provided support for a persistent association between CSA and reduced life chances, negatively affecting victims' and survivors' educational attainment, employment rates and income levels (Fisher et al., 2017). The socioeconomic impact of CSA has been shown to continue into mid-adulthood, with CSA linked to: increased unemployment and time out of the labour market; increased receipt of welfare benefits; income and financial instability; and reduced incomes (Fergusson et al., 2013). In many cases, these effects may be attributable to other outcomes associated with CSA, particularly poor physical and mental health. However one study of Irish male CSA victims in later adulthood found that they were four times more likely to be out of the labour market as a result of sickness or disability, after mental health problems and other negative health behaviours were controlled for (Barrett et al., 2014). CSA has also been linked to homelessness or housing instability, particularly in samples of young people, however studies investigating this socioeconomic outcome are limited in quantity and quality (Heerde et al., 2015). It should also be noted when exploring socioeconomic outcomes of CSA that, in some cases, CSA victims and survivors may be highly motivated to engage in work and achieve professionally as ways of coping and recovering from abuse (Fisher et al., 2017).

2.3.7 Religious and spiritual beliefs

The experience of CSA may be associated with increased disillusionment and confusion with religion and spiritual belief. Particularly in cases of institutional abuse perpetrated by church clergy, CSA victims and survivors can be deeply affected by "spiritual devastation" as they struggle to understand what has been done to them by someone considered to a representative of God (Fisher et al., 2017; Gall et al., 2007).

2.3.8 Re-victimisation

There is an emerging body of literature highlighting a link between CSA and later re-victimisation, such that those who have experienced CSA are at an increased risk of experiencing victimisation again in either childhood, adulthood or both. Victims of CSA may be more than four times more likely to experience sexual victimisation in adulthood compared to those without CSA histories (Trickett et al., 2011). A longitudinal study of female CSA victims and survivors found that, in addition to sexual re-victimisation, they were also twice as likely to experience physical abuse, with 53% of females with CSA histories reporting at least one incident of domestic violence, compared to 24 per cent for comparison females with no CSA histories (Trickett et al., 2011). Pathways to re-victimisation are complex, and likely involve other outcomes (such as PTSD, substance misuse, offending or low self-esteem) discussed above. Exploring the outcome of re-victimisation is further complicated by the experiences of perpetual or ongoing abuse, whereby the line between initial victimisation and subsequent victimisations can be blurred. In light of this, evidence suggests that re-victimisation should be viewed as a perpetual situation as opposed to an episodic occurrence, whereby CSA victims and survivors may find themselves at risk of experiencing repeated victimisations of various forms across their lifetimes.

Significant variation in outcomes associated with CSA are evident, both at the sub-group and individual level. Outcomes vary by life stage or developmental period, such that certain outcomes (e.g. conduct disorder, low educational attainment) are more relevant during childhood and adolescence, while others (e.g. physical disability, difficulties with sexual intimacy, employment problems) are problems emerging during adulthood. Some outcomes, particularly certain mental health problems (i.e. PTSD, anxiety) and vulnerability to re-victimisation, can emerge at any life stage (Fisher et al., 2017).

Evidence for gender differences in risk for certain outcomes was also suggested throughout the research, particularly for outcomes relating to mental health diagnoses, externalising behaviours and offending, intimate relationships and sexuality, and, unsurprisingly, outcomes relating to pregnancy and childbirth (Fisher et al., 2017). However, in many cases research on gender differences is contradictory, and a relative lack of research on populations of male victims and survivors limits any conclusions drawn.

2.3.9 Resilience and recovery

Resilience and recovery are terms used to describe the ways in which victims and survivors of CSA manage distress and achieve or maintain higher levels of functioning following abuse (Sneddon et al., 2016). Resilience refers to sustained healthy levels of functioning following trauma, while recovery is regarded as a gradual improvement in functioning following a period of considerable decline in wellbeing and functioning in the aftermath of trauma (Fisher et al., 2017). Risk and protective factors which may increase or reduce the likelihood of an individual experiencing recovery or resilience following CSA include: individual characteristics (e.g. beliefs, attitudes); abuse characteristics (e.g. age when abuse occurred; perpetrator identity); quality of the individual's relationships and immediate environment (e.g. attitudes of caregivers, reactions to disclosure); and the wider social and environmental context including experiences of external services such as healthcare or education (Mariott et al., 2014; Sneddon et al., 2016; Domhardt et al., 2015; Bick et al., 2014). Hobfoll and de Jong (2014)[49] talk about taking into account the potential for building environments that encourage and enable attachment:

> *"A place where the cognitive-emotional, brain and biological models of trauma and culture may meet is the transactional space between the self and the 'other'. That is, rather than seeing an individualised self, with a separate psyche and biology, we might construct an idea more closely related to the idea of a 'socially nested self', in a sense removing the border between the self and others. This kind of thinking is supported by attachment theory, which asserts and finds that those who have close historical attachments, mental models of attachment and actual attachments are more likely to be resilient and less likely to experience PTSD and other pathological responses to trauma (Ein-Dor, Dorin, Solomon, Mikulincer & Shaver, 2010)"*

Related to risk and protective factors are events, situations, or sensations that serve as triggers for CSA, which can evoke distressing memories and emotions for victims and survivors and negatively impact recovery or resilience (Allnock et al., 2015; Stewart et al., 2012). Triggers are often context and person-specific, but frequently referenced triggers include components such as: physical or sexual contact; situations in which an individual feels powerless or vulnerable; disclosing or recounting experiences of abuse; and sensory reminders (e.g. sights, smells, sounds) of CSA (Fisher et al., 2017). In line with this, certain situations have been highlighted as particularly triggering for victims and survivors, including medical and dental examinations, legal proceedings or any contact with the perpetrator, and

[49] Hobfoll S.E., de Jong T.V.M. *Sociocultural and Ecological Views of Trauma*. Eds. Zoellner L.A. & Feeny N.C. *Facilitating Resilience and Recovery Following Trauma.* (2014).The Guildford press. P84

therapy (Fisher et al., 2017). Childbirth and labour has been identified as a significant trigger for many female victims and survivors of CSA (Nelson, 2009). In response, many healthcare settings are developing plans and procedures in line with what is often referred to as 'Trauma-informed Care' in order to provide sensitive care by professionals that reduces distress or risk of victims and survivors being triggered or re-traumatized (Sweeney et al., 2016).

2.4 Theories supporting trauma-informed recovery

No better evidence-base for a trauma-informed recovery service could surely be drawn upon than the collective agreement on what works for trauma recovery from all the currently recognised and highly respected schools of philosophical and psychological thought. This, despite them espousing different concepts, language and historical/cultural traditions. Psychoanalysis, relational approaches and self-psychology, ecological and constructivist models are all outlined here, both to trace their commonalities and also to illustrate the depth and breadth of the empirical and theoretical contribution they collectively make to what works in helping a young person who has experienced trauma as a result of child sexual abuse and exploitation.

2.4.1 Classical psychoanalysis

Classical psychoanalysis is described here in order to illustrate the development of relationship-based perspectives. According to psychoanalytic 'drive theory' instincts drive all personality traits and behaviour. The practitioner's role is as a neutral facilitator of the individual's 'intra-personal' relationship. This is in contrast to the relational, inter-personal explanations for personality development and behaviour, with their focus on relationships between individuals and their 'inextricable participation in the social realm' (Mascialino, 2008 piv).

2.4.2 Relational psychoanalysis

A relationship-based perspective took shape from within psychoanalysis, in the early 20th century, based on a belief that Freudian theory underestimates the social and cultural impact on personality development and psychopathology. Greenberg & Mitchell (1983) described this approach (in the USA) as relational psychoanalysis.

Over the same period, in the UK, Melanie Klein developed 'object-relations' theory which argues that the emotional development of an infant (the subject) is always in relation to another person (the 'object'). Segalla (2007) describes key advances on this as being that a child's self-integrating task was relational (Fairbairn and Winnicott), and that the helping relationship is bi-directional (Lacan), including with positive regard (Loewald).

By the middle of last century the inter-personal nature of human personality development was accepted within the psychoanalytic establishment. Practitioners understood that a trusting relationship is needed for healthy personality development, they needed to make the connection that it could also be used to help when trauma precipitates the disintegration of the victim's personality (cohesive and continuous healthy self-concept), or elements thereof. Self-psychology made this connection.

2.4.3 Self-psychology

According to Banai (2005) 'self-psychology, developed by Heinz Kohut, has become widely accepted as one of the central psychoanalytic theories'. Banai summarises Kohut's position as follows: in self psychology, an integrated/cohesive self-structure is the outcome of normal

development for a person – comprising grandiosity[50], idealization[51] and the ability to form intimate relationships[52].

Before the turn of this century, relational psychoanalysts and self-psychologists had reached a common understanding that a trusting, inter-personal approach is the essential element needed to promote an individual's recovery from emotional and psychological harm. Two other very closely related schools of thought which came to the same conclusion over the same time period, are social constructionism and social constructivism.

2.4.4 Social constructionism and social constructivism

Social constructionism and social constructivism share a focus on 'meaning making' processes (McNamee, 2004). Constructionism is 'the process of understanding resulting from active, co-operative enterprise of persons *in relationship'* (Gergen, 1985). Whilst constructivism, based on 'personal construct psychology' (Kelly, 1955), explores how such inter-personal engagement (with people and their environment) contributes to the internal, cognitive processes by which individuals construe their worlds.

This means that each individual has a unique view of reality which can only be known by understanding the world from that person's perspective. Thus, for example, a practitioner wanting to help a young person who has experienced child sexual abuse and exploitation will need to develop a relationship with them in which the young person feels safe enough to describe the reality of their situation and their perspective on it. This then provides the basis on which the young person can construct or re-construct a positive identity and life trajectory.

2.4.5 Ecological approaches

Social constructionism recognises the relevance of social networks and the community, however young people's lived environment is not fully encompassed in that. And it is important because young people's lives are conducted in public and semi-public spaces – which have a profound influence on them. Ecological schools of thought answer this.

An ecological framework recognises a transactional relationship between the human condition and environmental conditions. Key characteristics of the approach described by Allen-Meares and Lane (1987) in Pardeck (2015) are the recognition of mutual inter-dependence between people, behaviours and the environment; the existence of continuous, interlocking systems and relationships between the three, and that behaviour is site specific.

Thus, Pardeck suggests that, from an ecological perspective a client's problems are not a result of individual pathology, but rather a product of a malfunctioning ecosystem. This would prompt, not only work with a young person, but also with the neighbourhood and community social and locational systems that facilitate (or hinder) their social functioning.

This is particularly important for young people because adolescence is recognised as the developmental stage when the focus of young people's identity-formation transfers from their families to their peer-groups, and their time becomes more concentrated outside of the family home. It is therefore not surprising that a range of social environments are associated with young people's experiences of child sexual abuse and exploitation – peer groups, schools, neighbourhoods and social media (Firmin, 2013, 2015); in addition to homes, have all been identified as contexts in which young people can encounter harm. Firmin (2015) calls for 'taking a 'contextual' approach to the phenomenon'.

[50] A sense of self-esteem, ambition and practical achievements

[51] A stable system of goals, ideals, and values

[52] A sense of belongingness and connectedness

In summary then, there is a consensus that a young person's emotional and psychological rehabilitation, relies not only on a trusting one-to-one relationship with the practitioner, but that the work they do must include addressing the young person's relationship with their environment.

2.4.6 Strengths-based practice

Implicit in the process of rehabilitation, then, is the identification of positive emergent self-constructs by the young person. Cowger (1994) and Kisthardt (2013) in Teater (2014) called this 'strengths-based practice'. Teater's description of the principles of strengths-based practice (Kisthardt, 2013) confirm the overlap and alignment not just with social constructivism, but with all the psychoanalytic theories outlined above. Included are – that the helping relationship is a collaborative process between the individual supported by a service and the person supporting them, allowing them to work together to determine an outcome that draws on the individual's strengths and assets. As such, it concerns itself principally with the quality of the relationship that develops between those providing and being supported, as well as the perspective and capacities that the person seeking support brings to the process (Duncan and Hubble, 2000). Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services (Morgan and Ziglio, 2007).

Rapp, Saleebey and Sullivan (2008) offer six standards for judging what constitutes a strengths-based approach. Practitioners may like to use the following list to consider their own practice. The standards include:

- The individual sets their own goals.
- Assessment is of the strengths/resources the individual has.
- The practitioner enables supportive links to resources in the environment (people, communities and services).
- Explicit methods are used for identifying client and environmental strengths for goal attainment.
- The relationship is hope-inducing, including through people, communities and culture.
- The individual is the expert in their own life and the practitioner collaborates to enable meaningful choice.

The strengths referred to in strengths-based practice are: 'the capacity to cope with difficulties, to maintain functioning in the face of stress, to bounce back in the face of significant trauma, to use external challenges as a stimulus for growth and to use social supports as a source of resilience' (Greene and Lee, 2002 in Teater (2014)). Sewell (2005) would see this as successful reconstruction or recovery; and the 'community' elements clearly resonate with the ecological model. Furthermore, the close relationship between a strengths-based approach and psychoanalysis is evident in this description of the same process by Howe (2005):

'Integration is probably the central process that enables self-regulation to occur. [ ] And with a self that feels more together and more under control, individuals begin to feel more connected to those around them. The more they can avail themselves of relationships, the more people feel they belong.'

A trusting relationship

A preliminary conclusion at this point therefore is that the key current psychological approaches to rehabilitation – relational psychoanalysis, self-psychology, social constructionism and social constructivism, all agree on the importance of a one-to-one relationship with a practitioner to help a young person recover from child sexual abuse and exploitation. Support for this comes from the American Psychological Association's meta-analyses to investigate the association between elements of the therapy relationship and treatment effectiveness, which concluded that:

> *'The relationship between the client and the clinician is a crucial, fundamental determinant of success.'* (Norcross, 2010).

The body of knowledge developed by the key current psychological approaches gave rise to a psychological 'perspective' (rather than a 'discipline'), based on t he single trusting relationship and drawing on a selection of their collective tenets – which has had a profound influence on social work practice[53]. That perspective is humanistic psychology.

2.4.7 Humanistic psychology

Humanistic psychology rose to prominence in the mid-20th century. It includes therapies such as, gestalt- , person-centred- (also known as 'client-centred' counselling), existential-, solution-focused brief-, therapies and transactional analysis. The major theorists considered to have prepared the ground are Otto Rank[54], Abraham Maslow[55], Carl Rogers[56] and Rollo May[57].

The humanistic psychology perspective is based on five core principles set out by Bugental (1964)[58] and refined by Greening[59]. They are that human beings:

- Are self-aware, including in relation to others.
- Are more than the sum of their parts.
- Exist within a unique human and environmental ecology.
- Can make choices and therefore have responsibility.
- Have intention and agency; seeking meaning, goals and value.

Humanistic therapy adopts an holistic approach, promotes building on strengths and encourages self-awareness. These are all aimed at assisting the individual to change their state of mind and behaviour from a sub-optimal set of reactions to a healthier one, with more productive self-awareness and t houghtful actions. Essentially, this approach allows the merging of mindfulness and behavioural therapy, with positive social support.

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[53] Payne, M. (2011). *Humanistic Social Work: Core Principles in Practice.* Chicago: Lyceum, Basingstoke, Palgrave Macmillan.
[54] Rank O. (1941) Beyond psychology. Dover Publications Inc. (1966)
[55] Maslow A. (1st ed, 1962; 2nd ed, 1968) *Toward a Psychology of Being.* Van Nostrand Reinhold
[56] Rogers, Carl. (1951). *Client-Centered Therapy: Its Current Practice, Implications and Theory*. London: Constable.
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[58] Bugental J.F.T. (1964) *The Third Force in Psychology*. Journal of Humanistic Psychology 4 (1): 19-25.
[59] Greening T. (2006). *Five basic postulates of humanistic psychology*. Journal of Humanistic Psychology, 46(3), 239-239.

Humanistic therapies seek to help individuals recognise their strengths, creativity and choice in the 'here and now'. Gestalt (roughly translated to mean 'whole') therapy, focuses on the whole of an individual's experience, including their thoughts, feelings and actions. Person-centred therapy starts from the premise that being valued as a person, without being judged, can help an individual to accept who they are and reconnect with themselves. The individual is encouraged to uncover their own strengths and resources. Solution-focused therapy aims to promote orientation towards personal goals and thereby stimulate a desire to change. Transactional analysis attempts to identify how individuals communicate, and how this can be changed.

The humanistic perspective developed largely in the USA, however there was a parallel approach developing only slightly later in Europe called 'social pedagogy'.

2.4.8 Social pedagogy

Social pedagogy was first named in Germany in 1844, by Karl Mager, as the 'theory of the personal, social and moral education in a given society, including the description of what has happened in practice' (Winkler 1988 as translated by Gabriel Thomas; in Cameron & Moss 2011). There are variations – both theoretical and national – in understandings of social pedagogy and how to practice it. However, Cameron and Moss (2011) identify a core set of elements of pedagogic practice with children and young people. These include the practitioner:

- Focusing on the child as a whole person and supporting the child's overall development.
- Using his/her 'self' in relationship with the child or young person.
- Inhabiting the same life-space as the child, not as existing in separate hierarchical domains.
- Constantly reflecting on their practice and to apply both theoretical understandings and self-knowledge to the sometimes challenging demands with which they are confronted.
- Being practical, undertaking activities with the young person as part of the young person's daily life.
- Incorporating the young person's associative life.
- Working from the basis of children's rights that is not limited to procedural matters, legislated (or regulated, outcomes related) requirements.
- Emphasising team work and valuing the contributions of others in 'bringing' up children: other professionals, members of the local community and especially parents.
- Focusing on the relationship, listening and communicating (Petrie et al, 2006; see also Social Education Trust, 2001).

From this it is clear that social pedagogy is fundamentally relationship-centred and focused on the 'self' of the child or young person, rather than on external aims (Lockenvitz, undated in Cameron, Moss, 2011). It depends on the development of trust between the practitioner and the young person. Trust can only be nurtured gradually and carefully, building strong relationships, it takes time and is bi-directional. Many studies of traumatized children find

that they have difficulty negotiating relationships – with caregivers, peers and subsequently, marital partners (Finkelhor, Hotaling, Lewis, & Smith, 1989; Schneider Rosen & Cicchetti, 1984). Offering the opportunity to engage in a pedagogic relationship to a traumatised child or young person provides him or her with an opportunity to practice building/re-building a positive relationship. Critically, too, 'placing trust in children, in their competence and responsibility, can be an empowering experience for them' (Cameron, Moss, 2011).

Systemic & supervisory support

Nohl (1970), in Cameron and Moss, describes the relationship as being underpinned by a particular *Haltung*[60] that includes an emotional connection with the child or young person at the heart. Thus the professional element to the relationship requires the practitioner to judiciously use his/her authentic, personal life experience – this requires him/her to have good supervisory support. Social psychoanalysis describes the necessary framework for this as follows:

> *'The traditional health and welfare organisation was intended to operate as the primary container for the complex, risky and emotionally demanding exchange process between practitioners and local populations that is the heart of welfare activity. Patients and clients sought, and expected to find, a* dependable relationship with these organisations*, and the organisation in its turn expected to provide this.'*
>
> *Cooper and Lousada (2005)*

However, Cooper and Lousada comment that as welfare organisational life is now configured and experienced, there is frequently no longer a structure of 'parenting', either for organisations or for those working within them, that can sustain a supportive, containing relationship – for the practitioner or for the service user. This stems from the shift over the past twenty years to 'pseudo-'market structures and the economistic priorities of efficiency, effectiveness and economy, target driven processes and outcome measurement in public service organisations (Froggett, 2014). As part of these new flexible structures the welfare task has been dispersed to multi-professional project networks, and professional expertise has been re-sited away from the individual practitioner and her expertise, in the direction of the team, network or project group and its 'skill-mix'. Following from this regulation, audit and outcome measurement have been introduced to 'hold the team, network or project group or multi-agency partnership to account'.

Practical application

Encompassing as they do, the body of knowledge developed by the key current psychological models, together the ecological schools of thought and the social pedagogy and humanistic approaches, will be seen to form the practice framework for the fieldwork for this Project, in section 3 Fieldwork, below.

[60] 'Haltung' can be translated as incorporating the practitioner's use of their 'self' together with an orientation to the young person's experience and perspective, providing the necessary integrity for a close and authentic relationship (Smith M. (unknown).

Project findings

3. Fieldwork

3.1 Introduction

The evidence and theoretical perspective presented by the Rapid literature review in section 2 provides clarity about what is understood by trauma. The literature also suggests that central to recovery from trauma is a trusting (and containing) one-to-one relationship. Also that a pedagogic and strengths-based approach is most likely to support recovery for an individual who has experienced trauma, in this case, from sexual abuse and exploitation. There is a recognition, also, that for a pedagogic and strengths-based approach to be effective there needs to be systemic and supervisory support for the frontline practitioners delivering the recovery support.

The fieldwork for this Project sought to understand:

a) The extent to which a pedagogic and strengths-based service can be delivered in the current local service commissioning environment

b) Whether sufficient support can be made available for frontline practitioners to deliver a pedagogic and strengths-based service

c) Whether a currently delivered pedagogic and strengths-based service can be 'successful' in helping young people to recover

d) What the elements of a pedagogic and strengths-based service look like – such that they could be identified within existing services and/or introduced into existing services, to meet the needs of young people across the country.

In order to undertake the fieldwork, exploring points a) to d) above, child sexual abuse and exploitation support services were identified which aimed to offer pedagogic and strengths-based support for young people following child sexual abuse and exploitation. Some of the services chosen were delivered by statutory services and others were provided by a voluntary sector and community organisation, commissioned by, and delivering support in collaboration with, statutory services.

The following criteria were used for judging whether the service is pedagogic:

- The young person trusts their keyworker
- The keywork support is young person-centred
- The keywork support addresses the whole-child's needs
- The keywork practitioner gives of themself.

The service and commissioning structure supports practitioners to give of themselves; providing support by:

- Offering practitioners space for reflective practice
- Providing managerial and team support

- Allowing enough time for individual contact and overall progress
- Making appropriate practice tools available
- Addressing the environmental influences on young people's lives
- Promoting flexible, multi-agency joint-working
- Developing and maintaining effective care pathways.

The following criteria were used for judging whether the service is strengths-based:

- The young person and the keyworker have been working on the young person's personal qualities and skills.

Also providing evidence of progress towards recovery are the fact that support is young person-centred, that the young people are working towards their own goals (see subsection 2.4.5 Strengths-based practice); and that they can name their own strengths.

The following criteria were used for judging whether the service is successful:

- The young person's view of their keyworker was exceptionally positive (a good relationship modelled so that in the future the young person can recognise/develop good relationships and has confidence to reach out for help)
- The young person and keyworker both thought the young person had made progress
- The young person was able to name their strengths
- The young person had realistic health/wellbeing and achievement goals and was actively pursuing them.

The four criteria listed here were identified as providing evidence of the development of 'autonomy' as one of the two principle elements to trauma recovery. Also providing evidence of progress towards recovery are the ability to enter into mutual support and a sense of safety (with others and the environment) which provide a sense of empowerment – the second principle element to trauma recovery (see 'Recovery' in subsection 1.4.1 Terms). Taken all together these criteria have been used to measure the success of the service.

The information needed to understand the degree to which the above criteria were met was gathered through interviews with the young people, their keyworkers and the service managers/commissioners and from a survey of the young people's social workers.

Presentation of the young people's views

The questions asked of the young people are presented in the blue-shaded boxes in subsection 3.2, below.

Fourteen of the 15 young people who participated in the Project, were receiving, or had very recently been receiving, a service from the currently commissioned organisation, delivering a pedagogic and strengths-based service for young people following child sexual abuse and exploitation. These young people's responses inform the findings in the rest of this section 3.

The responses from the young person who had not received a pedagogic and strengths-based service are set out in section 3.4.3 Young person who received an alternative service, below. The information is sourced from only one individual, nevertheless, the young person's experience provides an important contrast to the experiences of the 14 other young people.

Presentation of the practitioners' and managers/commissioners' views

The questions asked of the keyworkers, managers and commissioners are presented here rather than in subsection 3.2, below, because they are generally applicable to issues throughout the subsection.

The findings in section 3 are also informed by the views of the keyworkers and social workers for all fifteen of the young people who participated in the Project; and the responses from the managers/commissioners of the service. In order to establish whether the service is pedagogic and strengths-based:

- The keyworkers and social workers were asked the describe:
    - their view of a pedagogic/relationship-centred way of working and how effective it might be
    - whether they were working in a strengths-based way and how effective it was, or they thought it might be
    - their experience of tensions between a pedagogic approach and a need for services to be commissioned and to perform to clearly defined performance targets.
- And, the managers and commissioners were asked to describe:
    - what services/care pathways are commissioned/available locally for young people who experience child sexual abuse and exploitation
    - whether the young people's keyworkers and social workers are happy and thriving in post. Also whether the managers felt able to support these staff
    - their view of the young people's associative life in terms of its influence on the young people's experience of abuse; and whether the managers/commissioners had opportunities to influence the environment
    - the state of multi-agency working locally.

3.2 A pedagogic service

3.2.1 The young person trusts their keyworker

In order to establish whether a trusting relationship had developed, the young people were asked whether:

- They had the same keyworker throughout the current episode of support they had been receiving

- The keyworker did what she said she would do
- They met frequently with their keyworker (preferably at least once a week)
- The young person felt that the keyworker respected his/her views
- The keyworker negotiated with the young person or told them what to do.

3.2.1.1 Young people's and keyworkers' responses

The young people's responses to these questions are summarised in Table 3.2.1. All (100%) of the young people had the same keyworker during the full period during which they received support following child sexual abuse and exploitation. All (100%) of the young people described a quality of support which allowed for the development of a positive, trusting relationship between the young person and their keyworker. This was because the young person could rely on the keyworker to do what she said she would; to respect the young person's views and wishes and to negotiate ways forward, particularly on issues which the young person found difficult, rather than telling or advising the young person what to do or how to think.

All of the young people met with their keyworker once a week at the beginning of the period in which they were receiving support. Most (71%) of the young people continued to meet with their keyworker once a week throughout the period in which they were receiving support, although two of these young people said that they would like to meet their keyworker more frequently. At the time that three of the young people were interviewed the frequency of their meetings had lessened to fortnightly. For two of the young people this was sufficient, a third said that she would like to increase the frequency again and see her keyworker once a week.

Table 3.2.1 Trusting relationship

	Number of keyworkers in current support period	Keyworker does what she says she will	Frequency of meetings			Keyworker respects young person	Keyworker negotiates with young person
	One keyworker	Keyworker is reliable	Once a week	Fortnightly	Want more	Yes consistently	Yes consistently
Total	14	14	10	3	3	14	14
Total %	100%	100%	71%	21%	21%	100%	100%

Number of keyworkers in current support period

Having had the same keyworker throughout the current episode of support, one of the young people described her keyworker as, *"Someone who I've spent time with, so I feel comfortable talking to her."* She continued that, *"It's not a problem having additional people*

as long as I have one proper keyworker, the one person I talk to and who I know I can ask to help me."

Other young people contrasted having one keyworker throughout, with their experience of receiving support from social workers,

> *"I have a social worker but she sees me and my brother, so it's not the same. She's not 'there for me', she's for my family."*

and,

> *"In three years I have had 2 social workers. I don't know why the first one went, they just stopped seeing me and I was told I have to have a different social worker."* After that she made a decision not to talk to 'them' anymore, saying *"What's the point, you don't know when they are going to go off and leave you?"*

Keyworker does what she says she will

The young people described their keyworkers following through on commitments in relation to tasks, activities and advocacy.

> *"My keyworker always does what she says she will do. She also always gets back to me if I call or text, I'm confident that my keyworker would not forget or leave me."*

They also talked about how the keyworkers fulfilled their commitment of support through the quality of the relationship they established:

> *"Yeah, when you are getting to point where you can talk to someone and can be open with them, they need to be able to just listen. If they don't listen or they don't remember, is there any point in even talking! That's how I am with my social worker actually. I won't say anything as what's the point in me saying anything if they can't remember. 'You will write down in the notes once and you clearly don't refer back to them when you are about to come around', so there's no point."*

and,

> *"She has got a really good memory. For instance at one point I was getting followed by my ex's family, the one who is in prison and she remembered the exact time and everything, compared to the police who ask you about a million times or my social worker will ask you a million times."*

Frequency of meetings

Most of the young people who met with their keyworker once a week were happy. All of the young people who met with their keyworker less frequently wanted more face-to-face contact.

> *"I see my keyworker every two weeks and that is not enough. I would like to see her every week. I would have liked to see her once a week like in the beginning."*

and,

> *"So much happens in two weeks you can't talk about it by the time you get to see her again. I'm never dealing with just one problem at once. Then when I do see her*

there is only time to deal with one thing. It would be better to be able to talk about things in 'bite-size' way."

and,

"I used to see my keyworker fortnightly, now it has gone down to maybe once in 3 weeks or a month. I don't understand why this has happened. It might be because of the court case and court coming up. Maybe they don't trust her not to influence me. I would have liked to see my keyworker every week especially at the beginning when I really needed her."

Keyworker respects young person

The young people felt respected when they were listened to,

"She's always listened to me. The reason I know that is sometimes she repeats what I have said and if I say something to her she'll start speaking about it as well. We are quite close."

and,

"I am comfortable to talk to my keyworker because she doesn't interrupt."

In contrast to this, the young people recounted their experience of being interrupted, not being listened to or receiving a negative response by a professional when they have tried to say how it is or was for them, or to describe what had happened:

"I've had a lot of experience of social workers and other professionals! Most of them interrupt you with their story, what they think and what they want you to do. They interrupt before you have finished saying everything you want to say. My keyworker doesn't interrupt me, she listens to the end, she lets me say it all, everything I want to say."

and,

"I would trust my keyworker with anything, Some people don't talk to you with respect. They talk with attitude. They will get a negative response from a young person. They interrupt all the time and they don't listen to what you say. More people should respect you and listen to you."

and,

"Because my keyworker is more understanding about it. In the sense that she doesn't just say, 'Oh but that's bad', she doesn't talk over you, she lets you finish. My social worker always used to speak over me when I was trying to talk and the counsellor – I didn't really like her and I don't know why, I just didn't like her at all."

One of the young people spoke for the others when she explained that she did not feel that her keyworker had her own or another agenda which took precedence in their discussions:

"Sometimes I have things I want to talk about and sometimes my keyworker has things she wants to talk about. We have to discuss.

and,

"She would never push me to say or do anything to fit in with my mum or someone else. No. She is very good with me and that's why I like speaking with her. She'll listen and it's nice to have someone who doesn't answer you back, she just listens to everything."

Some young people also offered examples of where their keyworker had accepted a refusal of their offer of help and had supported the young person in their choice to try to manage on their own,

"My keyworker wanted to take me places, like to do sport and things. She wanted to take me to the sexual health clinic three times. But I'm independent. I wanted to go on my own – and she supported me to do that."

Keyworker negotiates with young person

The young people were very happy with the quality of the conversations or discussions they entered into with their keyworkers as the young people tried to manage their lives. Most of them commented on the difference between this 'respectful' communication and that which they entered into with other professionals; and some within their families.

"We have a little bit of a debate. It's not like I'm trying to talk to somebody who is trying to undermine me."

and,

"My keyworker won't tell me what to do but she'll sort of give me advice, not tell me what to do, but ask me I how feel about it. If it's the wrong thing, she'll say to me, 'Are you sure that's the right thing to do because you've got to think about the consequences after it?'

and,

"My keyworker gives me advice, but only once she has listened to me; once she's understood the situation fully. She doesn't tell me, she makes suggestions which help me to understand what I am going through. She helps me see things from a different angle and I can say 'no'."

and,

"I used to go to a shop and buy alcohol and go out with my friends and just sit in central London somewhere and drink and then….. I ended up in hospital so many times. My keyworker would talk to me and I'd be like, 'Yeah, I know what I did was stupid, but you know what I'm like when I'm in this mind set'. She just kept talking to me the right way and in the end I stopped. She knew me well."

When asked about a trusting relationship, all the keyworkers said that their work required a relationship with the young person which was based on *"mutual respect and trusting".* To the keyworkers and their managers, respect and trust were more than an empty form of words and the keyworkers gave animated descriptions of what this meant in detail.

"So, almost the first steps are just modelling that really trusted honest relationship. Without that it's impossible to even do this work."

A keyworker described trust as *"something that must be built".* All the keyworkers gave examples of attitudes, forms of words and exercises which they used to build trust with their young person. Being transparent about the boundaries of confidentiality was important:

> *"I always say to them, "I'm Janine[61] and I'll tell you everything I do … if you tell me that you know where a gun is or something about you or another young person being unsafe. I have to say. And it's actually good because there have been times where I've had to tell their mum something, or tell their teacher and I think when you build up that level of trust, they know that if you are doing it, you are doing it for their own good and they understand."*

Another keyworker spoke about the trust extending to the young person's family:

> *"Obviously, I have built a relationship with her where I could talk in that way with her and the family as well."*
>
> *"The most important part of our work is developing that relationship with the young person. I think that's fundamental, without that the young person is not going to open up to you, they are not going to trust you."*
>
> *"I just have been there consistently. That's helped a lot. Just letting her know that I'm not going anywhere, reassuring her…"*
>
> *"Obviously, I have built a relationship with her where I could talk in that way with her and the family as well."*
>
> *"Most of these young people do not need CAMHS – they need a trusted, supportive relationship."*

Shame

The factor which differentiates the trauma of child sexual abuse and exploitation from other traumas, is the degree of shame the victim experiences in relation to the abuse. It is possible that individuals believe on some deep level that they have let themselves (and possibly others) down and/or that there is something fundamentally wrong with them that they became victim to the abuse. For young people who have experienced child sexual abuse and exploitation recovery is critically dependent on the young person being able to process that shame. Rothschild (2004)[62] describes:

> *'One of the difficulties with shame is that it does not seem to be expressed and released in the same way as other feelings. Sadness and grief are released through crying, anger through shouting and 'stomping about', and fear through screaming and shaking. Shame does not discharge. However, it does seem to dissipate under very, special circumstances – the non-judgemental, accepting contact of another human being.'*[63]

3.2.2 The keywork support is young person-centred

3.2.2.1 Young people's and keyworkers' responses

[61] Pseudonym
[62] Rothschild B. *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*.(2004). Norton & Co.
[63] Ibid. P62

Contact, case length and agendas/disagreements

The young people's responses to questions about Contact, case length and agendas/disagreements are summarised in Table 3.2.2 a) Young person-centred relationship.

Table 3.2.2 a) Young person-centred relationship

	Talk when issue is burning	Support period long enough			Contact at right time		Young person sets the agenda	What happens when you disagree	
	Talk	Open - still need her	Closed - right time	Closed - not long enough	Right time	No	Important to you	Disagree - talk it through	Never disagree
Total	13	8	2	2	12.5	1.5	14	6	8
Total %	93%	57%	14%	14%	89%	11%	100%	43%	57%
Young person happy	100%*	71%**						100%***	

* One young person said: *"Sometimes it is right and sometimes it is too late, but so much happens in two weeks you can't talk about it by the time you get to see her."* ; and another young person said, *"I'm never dealing with just one problem at once. Then when I do see her there is only time to deal with one thing."*

** Young people were happy either that their case was still open – because they still needed support from their keyworker or that it was closed at the right time.

*** Young people were happy either that when they had disagreed with their keyworker the two of them had been able to talk it through amicably or that they had not had a disagreement with their keyworker. The young people's perceptions that there had been no disagreements appears to reflect the fact that when there was a conflict of opinion the keyworkers were skilled in getting the young people to explore their options and reframe their thinking rather than taking an overtly oppositional stance to the young person's stated aim or recent or intended actions.

Talk when issue is burning

The majority of the young people were able to talk to their keyworker in time to receive the support and/or advice needed in order to manage or respond appropriately to an issue that had arisen for them. This responsiveness appeared to be important not only in the pragmatic sense of assisting the young person to manage their day-to-day life, but also as a means of building the young person's self-esteem. The young people felt valued by the keyworker's quick responses, and the fact that this was consistent was important in building trust.

> *"Sometimes K4 was in a meeting, but she gets back to me that same day. It is important to me that she gets back to me the same day. She always does."*

Communicating between face-to-face sessions was important, as was the flexibility to fit in additional meetings:

> *"There are times when I want to see her more because obviously one day for one hour isn't sometimes enough, depending on what's been happening that week. If I texted her she would give me another meeting."*

One of the young people described very clearly why she needed flexibility in how and when she could communicate with her keyworker:

> *"I just can't get past the 'I'm unlovable' sort of thing. So when I am going through a rough patch, it's hard to see my keyworker when I would like to; but she's always available when I want to text her, sometimes you need that face-to-face sort of thing. I know that I'm going to be doing this or that during the week. But the weekend is the worst time for me because I'm alone, it gives me time to think and be with my thoughts. I don't have no-one, and in those hours my keyworker isn't working, so I can't get in touch with anybody that can help me. That's difficult".*

Support period long enough

Two of the young people whose cases had recently closed were happy that the period of time over which they had received keywork support had been sufficient. However, for two, the period of support had not been long enough. The majority of young people were still receiving support from their keyworker and wanted this to continue. These young people were anxious that the support would be withdrawn before they were ready to move on and cope on their own.

> *"I have had her for a long time, almost eight months, quite a long time, but not long enough, I have received contact at the right time I can text her and if I need anything, she'll contact me, it will happen."*
>
> and,
>
> *"I know that there's somebody to talk to now but when I turn 18, I still will need somebody to talk to and I know there's not going to be a lot of people around for me. My keyworker is somebody that I actually need to talk to."*
>
> and,
>
> *"It will be very hard when I can't see my keyworker after I'm 18, because everybody creates attachments to people, whether you like it or not, it's a normal thing for a human being to do. If you see somebody regularly enough, you create a bond. So*

for that to be broken off just because I'm 18, it's like…. 'Do they actually care?' It's like, "Oh yes, give me a time schedule! You don't feel better after a year, especially after you've gone through torment and a rough history, that's just hard, especially with me as I've been living with so many different people throughout my life. I've never ever had consistency. It feels like it'll be broken off again".

One of the young people put it this way:

"People who are a bit more vulnerable than me, maybe if they are suicidal or something they shouldn't be moved over to an adult they should be kept in the same one."

Contact at the right time

As well as being asked whether they were able to initiate contact to suit their needs, the young people were asked whether the contact arrangements set by their keyworkers worked well for them. Some young people talked about wanting to make sure the session with their keyworker did not have a disruptive impact on other commitments they might have. In all cases the other commitments were school and after-school jobs:

"I meet with my keyworker usually once a week, I don't want to miss lessons at school because I'm doing my A levels, because if I miss one lesson I'll end up being a million miles behind everyone which confuses me."

In terms of the content of communications with their keyworker, as with the young people's comments about being able to talk 'when the issue is burning' for them; they felt that the timing of contact was right:

"I have contact at the right time and my keyworker will always get back to me if I call or text, I'm confident that my keyworker would not forget or leave me."

and,

"I can call her because she gave me a mobile 'phone. She doesn't push me so I don't feel I have to talk about something if I am not ready to talk about."

A young person described a situation when she had been helped by her keyworker despite not wanting the contact and support:

"There was one session when I was self-harming at school and I said 'I don't want to see her, I don't like her' and I started shouting and my teachers told me to go outside and I was so angry and said 'No'. Eventually she came and she managed to calm me down and I was like….how did you do that?"

Young person sets the agenda

All (100%) of the young people said that the sessions with their keyworker were driven by their own agenda, rather than another agenda, such as that of the keyworker, their social worker if they had one or their parents/family.

Intrinsic to abuse and exploitation is the experience by the victim of being 'done to', with no account being taken of their wishes or wellbeing. This makes it critical for recovery that the young people's voices are heard and their wishes taken into account. In terms of the pedagogic approach this involves 'inhabiting the same life-space as the child, not as existing in separate hierarchical domains'. The young people described this:

"It always starts by listening to what is going on for me. Only after we have talked about that does she say if there is something she thinks is important. Mostly the issues are ones I already know about. And we discuss them."

and,

"When I first started seeing my keyworker I thought she did it because she was told to, but eventually I changed my mind. She does it because she wants to. She isn't coming in saying 'The social worker wants this or I think you should do this'."

and,

"My keyworker listens to me and respects me completely, we negotiate. She listens and then gives advice and she doesn't tell me what to do. When I have said and she has said, then we discuss it."

One young person described how her keyworker managed the tensions between the young person's desire to be independent and learn through her own experience, and acting to ensure that the young person was safe. It is interesting to note that the relationship between the two was sufficiently trusting for the young person to accept that the keyworker might break a confidence in order to keep her safe.

"It might sound crazy but if you go out and do stuff you learn what to do and what not to do. Sometimes you turn up somewhere and you wish you hadn't. You've got to live with what you've done basically. She said what she thought, but she respected my decisions, if they were too way out she told my mum…"

Another young person spoke for the majority in describing how misunderstood she felt by other professionals: *"Whatever I said to them they found a way to twist it to make it suit their agenda, if that makes sense?"* She said that she was upset at being labelled as *"having mental issues – like I was depressed and stuff like that. They didn't realise that I am just going through something and my past doesn't actually mean that I'm still there."*

What happens when you disagree

What happened when the young person and the keyworker disagreed was explored, as a measure of the quality of their relationship. The young people all described a relationship which was good enough to 'contain' disagreement.

"She always respects my view; if we disagree she respects me. She listens and tells me what she thinks – after I have finished. I think about what she says, but I don't have to agree."

and,

"My keyworker asks my opinion, then she says whether she thinks I'm right or not, and then we discuss it. If we still disagree then she doesn't tell me what to do or think. We just agree to differ."

Some young people did not recognize the exchange of views with her keyworker as 'disagreement':

"I want to know what she thinks. It doesn't matter what it is, I listen to my keyworker because she is a friend, I trust her. She helps me with a lot of things – we haven't disagreed."

and,

> *"I say how I feel about it and my keyworker says how she feels about it. It's all quite personal to me. The way I've been brought up I don't see something as a threat, because I'm used to it. So she'll just talk me through it to keep me safe."*

The young people were struggling to varying degrees with managing their emotions and not having had the opportunity to learn good conflict management within their family and social networks. This formed part of the modelling of a good relationship which the pedagogic approach promotes:

> *"My keyworker doesn't get into me about the important things, but she explains in a calm voice and she listens to me. That is negotiating, isn't it?"*

Being able to negotiate appropriately is a core life skill.

A keyworker commented:

> *"So it's not always appropriate when a young person's got lots going on in their lives, to say, 'Oh come on, let's do this activity about staying safe online' because sometimes young people just want to offload and I do feel there are some pressures in terms of getting that young person from A to B when sometimes that young person just wants to talk. I feel like you need an outcome or I feel like you need to tick a box, and I find that then takes away the emphasis of actually just listening to that young person, and understanding where they are coming from. Or just finding out a bit more about them."*

Rothschild (2004)[64] agrees that directed activity is not always appropriate or necessary for recovery:

> *"There is a large number of trauma clients for whom developing safety within the therapeutic relationship will take a very long time. In some cases working on feeling secure in the relationship may be a large proportion of the 'therapy', pushing direct work with the trauma to the sidelines."*

Another keyworker spoke about taking time to get to know their young person:

> *"I think I learn a lot from young people and each of them is an individual. I suppose it's about talking to the young person getting to know what their experience has been and understanding what life's like for them…"*

All (100%) of the young people said that they had either never had a disagreement with their keyworker, or that when they had disagreed about an issue or proposed action, they and their keyworker had talked it through and reached an amicable solution about how to respond or proceed.

Almost all the young people (93%) said that their relationship with their keyworker was sufficiently good for them to raise personal concerns, anxieties and experiences with the keyworker at the time. The two young people who gave a qualified response explained it as follows:

[64] Rothschild B. *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment* (2004). Norton & Co.

"Sometimes the time is right and sometimes it is too late. But so much happens in two weeks you can't talk about it by the time you get to see her. I'm never dealing with just one problem at once. Then when I do see her there is only time to deal with one thing."

In view of the fact that the experience of trauma can reduce an individual's ability to manage their emotions and make sound judgements, the young people were asked whether they were able to 'check in' with their keyworker about day-to-day challenges when they needed to. Many of them (89%) said that they were able to talk to their keyworker as needed. This took the form of the young person texting their keyworker between planned weekly sessions and the keyworker telephoning the young person in response, and where needed arranging to meet with the young person. These meetings usually took place within a day of the text. One young person felt that there had been occasions when she would have liked a more immediate response from her keyworker.

Almost two-thirds of the young people thought that the length of time that they had been receiving or had received support was right. In coming to this conclusion those whose cases were ongoing took into account how long they thought they would continue to receive support.

The keyworkers talked about the need to be flexible with case lengths because the young people usually have a range of adversities which contribute to their vulnerability to child sexual exploitation. These adversities need addressing as part of the recovery process, to avoid the young person remaining vulnerable and being re-victimised:

"I'd say in the majority of our cases it's never just child sexual exploitation. It's not a case of thinking 'Right, I've got six sessions with this young person and I can deliver healthy relationships, online safety, risk taking behaviour etc.' Because there'll be other things going on in the young person's life which will then come up as you get to know them. Such as violence at home or parental mental health concerns…"

Two young people (14%) whose cases had just been closed thought that they still needed the support their keyworker had been providing. In both cases the closure was due to the young person turning 18 years old. Case closure when the young person still needed support was something the keyworkers also struggled with:

"I find it difficult to say, "Right, been really nice working with you." Particularly when there's still so much going on for this young person, to say, 'I've got to close your case now.' I really struggle with that."

One of the keyworkers talked about having come from a youth work background and described running a 'drop-in', which meant that *"the door was always left open and once you built up that relationship, they would keep coming back."* She said that from her youth work experience she knew that:

"It helps a lot of young people knowing they have a bit of help and support when they needed it. They might not come for six months but they will come when they need to. But it doesn't work like that in this instance."

Assessing needs, safety and progress

The young people's responses to questions about assessing their needs, assessing their safety and measuring their progress are summarised in Table 3.2.2 b) Young person-centred relationship.

Table 3.2.2 b) Young person-centred relationship

	Young person is involved in their own assessment			Young person is involved in ongoing assessment of their own safety		Who decides whether the young person has made progress	
	Young person involved	Young person can't remember	Young person not involved	Young person involved	Young person not involved	Young person decides	Both young person & keyworker
Total	10	1	3	12	2	12	2
Total %	71%	7%	21%	86%	14%	86%	14%
Young person happy	100%			100%		100%	

Young person is involved in their own assessment

All (100%) of the young people said that they were happy with their involvement in their own assessment and in the ongoing assessment of their safety, and also with who decided how much progress they had made or were making in their 'recovery'. Within this, however, in relation to assessment of the young person's needs at the beginning of the support period, one young person (7%) could not remember whether or not she had been involved and three young people (21%) said that they had not been involved. Two of these young people reflected that they would have resisted involvement had they been invited to participate.

Where the young people provided more detail, they described assessments which included their associative life:

> *"We talked about everything in my life and what the problems are and what needs to happen. Not like, with a pen and paper, not in a formal way, like completing a form. Then we agreed what to work on. We talk about everything in my life."*

"We talked about it and then we agreed what I need. My keyworker is looking out for me so I listen to her and take it on board even if I don't always do it like we agreed. It's difficult, but I try."

One young woman described asking for – and receiving – counselling. However, she also talked about it not meeting her needs because the focus was too narrow:

"I asked for 'proper counselling' because I've got depression and was self-harming but the counsellor just focussed on the self-harming on its own and only to make me safe. I was happier with my key worker's support cos we talked about family and other issues, like school and friends and decisions about me being safe safety in everything are joint decisions that we make together."

One young woman could not recall the details of her keyworker completing her initial assessment with her. She described well her view that assessments should be undertaken jointly with the young person:

I know my keyworker has done assessment with me, but I can't really recall. I would always prefer it if someone would do it with me because obviously it is about me so I kind of want to know, I think so but I don't think she did it all with me, I think she also did it with a social worker."

Another young person compared her keyworker's approach and that of other professionals. The difference was in the identifying and tackling of issues within a relationship in which the young person is accorded both respect and responsibility:

"It's more like I'm just trying to get away from it and I'm trying to build myself and sometimes I get stopped by their reports of the past. My keyworker realises that it's just me needing to find a new way to make myself well. She doesn't immediately go into 'Oh, you've got a mental health problem' – because that diagnosis makes me feel worse in myself. She doesn't treat me like I'm an 8 year project!"

One of the young people's keyworkers described the beginning of their relationship as follows:

"When she began working with me there was that kind of initial reluctant stage where she didn't really want a social worker involved. She's got frustrated that she has seen a lot of professionals over the last ...however many years, and it's the whole thing about repeating the story. I've tried to minimise that as much as I can."

Young person is involved in ongoing assessment of their own safety

The majority of young people said that they were involved in an ongoing assessment of their own safety.

"When the social worker and everyone and my keyworker did the assessment, I had the final say – with my keyworker – about how safe I am. After that we always talked about what I was doing and if I was safe"

and,

"My keyworker never tells me what to do to be safe. She doesn't force me to do anything, none of that, she goes – 'whatever's best for you…' sometimes what she thinks is best is different to what I think but we talk about it and she will explain the thinking behind her position. She gives a big explanation and sometimes she's right. I think she does want what's best for me, not in a stupid adult way."

One of the young people described how she learned through the collaborative process with her keyworker of assessing and managing her safety:

"Before I didn't feel safe in the sense that I used to be really sad and I used to self-harm. My keyworker helped me figure out what was causing this, and she gave me options. We have done loads of work together to find out, relationship work, she started off with basic work just to try and get insight to what it was. Once she found out she suggested to me what it could be and it actually was that and I was shocked."

Who decides whether the young person has made progress

In relation to their own progress – described by all the young people in terms of 'distance travelled' since they had started receiving support from their keyworker – twelve of the young people (86%) were clear that they knew how much progress they had made. Some of them asserted this confidently:

"I know how much progress I've made better than anyone else. Who decides on progress? … Me. It's all down to 'how do you feel?' That's the key question. How do you feel?"

and,

"I make the decision about how much progress I am making. How do I know I'm doing well and everything that I'm supposed to do? I know because I am doing some of the things we agreed."

Others realized, in the process of answering the question that they knew what progress they had made:

"I don't really know. We just sit there and talk about loads of things. About me not staying out, and not smoking and stopping seeing some boys. And I have to stay off Facebook… I suppose I am not doing these things – so that's progress."

Two young people described coming to a judgement about their own progress together with their keyworker.

"I don't realise the progress I've made, but I know I've made progress. When I was angry I used to be really bad. I had anger, that's the reason I've got people worrying about me because they think I have anger problems."

and,

"Both me and my keyworker decide about my progress we discuss how I am doing and we both decide if I am making progress."

All the young people talked about their struggles with low self-esteem and negative self-talk. They described how their keyworkers continually identified and highlighted their good qualities, abilities and successes in the recovery journey. The difference in their responses appeared therefore to be more about two of the young people acknowledging their keyworkers' input and the other young people reflecting that they are able to judge the quality of the service they were receiving.

The young people talked about how much progress they had made since the beginning of the support they had received form their keyworker. The concept of 'starting from where the client is' originates in humanistic counselling[65]. The keyworkers clearly aimed to start from where the young person was, based on the young person's relationships, concerns and circumstances. Progress measured from there was therefore individual to each young person:

> *"Yes, that's your starting point – where they are. Not from anything else, it's from where that young person is when you meet them."*

One keyworker contrasted this with the social work relationship with a young person, which was based on the social worker's agenda of concerns or with teachers, struggling with discipline issues. Another keyworker articulated well the challenge which arose from the fact that the young person had been referred because of professional concerns, as opposed to coming to see her of their own volition. The referral process meant that the keyworker had to make a special effort to establish a client centred relationship, but this was not insurmountable:

> *"Yes, you start off on the wrong foot straight away and you have to overcome that somehow. It's usually overcome with a very laid back approach, a bit of banter, as you've got to win them over really quickly."*

3.2.3 The keywork support addresses the whole-child's needs

3.2.3.1 Young people's and keyworkers' responses

The young people's answers to questions about their associative life, advocacy, goals and whether they thought their keyworker cared about them are summarised in Table 3.2.3 a) Whole child.

[65] Rogers C.R. *Client Centred Therapy* (1951) Robinson; New Edition (2012)

Table 3.2.3 a) Whole child

	Keyworker & young person talk about young person's associative life		Keyworker acts as advocate for young person	Goals are discussed & young person can name them		Young person thinks keyworker cares
	Talk about associative life	Important to talk about associative life	Keyworker advocates	Goals discussed	Goals named	Keyworker cares
Total	14	14	14	14	14	14
Total %	100%	100%	100%	100%	100%	100%

Keyworker & young person talk about young person's associative life

All (100%) of the young people said both that their sessions with their keyworker always included talking about their associative life and that doing so was very important. From the young people's perspective it would not be possible to support them without embracing their home, school, social and community relationships and experiences. This is supported by the fact that the circumstances and locations in which child sexual abuse and exploitation occurs encompass all these aspects of the young people's lives and recovery includes them learning to manage themselves and their relationships within these or similar situations.

The young people said:

> *"She asks 'How's home going?', or 'How are your friends going?', 'Are you okay?', 'How's school going, how's your school work is it too difficult, it's not like she is just asking 'How's home life, is it good?' …she is more subtle, the tone of voice she uses is a nice tone of voice. She really wants to know."*

and,

> *"Yeah, the way she helps me, she sits there and talks to me about everything in my life. She has time for me."*

and,

> *"You need to talk about your whole life all the time – at home and at school. If my keyworker picks me up, she'll say, 'How are you? How is everybody in the house?' She always asks how school is going, especially when she notices that my attendance is dropping. She discusses how my relationship with friends is going but I only talk briefly about friendships as I don't think I need help here."*

and,

> *"We talk about everything (home, school, friends) this is definitely important, it helps, talking about everything. Sometimes we talk a lot. Sometimes we'll stop and then talk about my goals, what I want to do - good things, instead of bad stuff that I've done. You don't want to be talking about bad stuff all the time, it's nice to talk about something good."*

and,

> *"All those things home, school, friends and neighbourhood, friends and family. She'll say, "How's your mum?" coz me and mum don't have a bond, or with my step dad and then my brother and sister, I don't really speak to. It affects everybody when I was angry, that's the reason I didn't get on with my brother and sister and mum because of my anger. My brother and sister used to be scared of me… so I made them grow apart."*

and,

> *"My keyworker asks about my home and my school and how I am getting on….and my friends. We usually talk about worries from school, my friends and my teachers. What's going on with them."*

and,

> *"One thing affects the others – getting on at school, home, so we might talk about something more on that day when we meet up. Then another time we talk about something different. Every time we meet up we do try and talk about how everything is going; as a whole – we break it down and we try and see how we can solve it."*

and,

> *"With school, I don't really mix my home with school together. It wasn't really problems at school, but if I have a bad day at home… I used to bunk off school."*

The keyworkers and their managers understood that in order to start from where the young people were, keyworkers needed to find out about the young people within their context.

> *"I'll never force myself on the young person, but what I like to do as a youth worker is, 'to have a little chat, get to know you, you can tell me about yourself and what you do and what you like to do and if there is anything at all that I can help you with, that's my job, that's what I'll do. Anything at all, if you have any problems with school, home or with your friends or anything'."*

> *"Definitely you have to look at the whole person. You have to understand where they are coming from. You don't do that at the beginning if you've no understanding of them. So you have to find out where they are, what is the situation, what is their background, what's happened to them – their family life, what are the issues for them, what they want to achieve."*

Keyworker acts as advocate for the young person

All (100%) of the young people said that their keyworker advocated for them. For the majority of young people this took the form of representing their needs and circumstances to their teachers, but it was also very much liaison between the young people and their parents.

> *"I have always felt safe with my keyworker, once I got to know her. She respects me. She has been an advocate when I've needed her and wherever I want to go somewhere she will make time to come, she is there for me."*

and,

> *"I was invited to an interview at the college for a course, and I did not want to go to the interview because I was too nervous – I was scared to go, I was feeling sick. I said I'm not going and then everyone at home started shouting at me: 'you've got to go, what's wrong with you…'. My keyworker was the only one who didn't shout. She just talked to me and she persuaded me and supported me. So I went. I didn't get it. But I am trying again at another college."*

All the young people needed support in relation to their attendance and achievement at school. For many this was because they had missed a lot of schooling either due to the fact that their child sexual abuse and exploitation trauma was related to peers and the school or because the impact of the trauma they sustained meant that they did not want to leave home or could not maintain an emotional and behavioural balance at school.

The young people said:

> *"My keyworker always asks how school is going, especially when she notices that my attendance is dropping."*

and,

> *"My keyworker is working with another woman to sort out my school as there is a problem. The school are refusing to do anything so that I can go back to school as I want my GCSEs."*

and,

> *"She came into my college. I was excluded from college and they were not going to have me back and she came to the meeting and spoke to my teachers and they accepted me back. She did help get me back, yes."*

and,

> *"When it happened I was in year 11 so I was about to do my GCSEs, great timing! A week before my actual GCSEs I was having police interviews and I was meant to be revising and I am sitting there explaining my life. She talked to college for me to help me do my exams."*

The keyworkers showed themselves to be effective advocates for the young people, in relation to the partner agencies. They demonstrated a good ability to work flexibly with the young people's concerns, identifying ways of helping and then taking practical steps to ensure their needs were met.

> *"She talked to the police for me and she got me out of there, she got me bail. My keyworker has helped me a lot talking to people to get them to support me. I would have been in a lot of trouble if it wasn't for her. My mum doesn't do that sort of thing."*

The speed with which the keyworkers worked was also important. A young person said:

> *"If I told my social worker something needs to be done it would take her about five months to actually do it. I needed counselling and it was my keyworker that managed to chase up my counselling before my social worker actually did."*

They drew professionals together to make strengths based plans for the young people; they spoke up for the young people at statutory meetings; they accompanied young people going to new and potentially intimidating environments and ensured they developed coping strategies to continue attending; they not only got the young people involved in activities which played to their strengths, but also got them into training which might lead to a career.

Two young people were in their third week of peer educators training and another was being helped to train as a youth leader.

One keyworker described getting a very fast runner at a local running track to run against a young person who was a very talented athlete. The man turned out to be someone working on athletics with children in schools and also training at Olympic level. The young woman is now being trained by him. The young woman was a bit over confident, but he has placed her

with people who are a bit better. As the Team Manager pointed out, this also provided the young woman with a good male role model.

Sometimes it was necessary to advocate with other agencies, for example in a case where the police could not see the creator of indecent images, but could have prosecuted the young person who drew them to the attention of the professionals.

Another keyworker said:

> *"I feel like Pollyanna sometimes. At some meetings, when everybody is really doing the child down, I'll pipe up and say, 'Hang on, there are quite a lot of strengths here actually' or 'She wouldn't have told us that three months ago, so it's really positive that she is now able to tell us those things'. So I do that a lot in meetings in terms of being strengths-based in my multi-agency work."*

Goals are discussed and young person can name them

All (100%) of the young people said that they regularly talked with their keyworker about their goals, and were articulate in describing them (see subsection 3.4.1 Young people's assessment of their own recovery, including in particular Table 3.4.1 b) for information about the young people's short and long term goals).

> *"So it gets scary, the friends that I had, they are not my friends any more. They have got problems with me because I don't want to be friends with them. I don't want to do what they're doing. So it does scare me, I'm trying to get away from them. I've changed and I'm not trying to be out there in the world like I used to."*

Young person thinks keyworker cares

A critically important response was elicited from the young people in relation to whether, although their keyworker was a 'professional' rather than a family member or friend, they thought that the keyworker cared about them as a whole person. The young people were unanimous (100%), and in some cases vehement, that their keyworker cared about them:

> *"100% she cares about me. She always says, 'I believe in you, and that you can change… "*

When asked how they come to the conclusion that their keyworker cared about them, the young people talked about the quality of the keyworkers' communication – how authentic or genuine her interest in the young person was, and the fact that the keyworker made time for them:

> *"She asks 'How's home going?', or 'How are your friends going?', 'Are you okay?', 'How's school going, how's your school work is it too difficult, it's not like she is just asking 'How's home life, is it good?' …she is more subtle, the tone of voice she uses is a nice one. She really wants to know."*

and,

> *"Yeah, the way she helps me, she sits there and talks to me about anything. She has time for me."*

and,

> *"It doesn't come across that she just does it because it's her job. She does it because she actually does care. She goes out of her way to text you, even if you haven't seen her weekly."*

In several cases the keyworker appeared to be the only person demonstrating care for the young person. Thus for example, there were instances where the keyworker, rather than the young person's parent, attended the police station and s ubsequently accompanied the young person to the Sexual Assault Referral Centre. In many cases the young person's parent was not in a position to demonstrate care because of their own difficulties e.g. mental ill health or domestic abuse.

> *"My keyworker was there 100% for me and she was the only one. The social workers went on and on about my brother, they were only worried about my brother."*

and,

> *"The social worker's nice but I'm never going to trust her like I trust K5. I haven't had the same bond with any of the social workers and don't expect to have with the new one; although I think that I will get on well with her because the social worker was 'okay', but if I want anything to change I think my keyworker is the one that…… even if I … I would tell her first, because she helped me through a ton of stuff, more than anyone has ever helped me in my life really."*

Feeling safe – at home, at school, in the neighbourhood and with their keyworker

The young people's answers to questions about feeling safe at home, at school, in the neighbourhood and with their keyworker are summarised in Table 3.2.3 a) Whole child.

Table 3.2.3 b) Whole child

	Young person feels safe at home			Young person feels safe at school			Young person feels safe in neighbourhood			Young person feels safe with keyworker
	Didn't feel safe	Feels safe now	Doesn't feel safe now	Didn't feel safe	Feels safe now	Doesn't feel safe now	Didn't feel safe	Feels safe now	Doesn't feel safe now	Feels safe
Total	12	4	8	11	3	7	8	2	6	14
Total %	86%	29%	57%	79%	21%	50%	57%	14%	43%	100%

Young person feels safe at home

A key element in addressing the needs of the whole young person, is to help them to feel safe in their everyday lives; this is also critical to their ability to recover and assume or reassume a positive life trajectory. In response to questions about how safe they felt, twelve (86%) of the young people said that at the beginning of the support period, they had not felt safe at home, the language they used to describe this ranged from 'scared' to 'uncomfortable'.

> *"My social worker, she doesn't really do anything, I don't think, but I think the best decision that was ever made for me was to come here (foster placement). My keyworker has asked me how safe I feel and things like that. I don't know, I have felt scared ever since the whole situation happened. If you don't know what could happen – I used to be so free, I used to go outside. You think nothing bad is going to come my way and then a lot of stuff happens and now I need to just chill, I need to stay on my own."*

and,

> *"At home sometimes I feel safe; but other times I just don't. When it all goes very pear shaped I don't want to be around my family. And school ….. I don't even know where to start there because I'm not at school any more. I didn't feel safe in school because I went through stuff near the school and I was scared that this person would be waiting outside and everything."*

and,

> *"I don't really feel safe…. I mean I feel safer at home but... I wouldn't go out with friends in my neighbourhood, I don't really feel that comfortable. And at school, even if there's a lot of teachers around I don't like it, so I'd say I probably don't feel that safe."*

Young person feels safe at school

Eleven (79%) had not felt safe at school, describing school as, for example 'where everyone knows what happened, or actually the place where 'it' happened, or otherwise as 'worrisome' and 'bothersome' due to bullying or where the staff would not be able to intervene in time to stop the violence from peers carrying weapons.

> *"My keyworker has made me feel safer. School doesn't feel safe, but when she is there I do feel safe. No-one at school listens."*

and,

> *"I think I'm safe, but that's because I don't have anything to do with anyone. I don't really associate with a lot of people because there's a lot of people, I don't know how to say it, but they just talk rubbish behind my back and I don't trust them."*

and,

> *"School doesn't feel like school. It doesn't feel good, it feels bad. It is bothering and uncomfortable. The teachers don't listen, they ask but then they don't listen. So I give up."*

Young person feels safe in neighbourhood

Eight young people (57%), had not felt safe in their neighbourhood. They talked, for example about their rapist being 'out from prison' and in the neighbourhood, also about 'being stalked by friends of the perpetrator'.

> *"So she has helped me learn different ways I can get to college, to be safer. It's actually one of the first things she has done actually, and cheaper and a shorter route! Definitely better, my keyworker also helped me not to get panic attacks when I'm on the tube going past his area."*

and,

> *"To be honest I don't feel safe in my area because my rapist came out. He only got a year and he was only in prison for 6 months. Now he is around in my neighbourhood. I don't feel safe from him and his friends."*

and,

> *"Although the person who raped me is in prison on a 9 year sentence, his friends have been stalking me, and I'm having panic attacks. By changing my route to college I am managing to control panic attacks on tube. I have now sought help rather than trying to manage my anxiety and fears on my own."*

and,

> *"No. I was scared at school, home, neighbourhood with friends because I got into a lot of stuff, really bad stuff. Basically I started living out of a car, that's how bad it got. Before all of that happened, I never used to get stopped by the police and the police wouldn't even look at me."*

They felt safe with their keyworker

Whilst all of the young people felt safe when with their keyworker, the period of support had not raised their feelings of safety as much as could be hoped for. This is likely to reflect the fact that the keyworkers are not in a position to influence the home, school and neighbourhood environment enough to reduce the young people's feelings of vulnerability and insecurity. Thus at the point when the young people were interviewed, eight (57%) still felt unsafe at home, seven (50%) still felt unsafe at school and six (43%) still felt unsafe in their neighbourhood.

> *"Because I don't feel comfortable at home, I don't feel comfortable at school, I don't feel comfortable with my friends and I don't feel comfortable in my neighbourhood but I do feel comfortable and safe with my keyworker – yes, she's somebody that understands, somebody that listens."*

and,

> *"I'll tell her about the people in my school, what they have done to me and just …. some of that you don't want to hear, but she won't turn her nose up at it, she'll listen to what I've got to say and help me with my feelings about it. It's not something people want to hear, but she always listens so that's nice and it's made me feel better."*

and,

"There was one session when I was self-harming at school and I said 'I don't want to see her, I don't like her' and I started shouting and my teachers told me to go outside and I was so angry and said 'No'. Eventually she came and she managed to calm me down and I was like….how did you do that?"

3.2.4 The keywork practitioner gives of themself

3.2.4.1 Young people's and keyworkers' responses

The keyworkers' giving of themselves was a theme throughout the young people's responses to questions about the quality of their relationship with their keyworker. Some additional descriptions from the young people, of how the keyworkers worked with them are included here:

"I like spirituality and my keyworker is quite like that too, I like that. I can speak to her about what is important to me, like meditation, because it helps me calm. So she gives me tips on that. She sends me video links, website links."

and,

"I used to have meetings with professionals who just kept bringing up the past. My keyworker doesn't do that. We talk about things that are happening now, at school and out of school and with my family. It helps me to get through things that are now, not in the past and to work out about what I need to do to manage now and in the future. That's everything, school, friends and home."

All of the keyworker descriptions contained information about how they used themselves appropriately within the relationship with young people. This is illustrated by the following comment from a keyworker:

"I don't think you can adequately work with that person unless you listen to them and genuineness is a huge thing because I think young people see through that straight away if you are genuine or not, and that you do care, and that you do want to help."

Many of the keyworker's descriptions gave a good sense of the direct and equal way in which they spoke to young people. The way in which they spoke might be described as light, kind and helpful and not at all admonitory or demeaning. A keyworker said that she based the relationship on:

"*Not judging them, or forming any judgement because I think that can really cause barriers."*

Keyworkers all agreed that being persistent, resilient and strong was fundamental to the work they do.

"You have to be highly motivated for a young person because they don't really want to see you, and they don't have to see you, you can't allow your ego to get bruised.... So no matter how annoying it is, you've got to keep going and your resilience has got to be stronger."

In health, policing and social work, in the main it is not considered professional to disclose personal information to a client. The keyworkers were well aware of needing to find a balance between 'giving of themselves' to build a relationship of integrity and trust, and not offering too much personal information because it could confuse and complicate a support process. One keyworker explained:

"I find this difficult, because I am a very transparent person, so I don't hide … I can say anything and not feel afraid of judgement. But you have to be aware of also professional boundaries and how much you can tell a person. I think the more open you are the more you get out of a person. But it's finding a balance between what's appropriate to share."

The same keyworker went on to explain that a young person once asked them if they had ever had a sexually transmitted disease (STI). The keyworker had not, but explained to the young person that they were not going to answer the question because they didn't think it was appropriate. The keyworker said that she judged that answering the question would not have lessened the young person's fears about potentially having contracted an STI.

The majority of keyworkers described just 'being themselves':

"*I don't try and be anything I'm not and to me that's being authentic. It's the most respect you can give them."*

'Giving of yourself' does not just relate to what a keyworker might disclose or how honest they are it is also a reflection of what they might do, one keyworker said:

"I buy her books and stuff and she reads them and she does the exercises and stuff like that. So a lot of the work is … I'll take their Instagram, their phone and I will make them follow certain accounts which are helpful. I try to infiltrate their social media as well. Then she'll send me a quote and then we'll talk about the quote and stuff like that."

Another worker spoke about being accessible during times of crisis for her young person:

"Weekends are crucial and anything can happen, like the weekend before when I got these messages that she was in trouble at half twelve, half midnight".

3.2.5 Support for practitioners to give of themselves

In order to establish whether the service and commissioning structure supports practitioners to give of themselves, the keyworkers, social workers and managers were asked whether the service and commissioning structure supports practitioners to give of themselves; providing support by:

- Offering practitioners space for reflective practice
- Providing managerial and team support
- Allowing enough time for individual contact and overall progress
- Making appropriate practice tools available
- Addressing the environmental influences on young people's lives
- Promoting flexible, multi-agency joint-working

Developing and maintaining effective care pathways.

3.2.5.1 Professionals' responses

Offering practitioners space for reflective practice

Keyworkers

It was clear from all of the interviews with the keyworkers that their commitment to 'getting it right' for the young people meant that they had given a lot of thought to their practice. The interviews gave an unusually clear picture of the way in which these workers engaged with the young people and what they said and did to try and help:

> *"So if I put it to you this way, you are trying to create with the young person, you are trying to create a bond that is like a family, not professional, but then the minute you turn inwards towards your organisation, it then becomes professional… That's what's frustrating, because you know what you want to do and you know what you are trying to achieve, and you have a positive relationship with this young person, you don't want to go and jeopardise that and whilst you have it, do as much as you can with it."*

The keyworkers had varying views on the interpretation of reflective practice, most of them interpreted this as being professional support in respect of managing and carrying risk:

> *"There is no feeling that there is someone else who is shouldering some of your burden; all they are doing is giving you advice."*

It was also seen as a wellbeing function to support staff in managing vicarious trauma[66]:

> *"It's very difficult. I've had sleepless nights. It's been really tough and I don't think we get enough support from our manager because I don't think she really understands what we go through and how we get affected by it. But you can't help getting affected. If you don't get affected you're not human."*

Keyworkers felt that reflective practice was inadequate and that they did not receive the right level of support or the appropriate type of support for the work that they were doing. One keyworker described the way in which they were working – building intense supportive relationships with the young people, as being very different from the traditional children's social care approach. She felt that this led to a lack of understanding from management in particular about the personal impact the work had on staff:

> *"We're fighting our way because it's not been done before and that takes a lot out of you and like I explained to you as well, the amount that you are expected to do is emotionally draining, and we get supervision once a month, that's not enough."*

The degree to which keyworkers felt supported varied relatively widely. Several keyworkers felt very supported and connected to wider teams, others described working alone and feeling completely unsupported. The difference appeared to be largely explained by the experience and performance of individual managers. Furthermore, the workers' viewed their managers' performance as reflecting the pressures on them, rather than them lacking in core skills or specialist experience to oversee keyworker staff working with complex and serious issues. One keyworker commented:

[66] Vicarious trauma is a transformation in the self of a trauma worker or helper that results from empathic engagement with traumatized clients and their reports of traumatic experiences. It is a special form of countertransference stimulated by exposure to the client's traumatic material. Courtois C.A. *Vicarious Traumatization of the Therapist*. Ph.D. NCP Clinical Newsletter 3(2): Spring 1993

"So I don't want to be horrible about our manager because she's a really lovely person and it's not a thing I hope…. They make her do too much ..... she is doing the best she can do. .....I do feel that no one is really monitoring her."

In the same way that the young people explained the importance of flexible support when they required it, keyworkers talked about the need to be able to access the appropriate support 'in the moment', but they also wanted relevant, good quality support:

"We do have access to the two psychologists, once a fortnight. It's quite often not when you need it ..... also you know you'll get a standard response anyway. So there's not much point really."

Another keyworker described the support available from the same psychologists as follows:

"We have some psychologists here, you can talk to them, they are part of the team and they have their own clients, so… they are colleagues alongside us. Don't get me wrong, they are very approachable and I'm sure that if there was something that I desperately needed to speak to them about… but on a personal level I don't know how appropriate that would be, because again I am aware that they are there for young people and families and not for staff."

The keyworkers who spoke about feeling unsupported said that they did not feel that the managerial supervision or therapeutic talking therapy that they received was enough. In addition to not being accessible at the time it was needed, keyworkers described it as inconsistent in quality. Staff consequently felt that the burden of responsibility for the young person's safety and wellbeing was not shared (through discussion and agreement about needs, risk and reflective case management). It appeared that skills and competences supported via clinical supervision which endorsed intuitive action in relation to mental health and clinical risk, would alleviate frontline anxieties and concerns. This was articulated in a very similar way to that of the young people; a keyworker explained:

"I think what we need is somebody accessible that you can go and talk to, who knows your case inside out, that you can talk the issues through with as you go, have a different perspective, see patterns etc."

As well as consistent, good quality individual line management, they wanted:

"A good team structure; you need good team meetings where things can be discussed."

Where support had been most successful it had been separate, independent clinical supervision in addition to the individual line management supervision, which in the main was case discussion. Clinical supervision was described by one keyworker as:

"*The most powerful part of my support. You have it as a group. So it's good to recognise that everyone is struggling with the same stuff. Sometimes, especially as a lone worker, you could think 'It's just me..... ' working with only the high risk group distorts what is normal."*

Keyworkers who received regular clinical supervision felt that it was the ideal place to reflect as it was not linked to performance or with a line manager, so it was safe and secure to be honest and offload. They explained that the ability to talk through their concerns about the system, their performance or decisions and the impact of these and reflect on how this affected their confidence or thought process was energising.

Managers

It was striking that both the statutory and the voluntary and community sector services reported no, or very low staff turnover.

Offering practitioners space for reflective practice

The VCS organisation providing the CSA recovery service recognised 'space for reflective' practice as meaning 'clinical supervision'. The statutory services managers were not in a position to offer one-to-one clinical supervision to their keywork practitioners.

A manager described her attempts to meet her team's needs for clinical supervision as follows:

> *"So we started up a monthly meeting with the clinical psychologists, it's not clinical supervision (they can have a one-to-one session with the clinical psychologists whenever they want one); this was a chance to share difficulties and advice about their cases. I put it to them, "I don't have to be here and if you don't want me here, then that's fine, because you don't always want the manager in the room when you are being really open about yourself".*
>
> *However, I've noticed they've not been having that monthly session. I think it's because they don't value the time that they need for themselves, e.g. "I need to see that kid, so I can't do that session".*
>
> *But I also don't know if part of that is that they don't want to engage in what is really personal stuff with others around them."*

In the absence of clinical supervision the managers and commissioners spoke about offering their staff opportunity for reflective practice through line management supervision.

One of the team managers said:

> *"Supervision is critical for the social workers. Each practitioner's values and beliefs, their life experience, history and current circumstances impacts hugely on their effectiveness. Giving of yourself is exhausting. The practitioners need time for reflection and to gain insight. This needs to be ongoing in between social workers having to respond in real time. Unfortunately pressures of workload mean that supervision does get shifted. In order to mitigate the impact of this the team manager has developed an informal 'open door' policy and a supportive culture. This means that there is a fair amount of informal supervision and a family atmosphere; which is supported by the Head of Service."*

Line management supervision is however time consuming, and all of the managers talked about the challenge of providing this for their practitioners whilst simultaneously delivering in their role as service manager. An example was:

> *"The last case in which we brought a child into Care took two months of my time, working alongside the young person's social worker. I didn't talk to my team about any other cases for two months because we were literally in court at least once a week, with another application to try and stop her being left in her neighbourhood where she was being exploited repeatedly saying we need to move her."*

Thus managers described line management supervision scenarios which ranged from slightly inconvenient to unsustainable, in terms of staff support:

"The most frustrating thing is having supervision moved or interrupted."

and,

"And I know that certainly during that period, there was one worker who said, 'You don't listen to our cases any more' and I said, 'I physically can't, I'm sorry. I can't have that conversation with you right now because I've got a report deadline. I'll speak to you about it later."

The manager felt compromised by the demands on her time which rendered her unable to support her staff, as she went on to say:

"It's not great to have that conversation but I would always do that kind of stuff after hours, coz I have got that time for the staff, but when you've got a 4pm deadline I physically don't have that choice as I've got to do this right now. So yeah, I know that was an issue there."

Other managers said:

"I think for most of them, most of the time they feel pretty supported. The offer is always there to go to my seniors if I'm not here. I know that at times some people have, not necessarily gone to the seniors, but actually have gone to other managers, but the two other team managers have been, 'I haven't got time for this…' ."

In more than one area the manager also had a borough-wide role, as the Child sexual exploitation lead, which appeared to be entirely appropriate in terms of concentrating expertise and co-ordinating the local response to child sexual exploitation. However, it created line-management capacity issues, as described here:

"It's quite a difficult role to have because as well as being team manager of the service – managing ten people with caseloads, I'm the Child sexual exploitation *Adviser for Children's social care. I consult on cases borough-wide, also attending strategy meetings and a number of partnership meetings each month. That helps my team with capacity because we don't actually work with all the cases, but it's quite a lot to do, I could really do with a deputy."*

There may well be scope for introducing or re-introducing a 'senior practitioner' position in these and other teams such that the senior practitioner was responsible for supervision, creating capacity for the manager to focus on the tasks also critical to team wellbeing. These, in priority order would include improving multi-agency relationships, developing the team's influence over the young people's environment and increasing the team's access to resources.

Providing managerial and team support

Managers

<u>Support for practitioners</u>

The managers and commissioners spoke about the responsibility they felt to support their staff and what they did within the constraints of the organisation to provide this. Foremost were efforts to create a work environment and culture that was conducive to the wellbeing of their staff. This included good team relationships and peer support:

"Development of an informal supportive culture is assisted by the open plan office in that social workers can hear each other's conversations and can share incidents in their cases. A social worker faced with a child sexual exploitation young person's crisis can circulate an email to colleagues requesting a stand-in for a meeting or court, to free him/her up to manage the young person's crisis."

All of the managers operated an 'open door policy' for their staff. A manager said:

"I'd like to think that I'm like a role model. When they are having a hard time, or when one of our young people goes missing, or staff listen to horrific stories of what the young person has been through, that I'm able to support them and build them up, so that they can then, go back and do the job. That takes time. They'll come and say, 'Can I talk to you? And I'm like, yeah, of course. No problem.'. I always have an open door policy, because at the end of the day we are all human. I am happy for you to speak to my team as to hear what their experience is… "

One manager described an additional approach to supporting her staff:

"I make a point of doing home visits with my social workers – where they welcome me – to understand what they are dealing with and have a better idea about how to support them. Most workers say that me taking the trouble to accompany them makes them feel that their work and their contribution is important and valued. It also provides me with a good opportunity to get to know my staff through informal conversations travelling to and from visits."

Helping practitioners to cope with their work was seen as critical. In terms of practical arrangements two managers talked about giving their practitioners flexibility to help them cope with work:

"I am able to offer my staff the flexibility of working from home one day per week in order to help them to do their paperwork and telephone calls. The open-plan office, whilst creating a family atmosphere, also creates interruptions and makes it difficult to concentrate e.g. on a court report."

A manager alluded to resource limitations:

"I am also aware that if I could provide the social workers with laptops so that they could get on with some work whilst waiting at court."

Some of the managers also expressed commitment to addressing process issues:

"If a staff member has an issue, think we are able to have a voice and feel quite secure within our own service to actually come and raise it and likewise, if I felt that I could do something, I've had no problem escalating, which I do."

However, some keyworkers felt that their manager had not 'advocated' for their interests (by addressing long-standing partnership working issues).

<u>Support for managers</u>

For managers to be able to support their staff they would need to feel supported. The managers were as passionate about helping young people as their frontline practitioners and were driven by a desire to 'make a difference' to the lives of the young people. Some of this fuelled their anxiety about doing a good job and some of it was exacerbated by resource issues:

"This work is very intense. It doesn't always feel like we are making a difference."

"I worry that we're not working well enough, not doing enough for our young people. And when we come up against constraints on resources obviously, we know that children are not safe, but the battle we have to help them..."

Lack of capacity within the team or a more general disparity between the number of young people who need help and the number which the services are able to support was a theme:

"I left a previous role because the manager and I couldn't agree – she was much more about reaching vast numbers of young people. Whereas I was much more about doing the job properly for a smaller number of young people; rather than half the job with more young people."

Some of the pressure on managers also came from their awareness that any work with children who have been harmed is subject to enhanced scrutiny. This was expressed by one manager as:

"But I do still feel there is an element of watching your back with what we are working with. There is going to be a serious case review at some point because of the difficulty of managing risk in CSE. You know it's going to happen and the question will be did we do enough. Are we doing enough – I don't know…"

Another manager said:

"For some of our cases I felt quite confident that we've done everything we physically can. But then, there was an audit on a case that was in court and we were found not to have done enough work before we went to court. I would quite like to know what else we could have done. If my management of the case wasn't enough, that's because I didn't have any more time to give…"

Notwithstanding the pressures and frustrations, all the managers were very positive about their jobs, saying:

"This is not a 9 to 5 job but I love what I do. You've got to be passionate about it so that you can support your staff team."

"Yes I am happy and thriving. Senior management are very supportive."

In the light of the work pressures described by the managers, there is likely to be a correlation between their enthusiasm for their jobs and the support they received from their line managers. A manager said:

"I have a very supportive line manager. I do feel I can go to her and say, "This isn't OK, what are we going to do?" You also do get too stuck in it as a team manager, you get your blinkers on, and you need somebody else to look at it and to make a suggestion."

A senior manager/commissioner described his position saying:

"I am one of the seniors who should be supporting other people and other services and I think that's a really important function and that we have to make sure whether the staff are in children's social care or in commissioned services that they feel empowered and supported in carrying out their role."

And another senior manager/commissioner said:

> *"For me, it's about appreciating people and saying thank you and I think it's those small things that you do periodically. For example, last week we had a service lunch and everybody brought a dish. It was about networking and talking to each other because mostly we are all heads down and not able to take that time to say, "You know what, you did really well", …let's talk and have a laugh and engage and share a meal together. That makes the work environment different, and somewhere that you want to work."*

The need for appreciation was highlighted by one manager. She talked about an extremely difficult case and described when a senior manager (not line manager) commented that the case had been challenging and the outcome better than could have been anticipated:

> *"He didn't say 'a lot of good work', he didn't overtly praise, but I'll take it. At least somebody has acknowledged, it's been really hard."*

> Allowing enough time for individual contact and overall progress

Keyworkers

There were collective frustrations resulting from the time expected and required to complete paperwork. This included administration and compliance with case recording, and the detail required to support the evidence-base for reporting outcomes. Keyworkers acknowledged this was important for service governance and key performance indicators but many workers were unhappy with a structured model which pressured them to keep face-to-face time to a standard, irrespective of where the young person was in terms of the intensity of the support they needed.

One of the keyworkers said that although she was expected to deliver a session a week over a six week period for each young person, this was rarely possible and that all her cases lasted at least three months and many of them much longer than that:

> *"I sometimes feel that because it's supposed to be a short intervention, I need them to tell me things quickly. Some young people want to tell you everything the first time you meet them but with other young people it takes time. And I get that. I think young people are cautious about telling people things because they don't know where that information is going to go, or what you are going to do with it or if they are going to be judged or if you're going to tell a parent."*

> *and,*

> *"We're supposed to be in and out in six weeks, six sessions. But it's always much longer than that, always, at least three months maybe more because you always uncover more issues – with housing, with education or something, there's always something else. Always."*

De Thierry (2015) advocates strongly against short interventions:

> *'Those working with highly traumatised children need an awareness of the counter productivity of short term interventions such as 6 weeks of one hour sessions of mentoring or therapy; or 12 weeks of support or other short term interventions where the children will experience the building of an attachment which is then ruptured. This leads to the children experiencing increased confusion and anxiety*

about relationships and therefore increases the complexity of their coping mechanisms.'[67]

From a service commissioning perspective there appeared to be a range of intervention periods or case lengths specified, which the keyworkers were aware of, and felt pressure to comply with. However, alongside this there appeared to be a par allel acceptance from management and the commissioners that in most cases the young people could not be made sufficiently safe within these timescales to close the cases. Sometimes this was not even because the young person's reluctance to engage delayed the case:

"Sometimes it's quite difficult ... you also get some resistance from some of the parents that they don't want professionals involved."

Keyworkers agreed that other issues (or repeat victimisation) meant that it wasn't always appropriate to follow a structured recovery plan with the young person:

"I feel like you need an outcome or I feel like you need to tick a box, and I find that then takes away the emphasis of actually just listening to that young person, and understanding where they are coming from."

"There has never been one case when there hasn't been something else gets the conversation going and most young people love talking about themselves. I've never met one yet that didn't."

One keyworker explained that they were funded from a ring-fenced budget specifically for work with young people following child sexual abuse and exploitation and for this reason the workers did not feel pressured to close cases, they worked with a small case load and were largely able to give the young people the time they needed. The keyworker then explained that they often worked alongside other colleagues who were pressured to close cases if the young person did not engage quickly and consistently, or if management felt there was little or no visible progression in a case.

"We have a – I'm not sure exactly what we call it – a persistent or assertive outreach approach. So if a young person doesn't show up a few times, that's fine. As long as they have said, 'Yeah, I want to meet you' then I'll keep trying to meet them. Again, a lot of services wouldn't do that".

Managers

All the managers were fully aware of both the intensity required and the long term nature of working successfully with young people who have experienced child sexual abuse and exploitation. One manager explained that:

"The commissioned voluntary and community sector service has a low caseload; but the social workers' caseloads are also kept low because the cases are so complex and intense. As well as sexual abuse, they include missing, trafficking, family dysfunction, substance misuse and self-harm. There is also always potential knife violence. The social workers have two child sexual exploitation cases each, plus their other caseload. One child sexual exploitation case can feel like enough when it is really bad."

Another manager said:

[67] de Thierry E. (2015). *Teaching the Child on the Trauma Continuum*. London. Grosvenor Publishing

"We are supposed to work with young people for only a limited amount of time, but that doesn't really fit within a service that works with traumatised sexually exploited children. We are expected to time their 'recovery' to meet the standard length of our intervention. Every child is different, so with some of our young people, we do manage to put in an intervention and close that case down in a relatively short space of time. But there are children who are not going to be okay quickly or easily, they need that ongoing support, from a social worker to keep them safe."

The services which could offer relatively short interventions were those who supported children at the 'low risk' end of the child sexual exploitation spectrum. The term is in quotation marks here because even at level 1 of the Metropolitan Police Service categorisation of risk to a child of child sexual exploitation, the fact that the child is presenting with the warning signs indicates that she has already been harmed. Some services offered support to young people at this early stage of abuse, and were therefore able to achieve some success with relatively short interventions:

"For some young people we can offer them between six and twelve weeks, the work of intervention, for others it's supposed to be up to six months. However, we've got several who needed much longer because in reality you can't build the relationship and do the work in six months if they have got complex trauma and a chaotic home environment as well. But once we get to nine months, the pressure is put on to close the case."

There was recognition of the dilemma that whilst continuing to support some children the teams were not able to support others:

"We are a small team, the workers have about six or seven cases each, so actually if we were going to work with every child that got referred to us for up to two years, we wouldn't be taking any new cases after the first six months. So that can't happen but…"

Managers talked about their experience of transferring cases out of the specialist child sexual exploitation teams to generic social work teams. The fundamental flaw with this is that it completely disrupts the trusting relationship which has taken time to build and is essential to recovery for the child. A second challenge to this approach was that the generic social workers did not have the low caseloads needed to be able to give the young person the time they needed:

"So we do transfer them, and we look at, we consider what services need to deliver that child sexual exploitation work with them and the child protection social worker will be expected to do that. However, we find that very often support for the young person drops after transfer, because, for example, the social worker is trying to get an ICO on a baby and that is seen as more important than supporting an adolescent."

There appeared to be recognition amongst the managers and commissioners that the young people needed an average of six to nine months of intensive support; but that many of the young people actually need ongoing, less intensive support after that:

"A lot of our contracts with providers assume relatively short term working – six to nine months, and that fits with what most services say young people need. I think the challenge is what happens at the end of that and are there places that those young people can then go for more universal support that if necessary can be escalated again, if it needs to be. Essentially the support just stops at the end of

nine months and then they've got nothing. I think that is partly because youth services and other community resources have been cut in recent years."

and,

"The fact that we have a youth service that can do some of that is relatively unique. We have a bit of support in our children's centres but again, a lot of that is more targeted with the short user time limit. I think that's a real challenge and I think the relationship model is really important. It's at the heart of any work, but of course you can't just end that relationship really at the end of nine months. It's a real tension there needs to be ongoing lower level support and I don't think we have got it right."

Making appropriate practice tools available

Young people

The young people all described helpful practice activities or tools which their keyworkers introduced in order to help them to identify and manage their thoughts, feelings and behaviours. The young people recognised that this included developing a positive sense of who they are. Examples were:

"We play games, not games, but they are more or less … last week we played what was 'believable' and what 'wasn't believable'? I put them in order. Games like that, and the game about things I don't like and things I like - knowledge games."

and,

"She makes me say things about myself that are nice and write it down. She gave me cards as well that say things like, 'Tomorrow is a brand new day' or something like that. She has games we do in our sessions; like cards with strengths and you look at them and choose the ones that are you. My keyworker points to some good things which I wouldn't think of for me. I think I struggle with that. I don't know what I'm good at, so she'll say, 'well, I know what you're good at – and picks it out' or 'you're a good person'. She says I am a good communicator. …"

and,

"She helps me basically realise who I am by writing because I like to write in a journal, it helps to release how I feel and that kind of thing. So if I can't talk to anybody, she bought me a book to help me with it. It's really good."

and,

"I write everything down and it helps in a way. It splits my feelings from my thoughts a bit."

and,

"She'll sit there and say are you OK? Has anything happened?' and then after that we start speaking about it. Sometimes she'll bring an activity to do, cards or videos."

and,

"She would help me, she made me like a schedule to try and make myself work around all the stress going on."

and,

"Yes, my keyworker got me in touch with a counsellor. She gave me a paper which I keep in my bag now. It's about my anxiety and my panic attacks and whenever I have them I take out that paper and try and go through it. It helps sort out my thoughts feelings and it slows them down and helps with the panic."

Keyworkers

The collective consensus in respect of practice tools came down to routes to engage with and maintain a relation with young people, one worker describing:

"So I'll always think about that, about identifying it and wherever I can, if they like dance or whatever, I will encourage them in that way or I'll ask the school, 'What are they good at?' Those kind of things. That's something that's really…. without it being formalised and structured, that's something I do naturally."

Another keyworker confirmed:

"I think the environment thing is important because I do try to take them outside of what their normal things are, and get them to try new experiences, like I've taken them to a nice park I love. I try to vary, because I don't always meet all of them in school, especially in the summer holidays."

Another worker explained the importance of a different approach to the one that might be expected:

"*I'm a youth worker for the youth and family support service and quite often we go into schools and help particular students who've got a little issue or little problem or at home and do what we can to help. And sell it from that point of view. It usually works. It's a whole different approach than going in and saying, "Right, I'm a social worker."*

A worker explained the use of a 'Youth Star' assessment, its useful because it is visual interactive and gets conversations flowing:

"We've got a very good little thing which we use, it's a Youth Star assessment. It's quite good because it's different areas of their life and I say "it's just a way of us getting to know each other and it will help me understand where you're coming from."

The same worker continued:

"Yeah, they've got no confidence in themselves whatsoever, so you have to give them a little strategy for helping them cope. That's what you do but then you are building resilience and that is so difficult. It's lovely when you find something they like doing, that's a real plus. If they like doing something, then you can start building on that, building a strength they can recognise for them self, that builds their confidence."

Another keyworker commented that they didn't have a particularly good facility to be able to see young people:

"The drop-in that I mentioned before worked so well because it was young people friendly and it was welcoming and it was bright and it had artwork and it was a nice place for young people to be".

So often keyworkers are going into schools and it's not the best place to see young people because they are at school: *"that's their environment at school and they are missing lessons".*

Lack of resources sometimes makes it difficult to work with a young person:

"With Carly[68] there's been a lot more that I've wanted to do with her. The police took her phone and mum can't get another one for her, so I can't communicate with her, you know, texting, WhatsApp. That's how young people communicate. Also sometimes it would just get things going if I could have leeway to offer her an incentive or encouragement, like paying for an activity, you know that really helps with the situation and with a young person, continued engagement with a person. It could mean we get there (make progress) quicker. It's very frustrating."

There is also a need for a risk assessment/categorisation of the case which is not clumsy like the police and children's social care categories and this also crosses over into the managers' comments about the care pathway:

"*The problem isn't just that the incident has to fit into police category, it also has to have read across to a linked social care category. That's the same for child sexual exploitation cases. So there isn't enough from the police side to recognise a 12-year old who has met a 15-year old on line that there could be any element of the abuse taking place. That doesn't exist within policing. And that's where the problems come because the social care and police categories have to link."*

Need training/practice tools for strategies for coping:

- Strength Based – asset based (rather than a deficit model)
- Distance Travelled Measure
- Reflection Star
- Skills and strengths tool and formal recording:

"In our assessment we don't have a space to put in skills and strengths. We do have a base for engagement with services, so there we could say, they are going to church, youth group or they have come to different appointments, but that is not being specific about their skills, strengths and attributes, which I think we should. I think on our audit tool it asks when managers audit files, it says our strengths and skills of the young person noted and expanded upon, but there isn't a specific box for it in our needs assessment."

- Mediation Tools and processes
- Coping – Scoring progress:

"We use a scale of 1 – 5 to score a young woman's strengths in coping… She is talking to people, doing exercise, going out with her family and with friends who are a positive influence and she is reading."

[68] Pseudonym

- Women and Girls Network, holistic empowerment recovery model:

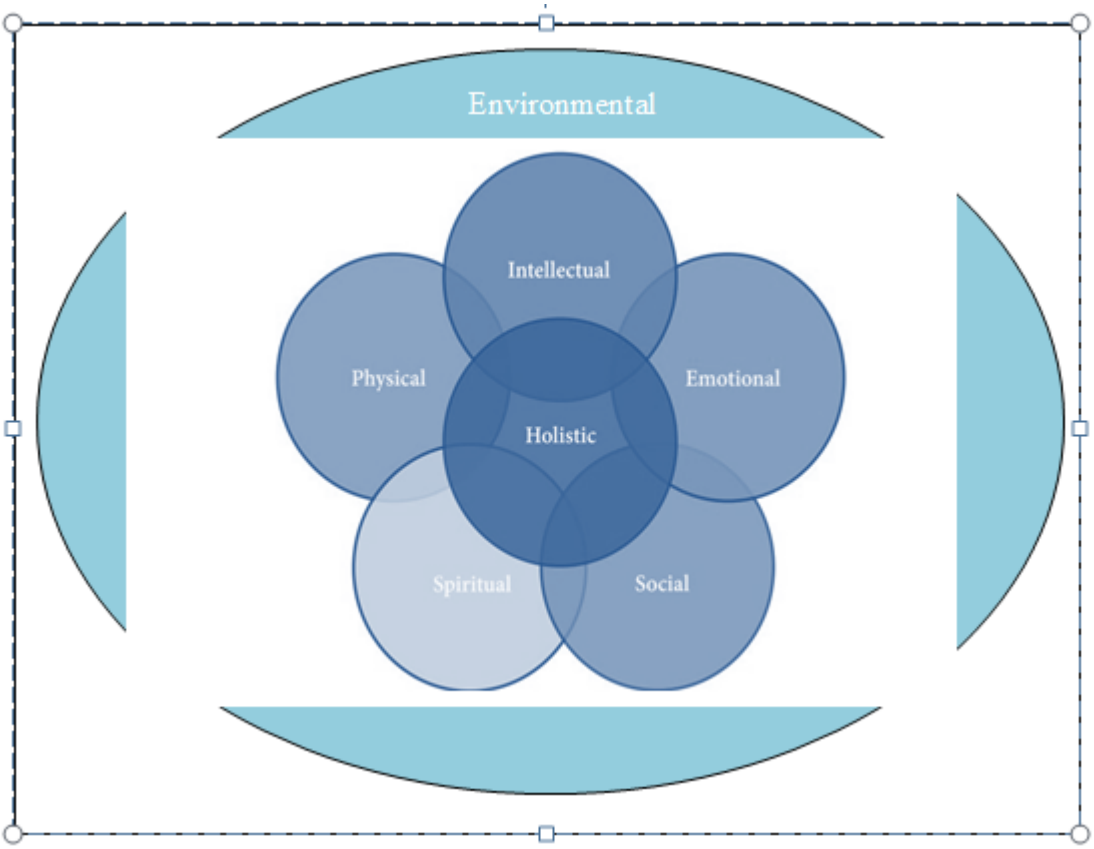
"I think they call it the 'Holistic Support Model'. In theory we all use the Holistic Support Model it would be good to revisit it at six months in, and a year in."

The Women and Girls Network Holistic Support Model practice guidance[69] used by one of the services in this Project focuses on the individual's internal and external worlds. With the former, the young person is helped to make sense of how they are feeling and to develop their resources to manage difficult and overwhelming emotions. With the latter, the young person is supported to improve how they manage their education, personal relationships and home life. The Holistic Support Model most closely embodies the humanistic and pedagogic perspectives discussed in subsections 2.4.6 and 2.4.7, above. It is client-centred, and has five dimensions, emotional, intellectual/psychological, physical, spiritual and social. The model posits that all of these dimensions must be evaluated when considering both the cause and treatment of a service user's trauma. The holistic embracing of all aspects of the individual could be contrasted with the biomedical model[70] treating only the symptoms of distress, through diagnosis and prescribing treatment – which is most likely to be medication or psychiatric intervention, or both.

Diagram 3: Dimension which features in the young peoples' descriptions of the support they have been receiving

[69] AVA (Against Violence & Abuse) Project. Practice guidance p8-9. Available at: https://avaproject.org.uk/wp/wp-content/uploads/2016/03/YWI-Practice-Guidance-FINAL.pdf.Accessed on 10 September 2017.

[70] The biomedical model of health is the most dominant in the western world. It is a conceptual model of illness that excludes psychological and social factors: biomedical model. (n.d.) *Medical Dictionary for the Health Professions and Nursing*. (2012). Retrieved November 9 201 7 from https://medical-dictionary.thefreedictionary.com/biomedical+model



The additional dimension which features in the young peoples' descriptions of the support they have been r eceiving; and the professionals' descriptions of the services they are providing, is their focus on t he young people's relationship with their environment (identified as important by the ecological approaches in subsection 2.4.4, above).

The Holistic Support Model together with an environmental dimension, fits with the trauma-informed treatment model proposed in subsections 4.2.3 Exemplar service core elements and delivery method and 4.2.4 An exemplar treatment model, below.

Addressing the environmental influences on young people's lives

Keyworkers

One of the keyworkers talked about having grown up in the area:

> *"I guess from my own personal experience I grew up in this area. So I'm familiar with the area, familiar with the schools, I am more aware of what happens and what goes on and that's useful. That does allow me to understand young people that bit more because I'm familiar. Automatically there's that …you've got something in common, there's instantly that connection, or that understanding. And they know that they can talk freely because they know you know the area they are talking about and the pavement, pathway and park or whatever."*

Managers

The managers, senior managers and c ommissioners, all recognised the influence of young people's associative life, their environment, both conceptually and in talking about individual cases. However the day-to-day focus on c asework meant that activity to address this was

generally driven by individual cases. So, the local operational child sexual exploitation panels share information about victims and perpetrator networks, with varying levels of success:

> *"We try and track the locations where child sexual exploitation happens…. which is difficult because we don't get clear enough disclosures from young people. But tracking where the young people are from, shows a very clear fit for all the demographics of the borough. The areas of deprivation are where you see most social care cases, peer-on-peer violence, our young offenders; and where you see most of our child sexual exploitation victims."*

Perhaps indicative of the lack of influence the teams have in terms of taking into account young people's associative life, the location of the Child sexual exploitation team itself was problematic. This was because of its position in relation to young people's victim and offender networks:

> *"We are also not in a building where it's really ideal for young people to drop in. Firstly we have got Youth Offending next door and we know that our exploited young people don't generally want to be coming to where Youth Offending is. We are also slap bang in the middle of gang territory, so for some young people, they are not able to access here, which has always been a problem for Youth Offending service, but it is also a problem for us."*

She continued:

> *"It's also not a particularly friendly building. We try not to bring young people here. We try to see them at home or in the community, at school maybe. It's not a minor thing, they don't want to talk at home; they don't want to talk at school; so yeah, put them in your car or take them for coffee."*

This manager, and all of the others, clearly understood that environment is important. Another manager spoke for all when she said:

> *"The young people's associative environment is critical – really important – but very difficult to influence. Housing is a big issue. There are certain estates where drugs are readily available and the public spaces are dominated by unsavoury individuals. There is an issue about whether young people can go to available recreational activities e.g. the youth club, because of the area they have to pass through unsafe areas to get there."*

Managers talked about the fact that:

> *"The key social influences are from school and peers. They are all trying to live up to peers' expectations and create reputations which give them status and safety. And, added to that, there are no role models to help young people avoid negative and/or risky activities and situations."*

Reflecting the fact that Children's social care's core business is working with family dysfunction, managers did not explicitly make the link between the concept of 'associative life' and the young people's families. However, one manager raised the issue of community and/or cultural influence on the young people's opportunities to receive professional help to recover from child sexual abuse and exploitation. The example she gave was that:

> *"There is a sizeable Turkish population in the borough, but we don't have a very large population amongst our child sexual exploitation victims. We have a very large Jewish community in the borough…. but, I've worked here for eight years and I*

don't think I've ever worked with a Jewish family or young person. It's about what communities keep within themselves and what communities will accept scrutiny and support for. I think it is much easier for us to identify white British females being exploited because generally they, and their communities, are more open about what they are doing."

Managers and commissioners were asked about their experience of trying to influence the environment to reduce child sexual exploitation victimisation and repeat victimisation. Managers talked about the multi-agency operational panels which they attended or chaired, and also opportunities through service commissioning, as ways of influencing young people's environments and associative lives:

"Some influencing of the environment, through partner agencies was possible at MACE (multi-agency child sexual exploitation) and VAWG (violence against women and girls) meetings, however, as resources shrink, voluntary and community sector partners can't afford to send a representative. We do have influence in terms of commissioning and looking at how best can we support youth and community services, but that the pot of money is getting smaller."

and,

"To make use of opportunities to influence you need time, and none of us have that. We know that keeping a young person in their family and neighbourhood, is often unsafe but we do not have the capacity to change that."

and,

"There is not enough time to be able to network within the Council to enlist support to influence the young people's environments e.g. estates, parks, transport hubs and provision, leisure, community and/or faith group activities etc. Similarly, there is not enough time to co-ordinate information and neighbourhood activity with the police."

Managers mentioned organisational initiatives, such as, the police Operation Makesafe[71]:

"We have initiatives such as, Operation Makesafe, where the police were going to hotels and off licences and there are things being done in the community."

However, they said that as individuals they did not have the capacity to make much of a difference: In the light of this feedback, it appears that managers and commissioners would benefit from having in place a framework or strategy designed to facilitate positive influence on the environments in which young people live. One local authority described an initiative which could sit within such a framework or strategy:

Case study

In one of the areas the Local Authority launched a 'community response' initiative to tackle knife crime, gangs and child sexual exploitation on a local housing estate. The initiative could be described as a 'resilience approach', bringing together people in the

[71] Operation Makesafe was developed in partnership with London's boroughs to raise awareness of child sexual exploitation in the business community, such as hotel groups, taxi companies and licensed premises.

community, including services, including parents, young people, businesses in the area, the local hairdresser and the shop keepers, to kind of identify their role in supporting young people in their community.

The initiative is Council led, with a plan for it to become community led once joint responsibility has been established for actively diverting and safeguarding the young people involved in/affected by the knife crime, gangs and child sexual exploitation. Included in the initiative are the two main secondary schools in the area; and youth centre, sports clubs. The premise for the initiative is that the influence of a connected community, who know what is happening on the ground, is the most effective response, *"They know the relationships between the young people, their siblings and their parents and so on. So it's trying to harness that".*

The youth service has a key role because the youth centre is right in the middle of the estate and lots of young people use it, but also the wider population on the estate walk past it every day. All the children go to the two schools. The schools in particular have needed to become much more community-focused

Promoting flexible, multi-agency joint working

When working with young people whose lives are chaotic and whose experiences have resulted in them being distrustful and non-compliant, multi-agency joint working requires practitioners to extend their professional responsibility outside of the usual organisational agendas to accommodate the needs of the child. Countering the impact of trauma which pushes a child to disengage is difficult, however, where this does not happen, the keyworker is left to carry the responsibility for supporting the child on his/her own.

Furthermore, if the multi-agency network is not collectively supportive, the child is denied the opportunity of learning that they can reach out for and receive help from, a range of people. The ability to do so is an important factor in building resilience for the future.

Young people

Many of the young people were unable to benefit from the counselling offered by CAMHS. From the young people's descriptions this appears to have been because the CAMHS professionals were not able or disposed to flexibly adapt their approach to assist the young people to engage. The young people needed encouragement through much more interactive communication with their counsellors than was offered:

> *"My keyworker and I talk a lot because I know when I went to the psychologist, I went to them for about an hour and they'd say, 'How are you feeling today?' I'm …'For God's sake, it's the same questions every week. You know what, I'm not going to tell you. They did not sort anything out when I told them stuff", so I decided not to tell the psychologist anything."*

and,

> *"My keyworker always listens to me. She is the only one who listens to me. The counsellors didn't listen to me; they didn't even look like they were listening to me. They just sat there and wrote things down and talked to someone else. I stopped going. My mum wanted me to keep going, but I just stopped."*

and,

"The counsellors asked, but then they didn't listen. They don't talk to you about what you said, I don't think they remember – because they weren't listening. I want my keyworker to ask about everything and I want to tell her."

One young person described her school's inability to step outside of their usual organisational agenda to accommodate the needs of the child.

"My keyworker talked to the school for me, about not feeling safe, but the teachers didn't do anything about it. They don't understand that I am confident on the outside but I am not confident on the inside. On the inside I am scared."

Keyworkers

Countering the impact of trauma which pushes a child to disengage, for example, from education, is difficult. A keyworker described one such situation:

"It is difficult because legally she does need to be at school. The school are coming from a completely different angle, their outcome is 'attendance'. So they accuse us of 'being on the child's side' in a negative way; saying we are colluding with the child to keep avoiding school. We are just working at a far slower pace because that's what we have to do."

If teams and staff are 'burnt out' by process and culture then it is impossible to imagine how bringing a vulnerable, damaged and at risk child into the environment can have a beneficial outcome:

"I think there is quite a low morale in our team, if I'm honest with you, and I think that where there is a lack of understanding about child sexual exploitation with other professionals fighting and people aren't very sympathetic towards these children and so you feel like you're constantly advocating for them."

Many keyworkers were frustrated with organisations such as police, mental health and social services because of the artificial barriers that enforce their inability to 'do right' by children. The frustration was exacerbated by the keyworkers' view that that these are not 'just any children' they are young people who have been harmed by the single most traumatic and invasive abuse that can be endured by a child or adult:

"*Yes, there are two police officers supposed to be attached to this team. We never see them. They don't seem to think it's important being here with us. There are so many occasions when we need the police."*

Several keyworkers explained that they did not have the relationship with the police that was needed and police not addressing the perpetrators or the perpetrators not being dealt with appropriately sent the wrong message to young people:

"*How if that young person doesn't see that anything is happening, why are they going to disclose it and why are they are going to talk about if nothing's being done and that perpetrator will just move on to someone else."*

Backed up by another keyworker:

"The police categorisation of child sexual exploitation 1, 2 and 3s is narrow and inflexible. Whereas we would be able to see indicators of vulnerability and intervene at a much earlier stage, for the police it would not be considered as something that they need to pursue unless there is actual evidence of abuse. Very

often that's not the case in relationships, you are not going to have actual evidence, but there will be circumstantial evidence which should be sufficient to support the young person."

One keyworker felt that co-location was the answer:

"I think the whole co-location of the police. That would definitely help the whole child sexual exploitation work that we are doing, bring us together as a team. Basically being in a different location is a problem."

Another worker stated that they didn't think enough is being done to work with young men:

"I think that would really help if we were doing some work in schools around appropriate behaviour and around consent and around contraception. These are things that come up from some of the discussions that we have … obviously the majority of young people we work with are females, but I don't think enough work is being done in schools to educate males and females, but males, definitely."

Keyworkers commented that:

"Often children's social care thinks that keyworkers are going to come and 'fix the child'. They see it the same way if a child is being referred to the Substance Misuse service for drug addiction."

There is agreement that there needs to be a parenting support service that works with families where there is a social worker involved. Currently when there is a social worker involved with a family, but a parenting support service do not become involved or do not work with a family or don't provide any sort of services, it was explained that this could be frustrating because a lot of the families has issues themselves:

"Parents are needy and often they don't know what parenting means, and of all the work that we do and we could prevent, there needs to be a parenting support worker within the service, that works with families. I think it would be helpful to have a multi-disciplinary sort of service with sexual health… all the key agencies that work with child sexual exploitation, things like social care and health services, the police, the education liaison officer. We have psychologists here, which is helpful and there's housing."

The general opinion from keyworkers is that approaches are changing. One worker explained:

"W*e've all been sharing information, we've all been aware of the situation and I think this young person knows that and I think that's been quite useful for her, knowing that there's lots of people on board and that she can say, 'Well I want this person to help me with that', and 'I know this person is there for that'."*

There was a feeling that there is more agreement now, more recognition that children need support e.g. at school and not just being seen as disruptive. Getting the young person to positive activities, both to divert them away from whatever it is they're doing, but also to find out what they are good at, what their strengths are, what they like doing was really important. One keyworker said:

"We've been lucky in the past because we – I – had the whole wealth of the youth service behind me, my organisation, with several youth centres in the borough and lots of programmes running."

Keyworkers agreed that if you could get young people into activities they can support confidence and self-esteem:

> "*That's a big stumbling block and you have to go with them for the first couple of times, and introduce them to the youth worker and then say to them 'I'm not going to come every week because Sarah will be here and she's going to be your point of contact'. This starts to build a resilient support network but it's never easy because there's never enough options and opportunities are not well resourced there are issues about money and resources. So nothing is ever simple, partnership needs to be looked at and strengthened."*

Another reiterated:

> "*Also I help her to do things on her own, just encouraging her to do things outside of the family home. That has been the biggest challenge for me, for this case, is getting her to do things outside of the family home, i.e. activities, getting her to maybe be involved in a hobby or an interest, getting in with other people encouraging that. It's an ongoing challenge getting her to be involved in outside activities. A couple of weeks ago she met with an Activities worker for the first time, it was positive. Last week she had a second session with her which she cancelled."*

Finally peer support proved very popular with a keyworker explaining:

> *"Then there's a Youth Leader Scheme as well, which I am supporting her to join because, one of the things is that she knows what she's gone through. She understands that it was a negative experience and she wants to talk to others, other young people who may have gone through similar experiences, be a positive reminder to them that things are going to be okay."*

Managers

Flexibility to meet the needs of young people was seen as important by everyone; and managers and commissioners agreed that the only way this could be achieved was through good multi-agency joint working. A manager described that as taking place through the Child Protection process, although this raises concerns about multi-agency working in support of young people whose need or risk does not reach the Children's social care threshold (this is explored in the subsection on D eveloping and m aintaining effective care pathways, below). Notwithstanding their importance, there was agreement that multi-agency relationships are challenging. Comments included:

> *"In multi-agency working there's a lot of phoning around and waiting for people to get back to you. Chasing, chasing, chasing."*

And talking about the benefits of having a multi-disciplinary team, one of the managers said:

> *"It allows us to build up a network of support internally, which means that we can get stuff done much quicker than when you are waiting for so and so in another agency to respond to your email and your phone calls."*

One manager was concerned that poor multi-agency relationships was affecting practitioner's commitment to their jobs:

> *"Some of them I think there are some people who may be questioning whether this is the right role for them. I think part of that is down to poor partnership working which has damaged their ability to feel satisfied in this role."*

Police

The quality of joint working with the police was not consistent. Some managers described a good relationship:

> *"We work really well with CAIT (police Child Abuse Investigation Team), and they come to my managers meetings every six weeks. We fostered that because it enables us to say, "This isn't working so well, can we have a look at this" and "This is working really well…" So we have a very good relationship with them and we pick up the phone to each other; it's working well."*

One manager described the reluctance of the police (and schools) to engage directly with the families, and with the young people, who were, or were suspected of being, involved in child sexual exploitation:

> *"We get it from schools and we are used to it from schools and all levels of social care you get schools phone up and say, 'Oh, the child has got a bruise. No we haven't told the parents that we are referring to you', because they don't want to damage their relationship, or because they don't feel confident in assessing the risks to that child if the parents know, which I understand it a bit more from schools. I don't understand it from police because you have power and authority as a policeman to remove that child or to deal with that in a different way. You have to do it."*

Other managers talked about either a reluctance on the part of the police to co-locate, despite an agreement to do so:

> *"We are supposed to be a co-working team, we are supposed to have two police officers based with us in our team. A year on, we are still chasing them to co-locate, it's not on their priority list."*

Or, the fact that:

> *"The local CAIT has had three police inspectors in one year. That's not ideal. They are such a key agency in this and the response we get is often not good enough. So the new inspector I do have hope in, he may not completely get it but he does get things done e.g. when you say to him it's not good enough that it's taken three months to download a young person's phone, it gets done."*

Schools

In relation to schools managers spoke about prevention work:

> *"We a do a lot of awareness raising work in schools which works well. Some schools you obviously have better relationships with than others. Some schools still won't let us in because then it's admitting there's a problem."*

and:

> *"I think the biggest gap in recognising and responding to child sexual exploitation, is schools and around SRE in schools. So how we really start tackling this early, before it becomes an issue for young people and what is a positive, safe relationship and how do they have that. We've commissioned a young men's health and wellbeing voluntary and community sector service to go into schools and deliver some of that work, together with our sexual health service and our youth service. It's*

really a kind of early intervention approach, but which will also then through that, start to pick up where there perhaps are individuals who we need to offer more support to. That's the idea, but it's not running yet."

However, when talking about the role schools play in the recovery of a young person following child sexual exploitation, a manager noted that:

"Most of the child sexual exploitation young people are not in school, so there is limited scope for joint-working with schools – teachers or the pastoral teams."

CAMHS

The managers were unanimous that working in partnership with Child and Adolescent Mental Health services (CAMHS) was extremely challenging:

"There is a CAMH service, but to get somebody into CAMHS is like getting blood out of a stone."

There was also a view that a referral to CAMHS was also not necessarily the right response:

"Sometimes you have to question, is it effective? The young people have learned a way of surviving. Speaking to them afterwards, their response is 'If you are going to be interviewed by a middle class person, you will go along and pretend you understand what that person is saying, but when you walk out of the room, you haven't got a clue what they were on about'."

A manager summarised the situation as follows:

"CAMHS has a very high threshold. The young people only get CAMHS when the damage is done and they have been taken into Care. We could save money with Early Intervention – but the budget has been cut."

In two areas arrangements are in place to manage the lack of access to CAMHS:

"We are also very lucky in that we have access to two clinical psychologists. We know our biggest criticism is that the time between trauma and getting the support the young people need is too long. We've had young people who have had that support and then made disclosures of more trauma, historic or in the time when we are supporting them. Our staff have been able to use the psychologists and have been supported through that. We are very lucky that we have our two clinical psychologists that we can tap into and we don't have to wait for CAMHS. The waiting list for which is four months or so. That's not the worst in the country; but the young person remains with that trauma in that time. So we are lucky."

"To mitigate the impact of the inaccessibility of CAMHS, a CAMHS worker has been seconded into the team for three days per week. Social workers can consult with her on their cases both within and below the CAMHS threshold. Most of these young people do not need CAMHS – they need a trusted, supportive relationship."

Health

Managers and commissioners agreed that multi-agency working with health services other than CAMHS was good.

"I think we have good relationships with our health services in this borough as well. We have a very good health SPOC who attend all meetings, any strategy meeting. If she can't attend she'll send a very clear report, so she is very on board with everything."

The health single point of contact (SPOC) in one of the areas was clearly highly valued by the Child sexual exploitation team manager:

"Local health services are very stretched at the moment, they are very short staffed so we don't necessarily get the feed-back from them that we would want. However, rather than them getting ten phone calls from us, we go through her and she gets us the information, which is a bit like a 'middle man' activity, but I think it does make it easier for their over stretched service."

Managers in two of the three areas responded positively when asked about the quality of joint working with Accident and Emergency services. They said that they did get notifications when there were concerns about the circumstances surrounding a young person's need for Accident and Emergency services. One of the areas participates in a r egional joint-commissioning arrangement which funds the placement of two youth workers in the local Accident and Emergency service. The youth workers support the health practitioners in identifying child sexual exploitation (and other safeguarding issues affecting young people). They meet with the young person and try to engage them.

Public Health

Managers talked about having a good relationship with the local sexual health teams, however it was interesting that they did not refer to this, or to school nursing, as joint-working with 'Public health'. One manager went so far as to say that there was, *"No joint-work with Public Health."*

A manager described an innovative Public health programme aimed at building resilience in young people:

"One of the things we did to support that was mental health first aid training for a whole range of practitioners in schools, in children's centres, in social work teams to give them that kind of common understanding about what we mean by resilience and what their role is in that with young people in their context and where they can get more support for young people in the wider system.

It gives people responsibility for actively supporting young people's health and wellbeing; but also to recognise where their limit may be and where they might need to draw on other services."

<u>Gap in services</u>

A common theme in managers' comments about partnership working and the support they valued from other agencies or disciplines, was the need for there to be a support service for parents. A commissioner said that: *"parents crying out for help…. parallel work needs to happen, to mend the fractured relationship parents have with their children; and also, often with Children's social care."* The service which managers and commissioners thought was needed ranged from a parent support worker to an integrated family support function:

"There is a desperate need for family support workers. The ideal structure service structure would be: 4 to 6 teams with 8 social workers and 3 family support workers

in each. This would free up time for the social workers and give them the flexibility to undertake complex casework with the child sexual exploitation young people."

Developing and maintaining effective care pathways

Managers

The route by which young people were referred in order to receive support to recover broadly included: a discussion at the MASH (multi-agency safeguarding hub) and referral from there to Children's social care. This would generate a strategy meeting, a care plan and overview of the child's case at the operational Child sexual exploitation panel (MASE/MACE/MET). One of the areas also has a youth MARAC (Multi-agency risk assessment conference). The information shared at the Panels identifies the connections between the victim and/or perpetrator networks which that young person is involved in or affected by. The Panels also provided an opportunity for a wider multi-agency discussion about how best to help the young person.

Two of the team managers spoke only about referral and case pathways for young people who reached the Children's social care threshold – risk level 2. This was described in more detail by one manager as follows:

"We screen all referrals in and we ask social workers that do it will make a judgement whether the risk level is 1, 2 or 3[72]. Other professionals just send the information, we don't ask for a judgement because they're scared to assign a level. Typically level 2 and above is where social care thresholds are met and have to have a strategy meeting to start with."

For an explanation of the risk levels, see *The Metropolitan Police Service Child Sexual Exploitation Operating Protocol* in subsection 1.4.1 Terms.

One of the team's was fortunate enough to be able to accept referrals at level 1:

"Typically level 2 and above is where social care thresholds are met and have to have a strategy meeting to start with. For the level 1s (e.g. where a young girl sends images of herself to a boy who sends them on to other boys), we can find her a youth worker to do some work with her. So we are lucky in that sense, they don't have to be high risk for us to be able to take on a case… well, the team's name is the Child sexual exploitation prevention team.

I'm very keen to keep prevention there because if we wait for them to hit the threshold, to be at level 2, it's already happened and they are more severely traumatised children. The trauma from just sending an image is huge and so that needs to be tackled, but obviously we are in a time where we very much have to work to that threshold because we are completely inundated. So, yes, we are lucky that we can work and respond to all levels of risk."

Online sexual abuse

This manager's desire to intervene earlier is a view likely to have been held by all the professionals, but where organisational constraints limited their scope, they did not expand on the issue. It is however concerning that online-only abuse is summarily relegated to a lower category of risk. In all probability this reflects the fact that there is as yet very little research addressing the impact of online only child sexual abuse and exploitation.

[72] See *The Metropolitan Police Service Child Sexual Exploitation Operating Protocol* in subsection 1.4.1 Terms.

One of the few studies to identify the impact on the victim of online grooming leading to online and/or offline sexual abuse was undertaken by Whittle et al. (2013). For the study eight young people (six females and two males) who had been victimised through online grooming and subsequently experienced sexual abuse online and/or offline were interviewed. A notable finding from the research was that, whether abuse occurred online-only or both on- and offline did not correlate with the extent of the impact on the victim. The link which emerged was that the young people experiencing multiple long-term risk factors suffered greater negative impact after the grooming and abuse on an individual level (e.g. self-harm, depression), compared to those who had more protection.

Following from Whittle et al.'s research, a pedagogic approach would prioritise the young people's experience over a managerially set threshold for accepting referrals. Though how this might be achieved would need careful planning to accommodate an assessment of impact.

Self-referral and identification of child sexual exploitation

A child-centred pedagogic approach would also not preclude young people securing help for themselves, rather than having to rely on a professional to make a referral. The manager of the Child sexual exploitation prevention team said:

> *"Young people cannot self-refer, it has to be a professional referral. We have tried to change that. They might not self-refer for 'child sexual exploitation' because they don't recognise that they are victims. But they may want help because they feel 'something's not right. Then where do they go? We have to hope that they all have universal services they feel able to approach and they should have somebody they can talk to and who can refer them.*
>
> *How we tend to deal with that is we do the awareness raising work in schools and the disclosure comes from that. Then the schools have to put the referral into us to formalise it. Most of our referrals come from schools."*

Whilst not explicitly advocating self-referral, a commissioner in another area described an attempt to widen opportunities for children and young people to be identified or to self-identify as needing help as a result of harm or risk of harm to themselves due to child sexual exploitation; and to make services accessible to them:

> *"We've taken a partnership approach across all of our services – that they are all part of the child sexual exploitation response with the young people that they are working with. Our youth service particularly has a big role in being able to pick up issues around child sexual exploitation and dealing with those."*
>
> *"The frontline response to child sexual exploitation is the commissioned voluntary and community sector service but we have a couple of commissioned family support services as well who should be doing that; as well as our children's centres and health visiting."that's needed, and enough capacity on their side to be able to respond to well. That's quite a big challenge."*

Recovery services for young people following child sexual exploitation

These comments were about the process of identification. In keeping with the focus of this Project, managers and commissioners were asked about the availability of recovery services for young people who had been harmed through child sexual exploitation. A commissioner described the local response as follows:

"I don't think we have a consistent response to that. I think what happens is based on the individual young person and individual situation. I think they do get support but it's not necessarily a consistent approach. CAMHS might be appropriate for some young people, but it's not always."

A commissioner talked about future plans:

"I think the 'Young People's Health and Well Being Service' will in future be one route, because there's a mental health programme within that service which is online counselling for young people, and locally that's proving to be a real success. It also has substance misuse provision within their social care and health support, so it's a holistic service. Together with the existing commissioned frontline service (for young people 13 years and over, experiencing gender-based violence) are probably two main responses."

3.3 A strengths-based service

3.3.1 Promoting young people's personal qualities and skills

3.3.1.1 Young people's responses

Strengths-based work

All (100%) of the young people were happy and able to describe their skills and abilities.

Many of the young people needed some encouragement to name their positive personal qualities, 12 (80%) of the young people did so, however even with prompting three young people could not think of any positive character or personality traits that they might have.

It is interesting to note that two thirds (67%) of the young people who named their positive qualities used words like 'honest, caring, sharing, seeing good in others, generous and kind; thoughtful, understanding and a good listener'. Two others described themselves as 'funny'. Only one young person referred to herself as 'strong', and even then prefaced the description by saying that her keyworker had told her that she was strong.

For information about the keywork support being young person-centred, the young people's goals and the young people being able to name their strengths, see subsections 3.2.1 The young person trusts their keyworker and 3.4.1 A successful service.

Table 3.3.1.a) Summary of young people's strengths

	Positive personal qualities	Skills and abilities	Using strengths to be happy and safe
Total	12	14	12
Total %	80%	100%	86%

Table 3.3.1.b) The young people's descriptions of their own strengths

	Positive personal qualities	Skills and abilities
1	Caring, kind & wanting to help people out the best she can. Honest.	Ice skating, judo (orange belt). Cheerleading.
2	Communicating. Overcoming troubled feelings and doing what I am supposed to do. Nothing else.	Music and art.
3	Only not so angry and depressed. Nothing else.	Looking after children and talking to people.
4	Honest and kind.	Make-up and dancing. Communicating. Being independent and confident to go up and talk to people.
5	She tells me I am strong.	Art & poetry. Now is pretty good, I'm doing good in school, I've got a job, I go to the gym.
6	None	Cooking. Doing make-up. Hairdressing.
7	None	Good communicator.
8	See good in everyone. Confident. Stubborn.	Drawing. Swimming, go to the gym.
9	Good at listening to people and understanding them (e.g. their anxiety or depression)	Running and good with children. Do things, don't sit around.
10	Sensitive. A good listener. Honest and kind and caring - I care about what happens to people who are not fortunate.	Schoolwork, studying, reading about politics and people. Good at talking about ideas and thoughts. Independent and good at meeting people.
11	Funny.	Art and music. Singing and dance and rap. Drawing people. Good at fashion.
12	Thoughtful. A good listener.	Schoolwork esp maths. Communicating. Leadership. Thinking and debating.
13	Articulate. Good listener. Caring, generous.	I play the trumpet, trombone, drums a bit on the guitar but I'm not very good ukulele. Sport. Schoolwork esp media studies.
14	Funny, caring & sharing.	Health and safety care. Looking after my little sister and babysitting my niece and nephew.

The young people described how they and their keyworkers had been working on the young person's personal qualities and skills:

> *"I am good at art and poetry. I like that she takes the focus off my negative things and we just speak about my strengths, what I find good, what my habits and hobbies are and what I like doing. I like the conversations about art and poetry, they cheer me up 'in the moment'."*

and,

> *"I am good at communicating with people, overcoming my feelings and I have better will power, you know, doing what I am supposed to do, pushing myself when I don't feel like it."*

and,

> *"My good qualities are only that I'm not as angry as I used to be and that I'm not as depressed. I don't really know about any other good things about myself."*

and,

> *"I'm caring and kind and everything, and I want to help people out the best I can. All my friends had lied but we didn't get a chance to talk to each other and I could not lie to save my life."*

and,

> *"Yeah. My keyworker says you don't have to be good at something; you can be just good in yourself. She talks about stuff like that, you know – you're kind, you're generous, you're honest, you're brave – all that kind of stuff. Yeah, we've talked about that for me. But I can't see it especially when I am down."*

and,

> *"I stick up for myself more. With some girls and boys I don't say anything because it's better that way. Because if I start – I'm not a person to start an argument, but if I'm angry and I feel like you are getting away with it, I won't let you get away with it. I'll be telling you how I feel because it's not fair, so you've got to realise that. I have my own opinion. I won't be nasty to anyone, definitely not, but I definitely stick up for myself if it's needed. Yeah. Today somebody was rude to me and I'm not going to let you be rude to me just because you think I'm 'something'. I won't stand for it."*

and,

> *"Everybody says that I am somebody that always sees the good in people, it doesn't matter if they are bad; I always see the good in people. I always defend people. That's a big problem that I have because even people that are bad, I still see the good in them."*

and,

> *"Listening to others as a personal quality as well as an ability. This is because I understand people, I didn't used to be understanding but because I've gone through stuff it's helping me to speak about it."*

and,

> *"My keyworker has helped me see that there are a lot of things that I do which will help me to get on in life. I am actually really good at schoolwork. I used to enjoy studying when I was still going to school, before everything happened; and I read a lot about politics and people. That's why I think I could go to university. I am good at talking about what I have been reading and thinking about. I can articulate it, but only really when I am feeling confident. I am independent, I go and do things on my own and meet people and talk to them."*

and,

> *"I think I could help girls who have had bad experiences like myself because I am sensitive and I am a good listener. I care about what happens to people who are not fortunate. Things like honest and kind and caring – that's me."*

and,

> *"I am good at art and music. I can sing and dance and rap. I can draw pictures of people I know, I have done my family and I can also do pictures out of my head. I make everything I wear match. Everything has to match."*

and,

> *"Some people say that I am funny".* She became more confident, *"I am funny! And I used to sing for my Gran."*

3.3.1.2 Professionals' responses

Strengths based practice was a concept with which everyone was familiar. It is an aspiration of children's services everywhere. Keyworkers spoke unprompted, revealing a constant and intense focus on reflecting the positive back to the young people as a way of raising their self-esteem.

> *"… it's always trying to build on their strengths and empower them and praise them if they've done well and things that they are good at."* The keyworker went on to say that she would try to identify these strengths herself, so that she *"could point them out to the young person, who might say 'Oh, actually, I did do that well,' or 'I am good at that', then that's something they can take away and build on hopefully."*

> *"I've never really understood it (the power of words)… until I had a young person who came up to me quite a long time after we'd had this conversation and thanked me for having that conversation and the things we spoke about. That was a real 'wow' moment."*

> *"I actually think that's amazing. I actually think that what you're saying is really articulate and everything you are saying has such valid points. The only thing you have to learn is when it's appropriate to say that. You don't talk too much. You are really, really bright and everything you are saying to me, I'm saying, 'You're right.' Response to a young person who thought they talked too much."*

> *"I talk about the fact that we are strength-based and it's a recovery and a holistic model. So we look at what the child is good at and what they are like, and the positives in their lives and look at how we can build on them."*

The strengths based model tends to focus on what the young person can do now and in the future, rather than dwelling on a difficult past experience, which is important for young people who may feel defeated by their history.

> *"So I would say, for me, strength based is 'I can do'. That's how we look at things, rather than what's gone wrong. It's 'what I can do', even things like coping strategies… Another example is when she is not getting up and going to school, I say, 'You were able to stay online talking to your friends for one whole hour, you were able to do that for a full hour. If you can do that for a full hour, you can do a 30 minutes lesson because you have shown that you have got the stamina to do this.' It's using something that she enjoys and …. that's how I feel when I look at strengths, I look at 'I can do' – what can that young person do already? "*

Other examples include a keyworker contacting her young people on social media and exchanging "inspiring quotes and things". Another said:

> *"So I say to them, 'That quality you have is so special, do you know that is your gift', and stuff like that."*

Survivor strengths

In the light of the young people's distrust (generated both by trauma and by previous poor experiences with professionals), the keyworkers regarded the young person's willingness to engage as very brave:

> *"They are open to recovery and that in itself is something that is actually quite difficult… A lot of adults do not want to face certain aspects because they know our service is… voluntary. It's not something that they have to do… they are survivors because they continuously are able to show up for our sessions and they are not easy sessions."*

This worker went on to talk about the bravery and determination of the young people who talked to the police, or engaged with the legal system with a view to prosecution of their abusers.

> *" 'You've come through all this, do you think that means that you are brave?' 'Yep'. We wrote brave down. 'When I ask you questions, are you honest and open with me?' 'Yeah, probably'. Wrote that down, and then we had the full poster and she took it home with her."*

For some keyworkers, even less than ideal coping mechanisms had positive aspects, which they reflected back to the young people.

> *"Sometimes coping strategies are not the best but we will say 'Okay, this person is trying to find a way to cope', so even when for example, one strategy is to smoke, that's not a good thing. But that young person knew that 'If I have this cigarette, I'm going to be able to cope with the next hour'. So that was her coping strategy of trying to do something. So we would recognise that. For me, that would actually be a strength… 'I'm feeling a bit wound up, I don't want to cause any aggro here, so I'm going to do this.' – which is the lesser of two evils."*

Helping peers

Some young people could be helped to build something positive out of their abusive experience, going on to help other young people. This is a strengths based approach which is

increasingly present in many areas of children's services, for example in anti-bullying work; in school mentoring schemes; in Children in Care Councils and other organisations for Looked After young people and in numbers of voluntary and community sector organisations, including some sexual exploitation projects.

One of the problems of this type of approach is that although it helps young people build their strengths and skills, the benefit is limited if there is no accreditation and no follow through into the world of work. For example, many Children in Care Councils now provide public sector apprenticeships for their most active members.

A keyworker described the helping ambitions of one of her young people in this way:

> *"She's a very outspoken young woman. She's got strengths. One of the things that she is able to identify, and I have seen it as well through our discussions with her, is that she knows what she's gone through. She understands that it was a negative experience and she wants to talk to other young people who may have gone through similar experiences. She wants to be a positive reminder to them that things are going to be okay. With her persona and the way she presents herself, I definitely see that she could do something like that and I think she's a good talker. So I would definitely see her doing something like that."*

In this case, the keyworker was helping the young person to become a youth worker. Within the cohort of young people who participated in this research, there were two other young people who wanted to support or mentor peer victims following child sexual abuse and exploitation. They were undertaking peer educator courses.

One keyworker who explored this in some depth, noted that her young person's positive qualities, indiscriminately applied, might be the ones which had led the young person into difficulties:

> *"At every opportunity, when they say 'I'm such a mug'. I'll say 'Do you know that actually it's not about that, it's about giving your kindness and love to the right people. You have amazing generosity…. would you like to be a heartless person who doesn't care about anyone? No.' People really struggle because, a lot of these kids are empathic and sensitive but they are just not aware…"*

3.4 A successful service

3.4.1 Young people's assessment of their own recovery

3.4.1.1 Young people's responses

The young people assessed their own recovery very positively. Their responses indicated that they had made significant progress in feeling autonomous since first beginning to receive support from their keyworker. They had an increased sense of separateness, self-possession (being able to regulate their emotions and manage their behaviour), an ability to define their goals and the flexibility to make significant choices. The young people were able to describe goals they had already achieved as well as goals they were aiming for. In terms of 'autonomy' the young people appear to have made good progress.

The young people's progress in terms of empowerment was more mixed. All of the young people who had a keyworker had demonstrated an ability to enter into and sustain a bi-directional or mutual relationship with their keyworker. In terms of their 'sense of safety', all of those young people felt safe with their keyworker. This is important not only in terms of 're-

establishment' of trust in another person, but also for modelling a t rusting relationship for young people who have not had one before. However, the period of support had not raised the young people's feelings of safety in other areas of their lives as much as could be hoped for. This is likely to reflect the fact that the keyworkers are not in a position to influence the home, school and neighbourhood environment enough to reduce the young people's feelings of vulnerability and insecurity.

For information about the young people trusting their keyworker and feeling safe, see subsections 3.2.1 The young person trusts their keyworker, and 3.2.3 Keyworker support to address the whole child's needs, above.

Table 3.4.1 a) A successful service – summary progress towards autonomy

	Positive changes in health & perspective	Managing a bad experience well	Short term achievement goals	Longer term achievement goals	Challenges they had/have to overcome
Total	13	14	14	14	14
Total %	93%	100%	100%	100%	100%

As part of the discussion about their progress, the young people were offered the opportunity of describing a relatively recent experience of their choice in which they had had to manage a bad experience well, or alternatively they were asked how they thought they might respond if someone they did not know unexpectedly shouted at them in the street. The young people's responses are included in Table 3.4.1 b).

Table 3.4.1 b) The young people's descriptions of their own progress

	Positive changes in health & perspective	Managing a bad experience well	Current/short-term achievement goals	Longer-term achievement goals
1	Reaches out for help (from kw or police) now when in difficulties/unsafe situations.	Not specified - write poetry or get a train to the seaside	Find a school and get GCSEs. Just done First Aid training.	To get into the police or army.
2	I want to do exercise. I promise myself I will start exercising.	Shouted at in the street - talk to them, saying it's rude…	Currently attending college doing music & art. Talking to modelling agency.	Graduate with music & art. Modelling.
3	Can talk or withdraw now instead of getting angry.	Overwhelmed by low feelings - talk to herself, scream into pillow.	I am at college at the moment doing animal care. I need to get science and physics to be a paramedic, so I am going to	I want to be a paramedic. I want to be caring for people.

	Positive changes in health & perspective	Managing a bad experience well	Current/short-term achievement goals	Longer-term achievement goals
			have to start those courses, get those GCSEs.	
4	Doesn't 'mess things up' by getting angry or into unsafe situations socially. Has a new concept of herself as an independent person who can 'walk away' and come back and talk to people.	Shouted at in the street - focus on not getting too angry, just move on because angry feelings are followed by being upset feelings.	Going to college, to get the qualifications not achieved at school.	
5	Manages anxiety & panic attacks. Understands now that it is both depression and fear of people judging her as 'unlovable' which stops her going out. Learning to do it anyway.	Bad feelings - anxiety, panic attacks and feeling 'unlovable' - carries a paper with her which she stops and reads. Don't withdraw into a dark room (as previously), read books and get out and about.	University & drama college.	English as a major and acting. I want to one day to write (educational) plays. Foster carer.
6	Could not say 'no' to anyone e.g. her mother, instead she would just go missing. Stop going missing. Can say no to others too. Stop smoking. Build & maintain good relationship with mother.	Shouted at in the street - maintain confidence and tell person not to shout at her.	Going to college to do hairdressing.	Hairdresser.
7	Learnt that if you fail you can just try again.	Shouted at in the street - Not allow herself to be abused (as in the past), but monitoring her safety before responding; and remaining civil.	My goal is have my own horse.	Horse riding. Hair & beauty.

	Positive changes in health & perspective	Managing a bad experience well	Current/short-term achievement goals	Longer-term achievement goals
8	Managing my anger. Easily swayed by friends/peers. Has now closed off all those (negative) relationships. Is actively seeking positive friendships.	Waves of negative feelings and responding to abuse from associates - write down feelings. Write down negatives & positives about the person.	Working for an agency.	I want to become an air hostess because I want to travel.
9	Can now recognise a bad (boyfriend) relationship. Working on how to put that into practice.	Abusive incident at home. If I start getting wound up about it I might go in my room, listen to music. Do things, go out…	Working for an agency.	I want to become an air hostess because I want to travel.
10	Able to recognise & leave a bad relationship (boyfriend).		Try to get GCSEs in order to go to college or university.	College or university.
11	Recognises & uses singing and caring for animals to lift depression. Reaches out to sister and friend for help.	Shouted at in the street - talk to the person, but not if they cannot hear. Walk away (get angry afterwards).	Get my GCSEs.	Do something with fashion & design in it.
12	Self-harming and angry outbursts have stopped. Working on communicating well.	Mother's partner kicked the family dog - told him not to hurt animals and took dog out of harm's way (to her room).	Get GCSEs, hoping for some A*s.	University to do Business administration. Get some job experience and then start her own business.

	Positive changes in health & perspective	Managing a bad experience well	Current/short-term achievement goals	Longer-term achievement goals
13	Has worked through depression enough to get on with her life. Managing panic attacks and practical changes (avoiding his neighbourhood) to reduce fear. Trusting people more.	Feeling sad and/or angry - stop and think (e.g. about how my family would react). Leave it, listen to music or take a nap, fine when wakes up.	Complete media studies at college.	Get a job in the media - television and/or journalism.
14	Not be so angry and 'sort out' bad friends. Recognises she can get to feel better by caring for her baby sister, nieces & nephews	Depression & fear (the perpetrator in prison but his friends have been stalking her), panic attacks – changed route to college, controls panic attacks. Seeks help because of increased trust in people.	Child care apprenticeship/practice placement.	Nursey worker or child minder.

The young person's view of their keyworker was exceptionally positive (a good relationship modelled so that in the future the young person can recognise/develop good relationships and has confidence to reach out for help):

> *"My keyworker always does what she says she is going to do, I completely trust her. I love the woman."*

and,

> *"The police tested me for drugs and it was negative as I didn't take drugs but the teachers thought that because I have mood swings and because of my depression, that I was taking drugs. So they used to search me every day. But my keyworker knows… she believed that I wasn't involved with drugs and spoke to the teachers for me and now everything is ok – everyone has backed off! My family is proud of me."*

The young person and keyworker both thought the young person had made progress:

> *"I admit that sometimes I do feel sad or angry and I am going to hurt myself or somebody else, I don't want to do it, even though I used to just do it. My keyworker helped me to interrupt the spiral by stopping and thinking about the consequences of acting on my feelings, and doing something different. It's an instant reaction you want to do it but then in the long run you regret it. So then I thought about that and I left it and then I listen to music or I'll take a nap and then when I wake up I will be perfectly fine."*

and,

> *"I wanted someone to really understand me. I liked it when she tried to do so by listening to me rather than listening to the feedback from other people about me, if that makes sense?"*

and,

> *"Yes, my keyworker calls me, messages me, making sure she knows where I am. She talks to my family to make sure I'm okay…. this shows me that she does care."*

and,

> *"My keyworker listens to me and respects me completely, we negotiate. She listens and then gives advice and she doesn't tell me what to do. When I have said and she has said, then we discuss it."*

and,

> *"It's not possible to turn to parents and/or grandparents for support because, you can tell them something but they won't understand you as much because times have changed. My keyworker understands because of working with young people on a daily basis. She knows what is going on in society now, knows what schools are like and how the times have changed since when my parents were at school. My keyworker obviously relates better because of experience she has loads of kids with the same kind of thing, so she can relate."*

and,

"She was better than the social workers, she's better than everyone. If I could just push away everyone else I have at the moment and keep my keyworker I would because no-one else has really helped me. She cares about me – if she didn't she wouldn't be here now would she?"

and,

"I think my keyworker more or less knew everything what happened, so she spoke to me about it and I think it was a bit awkward because I was really down and stuff as I didn't really know her. I said what was going on, but not really what I needed cos I didn't know. After about a month, I liked her and she's been really good to me. I think if I didn't have her I'd be really down."

and,

"Before all the bad stuff happened, I used to have hobbies and I then lost myself and didn't know any more what I was good at. I didn't know who I was. My keyworker has helped me to try and believe in myself, because I used to put myself down in terms of what I do. I don't have any confidence… even little things like telling me I'm a wonderful person, that helps. It gives me a bit of a boost. I feel a little bit happy and get on with my day."

and,

"My keyworker gives me advice, but only once she has listened to me; once she's understood the situation fully. She doesn't tell me, she makes suggestions which help me to understand what I am going through. She helps me see things from a different angle and I can say 'no'."

The young person was able to name their strengths:

"If I tell myself to get on and do things, push myself, then that is when I know I am making progress. I know I am not making progress when I just do nothing. There used to be a lot of the time that I just didn't want to do anything. I would wake up and not want get out of bed. There's lots going on at home and stuff at school as well, I don't want to know…. but more and more I've been pushing."

and,

"I'm a bit 'in your face' when I get cross. I get angry when people treat me bad. They don't believe me or they start on small things that aren't important. Then I start shouting and I get into trouble, this is because of what I've been through, but I've learnt to move on and I've done it with my keyworker, she calms me down."

and,

"My keyworker and me, we talk about how I am going to get through school. Now I am not in school at all and I don't know what I am going to do. I can't do anything if I don't have my GYEs, so I am going to have to get back into a school. It is all so difficult. I can't be there and think about that stuff."

and,

"I always felt safe and so there was no need to worry about my safety and 'needs' – except that I was getting into trouble a lot. But my keyworker is the best social

worker I've had. Lot's better than any of the others. She's brilliant. The way I know that I am making progress is that I have not got into trouble for months. I did so well that my keyworker gave me a mobile 'phone because my old 'phone was taken away from me by the police at the beginning."

and,

"I was shaking so much when I was in my exam, but I passed it, the examiners had told me that a certain number of people had passed and 5 had failed. I thought I've failed, I've failed, I've failed… then the examiner called my name and said, 'Unfortunately… you passed'."

and,

"When I first knew K9 I wouldn't listen to anyone. I was horrible to everyone, I was a horrible person. Yes, and now I understand people. I used to be rude to someone if they are horrible to me but I wouldn't now. People say horrible things because they are hurting and it doesn't help to have a go back at them. I try to just keep calm and not show if I am getting upset."

The young person had realistic health/wellbeing and achievement goals and was actively pursuing them:

"I am strong. She always, always tells me how strong I am and how far ahead I am than most people that have been in my circumstance, and that helps me a lot because I don't believe I am, I draw myself down a lot, but K1 helps me to realise I am nowhere near the bottom."

and,

"I am good at music and I am good at artwork, my keyworker tells me to do more of both of these and she encourages me to do things, these and other things."

and,

"I am good at communicating. I am independent and I have confidence. I can go up to people anywhere and talk to them. I'm better at what I'm good at because me and my keyworker talked about what I am good at a lot and wrote lists on pieces of paper."

and,

"Ice skating, Judo and cheerleading. I'm a cheerleader as well. I was so shy to start with and obviously as a cheerleader you need to be confident, when you go onto the pyramid and if you are in a competition you have got to be confident enough to look at the audience, you just want to get down and run off the stage."

and,

"I understand now that it is my depression and my fear that people will judge me as being 'unlovable' which stops me going out. I am learning to do it anyway and I try to talk to myself about self-love and self-worth because you'll be something if you believe you are something, lovable."

and,

"I can communicate with people instead of getting angry or just going away and staying in my room."

and,

"My changes are that I can now choose to talk or withdraw, instead of getting angry."

and,

"I won't ruin plans by getting into unsafe situations socially or by getting angry."

and,

"It was important that she kept telling me what I was doing right. The goals I have achieved are – I stopped smoking and I stopped going missing. I didn't get into college the first time, but I am trying again. And I am still talking okay to my mum."

and,

"I am no longer going missing I have also stopped smoking, made better friend choices and improved my relationship with my mother."

and,

"I used to think I was strong, but I couldn't stick to it all the time so people could pull me left or right. I have learned to make me a stronger person, if that makes sense."

and,

"I try to talk to the person, but if they aren't listening then I just keep quiet and get away from what is happening as quickly as possible. If they are telling me off, I know that I am trying my best. If they are just being horrible then I get very angry afterwards, but I don't go back and have a go at them."

and,

"I used to self-harm every single day and then I used to be in hospital at least once a week for trying to commit suicide but then it stopped, it went from once a week to every two weeks, to one month and then to never and then self-harm went down from every day to one week, to one month and now I don't self-harm at all and I haven't tried to do anything."

and,

"The positive changes in my health and perspective on life are that my self-harming and angry outbursts have stopped and I am working on communicating well and on recognizing and building good positive friendships."

and,

"I use singing and caring for animals to lift my depression, and speak to my sister and friend for help."

and,

"I have worked on how to manage my emotions with my keyworker and she has highlighted my skills, like caring."

and,

"I was like, that's it, I am laying here doing nothing with my life, so my depression hit quite hard and then my anxiety hit harder. I didn't want to know anyone; and no new people ever again! I'm not leaving my house, this is me."

The young person said that it had been *"really horrible"* however, she does leave her house now, *"I am out a lot, I trust people a bit easier than I used to."*

and,

"Although the individual who had raped me was in prison on a very long sentence, his friends have been stalking me, and I have been having panic attacks. By changing the route to college I have managed to control panic attacks on tube. I am now seeking help rather than trying to manage my anxiety and fears on my own I have worked through my depression enough to get on with my life; and I am managing panic attacks and practical changes, such as, avoiding the neighbourhood that the rapist came from, to reduce my fear."

3.4.2 Imposed or agreed outcomes measures

Measuring the progress of vulnerable young people who have suffered partner abuse or been sexually exploited is problematic. The type of performance indicators used in the public sector: are agency or government generated rather than individual client generated; are often time scaled; are about major achievements (getting particular GCSE grades or not going missing) which are not necessarily good proxy measures for the steps towards recovery. Finally, also, they tend to be designed to be amenable to numeric manipulation.

Such performance indicators are not always relevant to very vulnerable young people. Young people who have suffered trauma, or are still anxious about their abusers, or confused, may follow a recovery path where major change comes slowly, sometimes with occasional behavioural relapses and where apparently small changes are very significant and what appears to be major change has not really improved the young person's life.

This can lead to a situation where sexual exploitation services are burdened by having to collect two sets of performance data, or the real progress made by exploited young people is not fully represented in the team or agency's performance narrative and partners may not understand the quality of what has been achieved. Sometimes outcomes are erroneous, for example Police counting referrals as disruptions.

One Team Manager said that they measured young people on school attendance and behaviour and on their level of engagement, which she saw as *"all very subjective".*

A keyworker expressed it like this:

"It's not just about academics. I'm not a believer in that. That's what the problem is, if they are not good at maths and English, or big academically, people write them off. It's so frustrating. They don't do that in schools, they don't focus on anything else. I'm just one person."

and,

"Success doesn't look to me like it does to other people. Do you know what I mean? Like a lot of the time they are, 'Oh, she's back in school'. Great but that doesn't mean that the groomer has gone or the ….. and it's like, we get caught up in what looks good on paper, but really it's emotional and my success is emotional."

Keyworkers gave examples of young people's 'little victories':

"She'll text me and say, 'I did it' and I'll be like 'Well done'. You know, just the little things like their little victories…"

and,

"I've got her to a doctor now." And,

and,

"I've tried to encourage her to say 'no' to her employer."

and,

"How long has she gone now before she's had anxiety or depression? Are these periods longer? It might not go away but has she dealt with it better, so if she's had another anxiety attack, has it lessened and does she feel…."

and,

"Has she done something new?"

Keyworkers unprompted talked about measuring success in terms of the young person feeling happier and being more able to cope. One keyworker also talked about young people reaching the stage where they can generate their own coping strategies and tools. This keyworker talked about giving young people the skills to manage their future for themselves. She said:

"If I've helped them to see things differently or find things within themselves that they can take on beyond me, because I am not with you indefinitely, so I want to be able to see that my influence has helped you to think about things differently. And sometimes I can see that because they say to me 'This and this happened, but I remember what you said and blah blah', and it's those little things that make me think, 'Oh, I'm so proud of you because I know that's changed in your mind set now'."

3.4.3 Young person who received an alternative service

The young person who had not received a pedagogic and strengths-based service, had been a Looked after child, in a children's residential facility for several years. The service had not succeeded in persuading her to engage in developing a relationship with a single trusted adult. This young person had not felt sufficiently supported to be able to explore her experience of child sexual exploitation, process some of the trauma and gain the insights and strengths which might protect her in future. She said:

"No. I didn't have a trusting relationship. I don't really trust social services, that's why I don't really talk to them and I asked for an advocate and I have not been offered one. Nobody has helped me. All I've had are carers looking after me to make sure I don't go missing from here and to make sure I don't do anything stupid. That's all that has happened."

The young person was clear about the service she felt she should have received:

> *"I never really had anyone to talk to about what had actually happened to me. Only my mum… if they are saying my mum is not suitable to be my mum, they need to offer me that support. They need to offer me that type of support because they say my mum isn't capable to look after me."*

The young person talked about her experience of being assessed to gauge her progress in managing herself – in particular her anger – and in keeping herself safe. She said that she had learned about the assessments of her progress through reading the minutes of her six-monthly Looked After Children reviews. From her questioning of staff as to the source of the information for the review reports, her understanding was that:

> *"My social worker and the carers here (at the children's home) will write a report or something on me and my social worker will get that emailed. They are watching me but I don't know what they are watching for. I just feel so weird that someone is watching me but they are not telling me what they are looking for."*

and,

> *"They say also that they don't want me having a phone because they don't want me on any website and I was like 'what do you mean?' They explained about meeting someone online… But, I have been warned. When I was in primary school we got taught about these things. You don't give your information. You don't meet up with strangers. I'm educated in all of that. That's not happening with me and….. I get really frustrated because they think I am vulnerable, but I am really not."*

The young person's 'phone use had been controlled because she was vulnerable to being contacted by members and affiliates of the gang who had kidnapped and sexually abused her. However, this appeared not to form part of her narrative.

The American psychiatrist, Judith Herman[73] said:

> *'The ordinary response to atrocities is to banish them from consciousness. Equally as powerful as the desire to deny atrocities is the conviction that denial does not work. Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims.'*
>
> Herman (1997)[74]

In Herman's 'three-stage' model of the healing process for people who have had abusive and/or traumatic experiences, the first stage goals are personal safety, genuine self-care (improved self-esteem), and healthy emotion-regulation capacities. Herman explains that in order to achieve even the stage one goals, the individual needs to acknowledge the powerlessness, shame and guilt, distrust and re-enacting of negative patterns in current relationships attached to the trauma. Increased awareness of these issues brings greater understanding, ability to take responsibility for them, and capacity to choose new, healthier responses and actions.

[73] Professor of clinical psychiatry, Harvard University Medical School and Director of Training at the Victims of Violence Programme in the Department of Psychiatry, Cambridge Health Alliance, Massachusetts.

[74] Herman J.L. *Trauma and recovery: the aftermath of violence - from domestic abuse to political terror.* (1997 reprinted 2015) New York: Basic Books.

The young person did not appear to have achieved stage one goals, from the perspective of the model, this would have been because she was still in denial that she had been abused. She talked pityingly about a peer in the children's home who was 'was groomed by men'; and:

> *"…used to self-harm… I could see she was on medication; she had depression; ADHD and bipolar; she was really traumatised about everything that had happened. What was happening with her was what social services thought was happening with me, and I was like, 'You can't compare the two!'"*

The young person said:

> *"Child sexual exploitation… if that happened. But at the end of the day it will not happen to me, I'm not a risk like that."*

and,

> *"I really liked him, but he thought I was sixteen at the time, so he never knew I was a child. So I can understand where he's coming from, but I can also understand where my social worker is coming from. He never knew I was younger than I was. So he never knew that what he was doing was bad…"*

In response to questions about whether she had been involved in an initial assessment of her needs the young person said that she was not involved:

> *"That (talking with your keyworker or social worker about your progress) never happened."*

She was clear that she did not need the staff to tell her that she was making progress:

> *"They were just telling me stuff that I know already. 'Your behaviour has improved, your anger has improved'. I know all of that. When I did get angry I used to black out so I didn't know what happened next. Now me getting angry has dropped because I have matured and I'm seeing that throwing stuff around and hurting other people will not get me what I want."*

She said that she knew she was making progress:

> *"I know I'm making progress because when I got here I asked them if I could change my phone number because I don't want to be in contact with friends. I know I'm also making progress because I wrote down on a piece of paper – when I first got here I was really shy. I wrote down on a piece of paper things I wanted and the things I needed and I wrote down on the piece of paper and gave it to the manager. If I'd been a 13 year old I probably wouldn't have done that. I gave them my phone in the night. I'm not happy with that rule but I did it anyway. That was progress."*

Also:

> *"The way I deal with my anger now and recently. If I get pissed off I just go to my room and fall asleep. Then nobody will get hurt, I won't get hurt and no one else gets hurt. I just go to my room and stay in there until everything has died down, or until I'm a bit calmer."*

Asked whether she felt that there were things she still needed to work on, the young person considered that in the light of a 'deficit model' in which incorrect attitudes or behaviours

needed correcting, rather than thinking in terms of building on successes to achieve more (such as, more self-awareness or emotional control or skills):

> *"I don't see what I'm doing wrong at the moment. I don't think I'm doing anything wrong that I need to work on."*

The young person talked about her strengths in the following way:

> *"They (the social worker) wrote a few of my strengths. They never called it that but they were complimenting me about what they believed I am good at. They said I'm comical and I'm good at being centre of attention but not in a bad way. I am understanding and I can have a conversation with someone without getting offended or without bursting out into anger – now! Stuff like that."*

More spontaneously she said:

> *"I am good at drawing. I do graphic design. I want to be a paramedic or a graphic designer."*

When asked about her goals and aspirations the young person said that she understood from her social worker that as a Looked after child she was entitled to a free place at university: *"So I thought, 'Oh, might as well go to uni then'. That's a bonus for me being put in Care, I get to go to uni…"*

However, she followed this with the fact that she had not got the qualifications needed to go to university. The interesting pointing was that she held the social worker(s) responsible for lack of qualifications, saying that once she became a Looked after child:

> *"I was so pissed off and angry, I stopped going to school. So I stopped going for eight months and I never got to do my GCSEs. What they done, taking me into Care, had a big impact on my life – a really, really big impact on my life. Because now, the college I wanted to enter said I can't go unless I had eight GCSEs."*

Finally, and very importantly, the young person was asked what she would recommend to support another young person who found themselves in her position. She said:

> *"Get them an advocate or a keyworker – who can take you to MacDonalds and you lot can just chill and you can talk about how your day has been. You don't always have to talk about what your previous experience has been like. You can just talk about being a bluebird in the trees. You can go to the cinema with your keyworker and just chill, you know. If you have no-one to talk to you can call them up and say, 'Can you come and pick me up, let's go to the cinema?' Because that's their job, they (the Government) should fund it. If the girls are worried because they don't have money to go to the cinema, get the Government to fund it for them. At the end of the day, they will need something like that to get better…".*

3.5 The young people

3.5.1 The young people's emotional and behavioural challenges

The young people in this Project were all struggling to manage emotions and behaviours which adversely affected their ability to achieve or sustain health, wellbeing and achievement. The impact of child sexual abuse and exploitation is explored in section 2.3 The impact of

child sexual abuse and exploitation, above; it is summarised here from Browne and Finklehor (1986)[75]:

> *'In regard to initial effects, empirical studies have indicated reactions – in at least some portion of the victim population – of fear, anxiety, depression, anger and hostility, aggression, and sexually inappropriate behaviour. Frequently reported long-term effects include depression and self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, a tendency toward revictimisation, substance abuse, and sexual maladjustment.'*

Table 3.5.1 presents a sample of the social and emotional challenges which the young people who participated in this project were facing. The table is shaded to highlight what might be regarded as the most common social or emotional challenges for young people:

- Pink-shaded are the struggle with low self-esteem and outbursts of anger experienced by 90 – 100% of the young people.
- Orange-shaded are the depression, isolation/shallow relationships and anxiety and panic attacks experienced by three-quarters to 80% of the young people.
- Blue-shaded are the experiences of flashbacks and detachment/denial (dissociation) common to two-thirds of the young people.
- Grey-shaded are the difficulty with boundaries/self-protection and fear for their own safety in home, school, neighbourhood experienced by approximately half of the young people.

In addition, more than a third of the young people struggled with drink, and a third of them had difficulty sleeping, had no self-care skills, smoked, took drugs and self-harmed (cutting). A quarter of the young people had gone further and had attempted suicide at least once.

Table 3.5.1 Young people's emotional and behavioural challenges in order of prevalence

Presenting issue	Number of young people experiencing each issue	
	Total	Proportion
Low self-esteem	15	100%
Outbursts of anger	14	93%
Depression	12	80%
Isolated/shallow relationships	12	80%
Anxiety & panic attacks	11	73%
Flashbacks	10	67%
Detached/in denial	10	67%
Difficulty with boundaries/self-protection	8	53%

[75] Browne A., Finkelhor D. *Impact of child sexual abuse: A review of the research*. (1986) Psychological Bulletin, *99* (1), 66-77

Scared in home, school, neighbourhood	7	47%
Drink	6	40%
Self-harming - cutting	5	33%
Smoking	5	33%
Drugs	5	33%
Difficulty sleeping	5	33%
No self-care skills	5	33%
Attempted suicide	4	27%
Eating disorder	2	13%

Over three-quarters of the young people were struggling with low self-esteem, depression, outbursts of anger, isolation/shallow relationships and anxiety with panic attacks.

Low self-esteem

Low self-esteem clearly appears to be the single most pervasive challenge which the young people struggle with. Roberts and Monroe (1994)[76] synthesised what was known about the factors which contribute to self-esteem which could be understood in a way that might be useful in this context. Simply put, they divide the population into two broad categories, those whose self-esteem largely depends upon approval from others and those whose self-esteem derives from successful achievements; Brown et al. (2001)[77] refer to these respectively as, the 'inter-personal' and ' achievement' domains. The latter group has a further sub-division to accommodate those who measure themselves predominantly in terms of success in external activities, and those whose measure of success is 'intra-personal', that is, that they strive to meet their own expectations. All the groups, but particularly the latter two, apply self-criticism which magnifies the deficits in their actual achievements or personal abilities and qualities.

The majority of people have a combination of these drivers of self-esteem. This suggests that keyworkers will need to tailor the focus of support for a young person to suit the balance of drivers for each young person's self-esteem.

Outbursts of anger

Many studies of traumatized children find that they have problems with unmodulated aggression and impulse control (e.g., Burgess, Hartman, McCormack, 1987; Cole, Putnam,1992; Lewis, Shanok,1981; Steiner, Garcia, Matthews, 1997; Van der Kolk, Perry, Herman, 1991). Hosier (2014)[78] talks about how for individuals who have experienced abuse,

[76] Roberts J.E., Monroe S.M. *A Multidimensional Model of Self-esteem in Depression*. (1994) University of Pittsburgh, University of Oregon. Clinical Psychology Review. Vol 14., No 3, P161-181.
[77] Brown J.D., Dutton K.A., Cook K.E. *From the top down: Self-esteem and self-evaluation.* (2001) University of Washington, Seattle, *WA, USA.* Cognition and Emotion, *15* (5), P615–631.

[78] Hosier D. *Anger Management Problems: Their roots on childhood*. (2014) Kindle.

expressing anger can produce a feeling of power or taking back 'control' – the power and control that was denied in the abuse. Hosier contextualizes anger using three categories:

a) Primary anger – which is a reasonable, relatively immediate, response to an incident. It is directly related to what has happened and is not influenced by extraneous factors

b) Secondary anger – defined by Beck (2000)[79] as resulting from fear or hurt and used as protection against further trauma. It can be explosive and feel as if it is 'taking over'; it may occur in response to perceived rejection, slight or threat

c) Past anger – referring to anger which stems from the past but which is 'triggered by current events'. It is similar to secondary anger and is often disproportionate to the current event.

Secondary and past anger may trigger conscious or unconscious replay of the original trauma; explaining the often disproportionate intensity of the reaction.

Hosier notes that repressed anger is painful and stressful and that misdirected it becomes destructive to the individual. In the latter case it can isolate a young person, and derail educational and other achievements. It can also be turned inwards in the form of self-harm and suicide attempts. The young people in this Project all struggled with overwhelming 'secondary and past anger' and the keyworkers helped them manage these anger responses; better understanding this anger response by other professionals e.g. teachers, would also be helpful.

A review of the literature on adaptive and maladaptive anger from child sexual abuse a study by Thomas et al. (2013)[80] noted that:

> "Survivors may deny their anger, disguise its expression by being overly compliant and perfectionistic, fear expressing anger, identify with the power of the perpetrator and manifest self-destructive, self-blaming patterns, or inappropriately and indiscriminately express anger" Scott and Day (1996)). Some clinicians assert that externalizing anger and expressing it in some way toward their abuser contributes to survivors feeling less depressed (Morgan & Cummings, 1999). In contrast, Van Velsor and Cox (2001) contend that empowerment for survivors of sexual abuse has less to do with blame toward an abuser, and more to do with a survivor's access to the genuine response of anger. Regardless, they recommend that therapists attend to the process of uncovering and expressing anger as an integral part of the recovery process.
>
> Scott and Day (1996) found that adult female survivors of childhood sexual abuse who tend to suppress their anger report significantly more abuse-related symptoms than do survivors who appropriately express their angry feelings. Inwardly directed anger was correlated with higher scores on measures of guilt/shame, vulnerability/isolation, emotional control/ numbness, sadness, and sense of powerlessness. In contrast, outwardly directed anger, either toward other people or objects, was not significantly correlated with scores on the symptom scales.'

Depression and anxiety

[79] Beck A.T. *Prisoners of Hate: The Cognitive Basis of Anger, Hostility, and Violence* (2000) Harper Perennial

[80] Sandra P. Thomas S.P., Bannister S.C., Hall J.M. *Anger in the Trajectory of Healing from Childhood Maltreatment.* Arch Psychiatr Nurs. 2012 June; 26(3): 169–180. doi:10.1016/j.apnu.2011.09.003. P4

The association between depression and anxiety and child sexual abuse and exploitation is well established[81]. Ellen McGrath (2003)[82] describes the development of depression in terms of the sensitised stress response young people experience as a result of child sexual abuse and exploitation. This creates a situation in which:

> *'Even small degrees of stress provoke an outpouring of stress hormones, and these hormones in turn act directly on multiple sites to produce the behavioral symptoms of depression—the vegetative state, the sleep disturbances, the cognitive dullness, the loss of pleasure. They push the brain's fear center into overdrive, churning out the negative emotions that steer the depression's severity and add a twist of anxiety.'* [83]

McGrath continues to explain that recovering from the trauma of abuse, including child sexual abuse and exploitation, requires individuals to get a general map of their individual 'abuse landscape' (not necessarily the detail) because: *'to undo the imprint of abuse, you must access it, expose it and process the experience.'*[84] The young people and the keyworkers in this Project talked about the practical help the keyworkers provided to enable the young people to overcome not only their anxiety in dealing with day-to-day situations; but also, their depression – which often manifested as a reluctance to face the world every day i.e. getting up in the morning and/or leaving their bedrooms.

Isolated/shallow relationships

The impact of chronic trauma upon the self-structure has been described as creating a continuing experience of the 'self' as powerless or a failure[85,86]. Cole and Putnam talk about chronically traumatised children's problems with self-definition as *'uncertainty about the reliability and predictability of others, which is expressed as distrust, suspiciousness, and problems with intimacy, and which results in social isolation'*[87]. Zepenic concurs that for most trauma victims there is evidence of a struggle to rebuild their own self-structure. However they often fail to seek the 'proximity and affection' of trusting relationships, distrusting their own and others' good will and striving to maintain self-reliance and emotional distance. This makes them unable to relieve distress, perpetuates the feeling that their security is undermined and promotes negative models of self and others – emotional problems are exacerbated and maladjustment increases[88].

The keyworker's single most important function is to assist the young person in rebuilding confidence to enter into, and sustain, a positive relationship – first with the keyworker and then with others. In doing so, the young person will be assisted to re-integrate their own self-structure and rebuild a sense of a worthwhile self.

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[81] Browne A., Finkelhor D. *Impact of child sexual abuse: a review of the research.* Psychol Bull. 1986;99:66–77; and Polusny M.A., Follette V.M. *Long-term correlates of child sexual abuse: theory and review of the empirical literature.* Appl Prev Psychol. 1995;4:143–66.

[82] Executive Director of the Psychology Centers in New York City; Chair of the American Psychological Association National Task Force on Women and Depression; Lead author of the Task Force book, *Risk Factors and Treatment Issues*.

[83] McGrath E. *Child Abuse and Depression: Most serious adult depressives have experienced child abuse* (2003). Psychology Today, online at: https://www.psychologytoday.com/articles/200305/child-abuse-and-depression

[84] Ibid.

[85] Zepinic V. *Disintegration of the Self-Structure Caused by Severe Trauma*. Psychology and Behavioral Sciences. Vol. 5, No. 4, 2016, P83-92

[86] Wilson JP, Drozdek B (ed). *Broken Spirit,* Brunner-Routledge, New York, (2004)

[87] Cole P.M., Putnam F.W. *Effect of incest on self and social functioning: developmental psychopathology perspective.* Journal of Consulting and Clinical Psychology. 1992; 60(2); 174-184

[88] Zepinic V. *Disintegration of the Self-Structure Caused by Severe Trauma*. Psychology and Behavioral Sciences. Vol. 5, No. 4, 2016, P83-92

Bereavement

A 2011 review by Akerman and Statham, of the literature on childhood bereavement[89] reported that one in five bereaved children are likely to manifest such disturbance at a level sufficient to justify referral to specialist services. Symptoms included anxiety, depressive symptoms, fears, angry outbursts and regression regarding developmental milestones. Akerman and Statham reported analysis of data from the Office for National Statistics survey of mental health among 5 to 16 year olds suggested that bereaved children are approximately one-and-a-half times more likely than other children to be diagnosed with a mental disorder (Fauth et al., 2009). The report authors were not able to establish the exact link between bereavement and the mental ill health. Nevertheless, the report found that children whose parent or sibling had died were more likely than other children to have problems with anxiety and drinking, whereas children who had experienced the death of a friend were more likely to display conduct problems, use substances and engage in troublesome acts such as staying out late or truanting from school.

A recent review[90] by a multi-disciplinary (local authority, health and police) child sexual exploitation team found that 41% of the young people referred to the service had experienced a significant bereavement. In terms of experiencing loss of an important relationship at a critical developmental stage, this correlates with the fact that 40% of young people in this Project experienced a family member dying or going to prison. An example of the keyworker support offered is where a young person's father had died. The keyworker said:

> *"She was 'wound up' by the fact that she doesn't know where he is buried, so I have been helping her to search local authority records to find out. We haven't been successful yet; but it has meant she has started to talk about her feelings around his death – the fact that for her he just 'disappeared'. It obviously has had a massive impact on her."*

See subsection 3.5.3 Adverse Childhood Experiences, below for more comment about the young people's emotional and behavioural challenges.

3.5.2 Treatment Implications

Treatment for children who have experienced sexual abuse and exploitation needs to take into account the concepts of 'Developmental Trauma' (van der Kolk)[91], 'Complex Trauma' or C-PTSD (Herman in 1992)[92] and 'Disorders of Extreme Stress, not otherwise specified' (DESNOS) raised in subsection 2.2.2 Defining the impact of childhood trauma, above. All three concepts accommodate the more prevalent presenting issues for the young people in this Project, as set out in Table 3.5.1 Young people's emotional and behavioural challenges in order of prevalence. The fact that the young people who participated in this project (and others similar to them) are likely to be experiencing Developmental Trauma/C-

[89] Akerman R., Statham S. *Childhood Bereavement: a Rapid Literature Review* (2011) Childhopod Wellbeing Research centre. Available at: http://webarchive.nationalarchives.gov.uk/20111121200543/https://www.education.gov.uk/publications/eOrderingDownload/Childhood%20bereavement%20literature%20review.pdf. Accessed on 21 November 2017.

[90] The review covered a 3 month period July to September 2016.

[91] van der Kolk B.A. *Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. Available at:* http://www.traumacenter.org/products/pdf_files/preprint_dev_trauma_disorder.pdf. Accessed on 8 January 2018.

[92] Herman J. *Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror* (1992 reprinted 2015) New York**:** Basic Books

PTSD/DESNOS is supported by the young people's high Adverse Childhood Experiences scores. See subsection 3.5.4 Adverse Childhood Experiences, below.

The importance of recognising these concepts over the simple diagnosis of PTSD, is rehearsed by van der Kolk et al (2005)[93] as follows:

> The presence of DESNOS has been shown to be a powerful negative prognostic indicator of PTSD treatment outcome and behavioural disturbance in diverse clinical samples (Ford, Kidd,1998[94]; McDonagh-Coyle et al, 1999[95]; Zlotnick,1999[96]).
>
> The phenomenological differences between DESNOS and PTSD have important treatment implications. The diagnosis of PTSD focuses on the memory imprint of particular experiences. Post traumatic stress disorder as the central psychological consequence of traumatization implies treatment that focuses on the impact of specific past events and the processing of specific traumatic memories.
>
> In contrast, in traumatised patients with histories of early abuse and DESNOS, the treatment of other problems, such as loss of emotion regulation, dissociation and interpersonal problems, may be the first priority because they cause more functional impairment than the PTSD symptoms (Cloitre et al., 2002[97]; Briere, Spinazzola, 2005[98]; Ford et al., 2005[99]; Pearlman, Courtois, 2005[100]).
>
> Issues of affect regulation and dissociation have been largely neglected in the treatment research literature for PTSD. For example, in *the International Society for Traumatic Stress Studies (ISTSS)* treatment guidelines for PTSD, there is no mention of techniques to deal with loss of self-regulation or dissociative problems.
>
> In recent years, an emerging research literature has started to demonstrate the importance of helping patients with the management of current problems with dissociation, affect regulation, and altered relationships with themselves and others prior to engaging them in trauma exposure (Cloitre et al., 2004[101]; Ford et al., 2005[102]; Ford, Fisher, Larson, 1997[103]; Ford, Frisman, 2002[104]).

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[93] Van der Kolk B.A., Roth S., Pelcovitz D., Sunday S., and Spinazzola J. *Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma.* Journal of Traumatic Stress, Vol. 18, No. 5, October 2005, P389-399

[94] Ford J.D., Kidd P. (1998). *Early childhood trauma and disorders of extreme stress as predictors of treatment outcome with chronic PTSD*. Journal of Traumatic Stress, 18, 743–761

[95] McDonagh-Coyle A., McHugo G., Ford J., Mueser K., Demment C., Descamps, M. (1999, December). *Cognitive–behavioral treatment for childhood sexual abuse survivors with PTSD*. Paper presented at the 15th Annual Meeting of the International Society for Traumatic Stress Studies, Miami, FL

[96] Zlotnick C. (1999). *Antisocial personality disorder, affect dysregulation and childhood abuse among incarcerated women.* Journal of Personality Disorders, 13(1), 90–95

[97] Cloitre M., Koenen K.C., Cohen L.R., Han H. (2002). *Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse*. Journal of Consulting and Clinical Psychology, 70, 1067– 1074

[98] Briere J., Spinnazola J. (2005). *Phenomenology and psychological assessment of complex posttraumatic states.* Journal of Traumatic Stress, 18, 401–412

[99] Ford J.D., Courtois C.A., Steele K., Van der Hart O., Nijenhuis E.R.S. (2005). *Treatment of complex posttraumatic self dysregulation.* Journal of Traumatic Stress, 18, 437–447

[100] Pearlman L.A., Courtois C.A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. Journal of Traumatic Stress, 18, 449–459

[101] Cloitre M., Chase Stovall-McClough K., Miranda R., Chemtob C. (2004). *Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder*. Journal of Consulting and Clinical Psychology, 72(3), 411– 416

The implications for treatment, as concluded by van der Kolk, support the conclusion from subsection 2.4 Theories supporting trauma-informed recovery, above. That is, that developing a trusting one-to-one relationship with a positive adult is central to trauma recovery – because it helps the young people with the management of current problems with feeling disconnected from the world around them or from themselves (dissociation), with regulating their emotions, and with the altered relationships trauma can create with themselves and others. The collective agreement on what works for trauma recovery from all the currently recognised and highly respected schools of philosophical and psychological thought discussed in subsection 2.4, identified a trusting relationship and a pedagogic and strengths-based approach. The fieldwork for this Project goes a long way towards confirming that these three elements address the Developmental Trauma/C-PTSD/DESNOS issues raised by van der Kolk.

See subsections 4.2.3 Exemplar service core elements and delivery method and 4.2.4 An exemplar treatment model, below, for translation of this into recognised models of intervention.

3.5.3 The young people's circumstances

Age at referral for child sexual exploitation incident

The average age for the young people at the time of referral for the child sexual exploitation incident was 15 years. Within this the young people's ages ranged from 10 years to 17 years old at the time of referral for the incident of child sexual exploitation for which they were receiving support when they participated in this Project.

Disability (not necessarily diagnosed)

Whilst the young people did not have a formal diagnosis of learning difficulties or disabilities, there were several who were recognised to have a learning difficulty/disability and this was indicated by their keyworker, their social worker and their case notes. The number of young people in this category was 5, 33% of the total. Other issues flagged through the professionals and case notes were one young person having Attention deficit hyperactivity disorder (ADHD) and another young person having been diagnosed with 'Oppositional defiant disorder' (in her early childhood).

Ethnicity

The young people's ethnicity, based on that of their birth family, was recorded as follows: 9 were Mixed race, 3 were White UK, one was Black African, one was Black Caribbean and one was White European.

Family previously known to Children's social care

Thirteen (87%) of the fifteen families had been known to Children's social care since the young person's early childhood. A feature of the families appears to be the fact that the majority of the young people's fathers were absent and their mothers were unable to parent

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[102] Ford J.D., Courtois C.A., Steele K., Van der Hart O., Nijenhuis E.R.S. (2005). *Treatment ofcomplex posttraumatic self dysregulation*. Journal of Traumatic Stress, 18, 437–447

[103] Ford J.D.,Fisher P., Larson,L. (1997).*Object relations as predictors of treatment outcome with chronic PTSD*. Journal of Consulting and Clinical Psychology, 64, 547–559

[104] Ford J.D., Frisman, L. (2002, November). *Controlled evaluation of a present-focused trauma-processing therapy.* Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, Baltimore, MD

them well. In consequence, all of the young people experienced physical and/or emotional neglect (in one case of emotional neglect, this was not long standing, it had been triggered in the years prior to the child sexual exploitation). The reasons for this included domestic abuse, parental mental ill health and substance misuse, and in some cases criminality (inappropriate sexual activity). A number of the young people appeared to be young carers for their mothers or grandmothers. The young people's Adverse Childhood Experiences (ACEs) scores testify to the fact that their family lives were relatively unsafe. Some of the young people said that they felt unsafe at home.

Referring agency/person

The agency or person who made the initial referral to Children's social care was as follows:

- The police in 4 cases, two of which related to 'county-lines' investigations
- The school in 4 cases; in one of these cases a member of the public also made a referral
- The young woman's mother and the school in two cases
- The young woman's aunt in one case
- The young woman's mother and sister in one case
- The young woman's friend in one case
- The local authority Housing Department in one case (homeless), and
- A Sexual Assault Referral Centre (SARC) in one case.

In three cases referrals were made by more than one agency or person, in one of these the school and the young woman's mother both made referrals because she was missing; in one case the sister alerted the mother as a result of information from the young woman's Facebook page; and in one case a member of the public called Children's social care at the same time that the young woman's school was making a referral to Children's social care. These simultaneous referrals have been detailed as a record of the part family and the public can play in safeguarding young people from child sexual exploitation.

Level of need as assessed by Children's social care

The level of need which Children's social care assessed the young people to be at during their case varied from two being categorised as 'Early Help'; nine moving between Child in Need and being subject to a Child Protection Plan; and two young people becoming Looked After to ensure their safety, one as a first intervention and the other as a last intervention (both having been removed from gangs in their neighbourhoods).

During the course of their cases the young people's assessed level of need/risk fluctuated and the categorisation into Early Help, Child in Need and Child Protection Plan appears to reflect the changing circumstances around the case and what was known about the case, rather than being an indicator of the harm she was experiencing or had experienced. This included assessments about the young woman's resilience, her ability to accept help and the amount of support the young woman's family were able to offer her, both the latter indicating the degree to which the young woman could be contained emotionally; and also, how much ongoing risk she was subject to, reflecting the amount of information the professional network had about the perpetrator/s and of gang activity, in her neighbourhood and school.

Incident which triggered a referral for specialist child sexual exploitation support

Thirteen (87%) of the young people were referred for specialist child sexual exploitation support as a result of an incident which clearly involved sexual exploitation, and two of the young people were referred following incidents of gang involvement with a child sexual exploitation element. Eight of the young people were missing at the time of the incident, though not all had been reported missing by their parent or family.

The perpetrator/s

The perpetrators ranged in age from 15 years to mature adult men, although by far the majority were described as 'in their early 20's'. In three cases there were perpetrator/s below the age of 18 years, in the other 12 cases there were perpetrator/s above the age of 18 years. The modus operandi of the perpetrators can be categorised as follows:

- Random encounters: 4 cases
- Gang rape: 2 cases, one of these young people then experienced random encounters of child sexual exploitation, so her case is also counted above.
- Single perpetrator ('boyfriend') who remained so, rather than being a lure to get the young woman into gang or group child sexual exploitation: 4
- Gang rape and trafficking for drugs: 3 cases
- Online grooming for the purposes of offline child sexual exploitation: 3 cases

The services involved during the case

The services which the young people and/or their parents were referred to (as part of a multi-agency care pathway) included:

- Specialist child sexual exploitation – 15 (100%)
- Children's social care – 13 (87%)
- Sexual health services – 3 (20%)
- Child and adolescent mental health service (CAMHS) – 10 (67%); of which 6 young people attended a majority of sessions offered. Two young people went for one session, one attended two sessions and one young person was offered CAMHS but refused the offer)
- Other health – between them the young people used the following health services once: a school nurse, Accident & Emergency, a substance misuse service and a Looked After Children's GP
- Police – 15. There were two prosecutions, one achieved a conviction (9 years). One Abduction notice was serviced. For one young person the police run checks on every new man in her life. In one case the police decided against prosecution on the grounds that the perpetrator was a Care Leaver
- School pastoral – 5 (33%)
- Special educational needs co-ordinator (SENCO) – 0

- Other – Empower, Princes Trust and the Fairbridge Project; domestic abuse support (mother) refused; parenting classes (father); IAPT (mother); parenting support; joint-psychiatric assessment (young person and mother) refused; the youth offending service, residential care out of town; Lucy Faithful, refused while prosecution was pending[105].

3.5.4 Adverse Childhood Experiences

The Adverse Childhood Experiences (ACEs) Study

An important series of studies conducted by the Centers for Disease Control and Kaiser Permanente in San Diego between 1995 and 1997. The Adverse Childhood Experiences (ACEs) Study[106,107] found a highly significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases[108]. In addition, that histories of ACEs, were strongly associated with the leading causes of death including heart disease, cancer, diabetes, liver disease, and emphysema (Felitti et al., 1998) [109].

The finding from the Study was that two-thirds (64%) of the participants had experienced one or more categories of adverse childhood experiences. A critical finding was that there is a link between individuals who had four or more of the ACEs tested for and adverse health and wellbeing life course consequences. These consequences included not only the diseases listed above, but also that there were strong links between untreated ACEs and adult risky behaviours and illness. The Study confirmed that untreated child abuse and neglect has long-term impacts. Individuals who had experienced child maltreatment were more likely to engage in risky health-related behaviours during childhood and adolescence such as, smoking and illicit drug use, sexual activity, becoming pregnant and attempting or dying by, suicide.

The impact of ACEs (DESNOS/C-PTSD/Developmental Trauma Disorder) is described by van der Kolk[110] as *'setting the stage for unfocused responses to subsequent stress[111] leading to*

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[105] Empower (Safer London) offers services for young people who have experienced sexual exploitation. The Princes Trust is a youth charity that helps young people get into jobs, education and training. The Fairbridge Project (part of prices Trust) offers young people a mix of group activities and one-to-one support to develop skills and confidence. The NHS Improving Access to Psychological Therapies (IAPT) programme. The Lucy Faithfull Foundation works with families affected by sexual abuse.

[106] Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P., Marks J.S., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults; The Adverse Childhood Experiences (ACE) Study* (1998). American Journal of Preventive Medicine;14(4) PII S0749-3797(98)00017-8. P245

[107] Felitti V. J., & Anda, R. F. (1997) *The Adverse Childhood Experiences (ACE) Study*. Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/ace/index.htm

[108] Van der Kolk B.A. *Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. Available at:* http://www.traumacenter.org/products/pdf_files/preprint_dev_trauma_disorder.pdf. Accessed on 8 January 2018.

[109] Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P., Marks J.S., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults; The Adverse Childhood Experiences (ACE) Study* (1998). American Journal of Preventive Medicine;14(4) PII S0749-3797(98)00017-8. P245

[110] Van der Kolk B.A. *Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. Available at:* http://www.traumacenter.org/products/pdf_files/preprint_dev_trauma_disorder.pdf. Accessed on 8 January 2018.

dramatic increases in the use of health, mental health, social and criminal justice services'[112]. These findings have been confirmed through other research, including, for example Edwards, Holden, Felitti, Anda, (2003) reporting that depression (rapidly becoming the second most costly illness in the world: *The World Health Report*, 2001) is at least 3 to 5 times more common in individuals with histories of child maltreatment; Dube et al. (2001) found that victims of child abuse are about 12 times more likely to attempt suicide than non-abused individuals and that Physically abused adolescents are 6 to 12 times more likely to have alcohol and drug problems, and sexually abused adolescents are 18 to 21 times more likely to become substance abusers (Dube et al., 2005). According to the National Institute on Drug Abuse, as many as two-thirds of people in drug treatment programmess report being abused as children (Engels, Moisan, Harris, 1994)[113].

ACEs for the young people in this Project

The fact that individuals with ACE scores of four or more, untreated, experience adverse health and wellbeing life course consequences is important both on a personal level and as a cost to the public purse. The average ACEs score for the very small sample of young people who have experienced child sexual abuse and exploitation, in this Project was 6.

Table 3.5.2 presents the adverse experiences in order of the frequency with which they were present in the childhoods of the young people in this Project. The table is shaded to highlight what might be regarded as the most common pre-disposing factors for young people who had been harmed by child sexual abuse and exploitation, in this project:

- Pink-shaded are the experiences of sexual abuse and emotional neglect which had formed part of the childhoods of almost 90% of the young people.

- Orange-shaded are the experiences of parental break-up and mental ill-health (of a parent in this Project) which had formed part of the childhoods of almost three-quarters of the young people.

- Blue-shaded are the experiences of humiliation and fear of violence; and the experience of neglect which had formed part of the childhoods of approximately two-thirds of the young people.

- Grey-shaded are the experiences of parental substance abuse and domestic abuse which had formed part of the childhoods of almost half of the young people.

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[111] Cicchetti D, Toth, SL. Developmental psychopathology and disorders of affect. In: Cicchetti D, Cohen DJ, eds. Developmental psychopathology, Vol. 2: Risk, disorder, and adaptation. Wiley series on personality processes . New York: John Wiley & Sons; 1995: 369-420

[112] Drossman DA, Leserman J, Nachman G, et al. Sexual and physical abuse in women with functional or organic gastrointestinal disorders. Ann Intern Med. 1990; 113(11): 828-833

[113] These statistics from Putnam F.W. (2006) *The Impact of Trauma on Child Development.* Juvenile and Family Court Journal. Available at: https://scholar.google.co.uk/scholar?q=Putnam+F.W.+(2006)+The+Impact+of+Trauma+on+Child+Development.&hl=en&as_sdt=0&as_vis=1&oi=scholart&sa=X&ved=0ahUKEwiTzOPejPvWAhVXF8AKHRj_DmsQgQMIJDAA

Table 3.5.2 Adverse Childhood Experiences in order of prevalence amongst the young people in this Project

Order of prevalence	Adverse childhood experience	Proportion of young people
1	Sexual abuse as a child or teenager (3) *	87%
2	Emotional neglect; and family not close or supportive of each other (4)	87%
3	Parents separated or divorced (6)	73%
4	Household member depressed or mentally ill or attempted suicide (9)	73%
5	Emotional or physical abuse (humiliation, verbal abuse/fear of violence) (1)	67%
6	Physical neglect (food, clothing & medical needs) (5)	60%
7	Household member abusing substances (8)	47%
8	Domestic abuse (7)	47%
9	Household or family member went to prison or died (10)	40%
10	Actual physical abuse (2)	33%

* Bracketed numbers indicate original position in ACEs questionnaire

The average ACEs scores for the young people in three areas differed as follows: 8, 6 and 5. An interesting finding was that the total scores for the young people in each area, in terms of the emotional and behavioural challenges they faced, did not correspond to the average ACEs scores. The totals for emotional and behavioural challenges for the areas respectively were: 46, 40 and 50 This would appear to confirm other research findings that the impact of child sexual abuse and exploitation on an individual depends on a range of factors including the circumstances of the abuse (e.g. whether force was used), the duration and frequency of the abuse, age at onset, the child's reporting of the offence, parental reaction, the institutional response (Browne, Finkelhor, 1986)[114]; as well as the child's personal and environmental resources at the time of the abuse and subsequently.

Project outcomes

[114] Browne A., Finkelhor D. *Impact of child sexual abuse: A review of the research.* (1986). *Psychological Bulletin, 99* (1), 66-77.

4. Implementing trauma-informed practice

4.1 Introduction

The primary aim of this Project was to produce an evidence base on an effective and efficient non-clinical trauma-informed delivery of recovery services for young people who have experienced sexual abuse and exploitation. The evidence from academic and clinical theory and the findings from the fieldwork for this Project suggest that such a service is most likely to provide positive outcomes if it features as core elements: a trusting relationship, and a pedagogical and strengths-based approach.

This section describes an exemplar for a trauma-informed service for young people who have experienced sexual abuse and exploitation. It presents the frontline service delivery activities, frontline service delivery costs and the core elements and approach required for such a service.

A secondary aim of this Project was to suggest that the same trauma-informed response is likely to be effective for sexually abused and exploited young people whether it is delivered via a local 'safeguarding children care pathway' or a local 'violence against women and girls (VAWG) care pathway'. The practical information in this section is offered to enable such a service to be delivered – through either or both care pathways.

Young people with harmful behaviours

The practical information in this section may also contribute to the delivery of services for young people with behaviours which are predominantly[115] harmful to others. This is in recognition of the fact that many young people who present with harmful behaviours have a history of traumatising childhood experiences. The Inquiry into Child Sexual Exploitation in Gangs and Groups (2012)[116] noted a cross-over, with many victims also known to have committed offences. There is also a growing body of evidence about the high prevalence of ACEs in the UK young offender population.

> A study by Grimshaw et al. (2011) into the childhood experiences of young people in custody in the UK identified: neglect, multi-generational abuse, including sexual abuse and exploitation, bereavement and the normalisation of continuous and intrusive trauma. These first-hand stories confirmed and developed much that is known about the life experiences of troubled young people. The authors stressed the need for positive, nurturing support to help the young people forge more positive lives and maximise their potential.

[115] Liddle M., Boswell, G., Wright, S., Francis V., Perry R. *Beyond Youth Custody: Trauma and Young Offenders – a review of the research and practice literature* (2106). NACRO. Available at: http://www.beyondyouthcustody.net/wp-content/uploads/Trauma-and-young-offenders-a-review-of-the-research-and-practice-literature.pdf. Accessed on: 10 July 2017.

[116] *"I thought I was the only one. The only one in the world"* The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups
Interim report. (2012). P85

[117] Grimshaw R., Schwartz J., Wingfield R. *Young People talk about the Trauma and Violence in their Lives* (2011). Centre for Crime and Justice Studies. ISBN: 978-1-906003-31-9

In recognition of this, the Youth Justice Board has for some time now been recommending a therapeutic needs and strengths-led service approach. This should offer children and young people an opportunity to develop a consistent, non-judgemental one-to-one relationship with a case/keyworker. Furthermore, support should address children and young people's needs in the right order, starting with building trust and stability *because 'safety is the base for new skills and long-term plans'*.[118]

4.1 A trauma-informed recovery service model

For this section of the Project, the frontline engagement activities for an existing trauma-informed recovery service for young people who have experienced sexual abuse and exploitation were identified and costed.

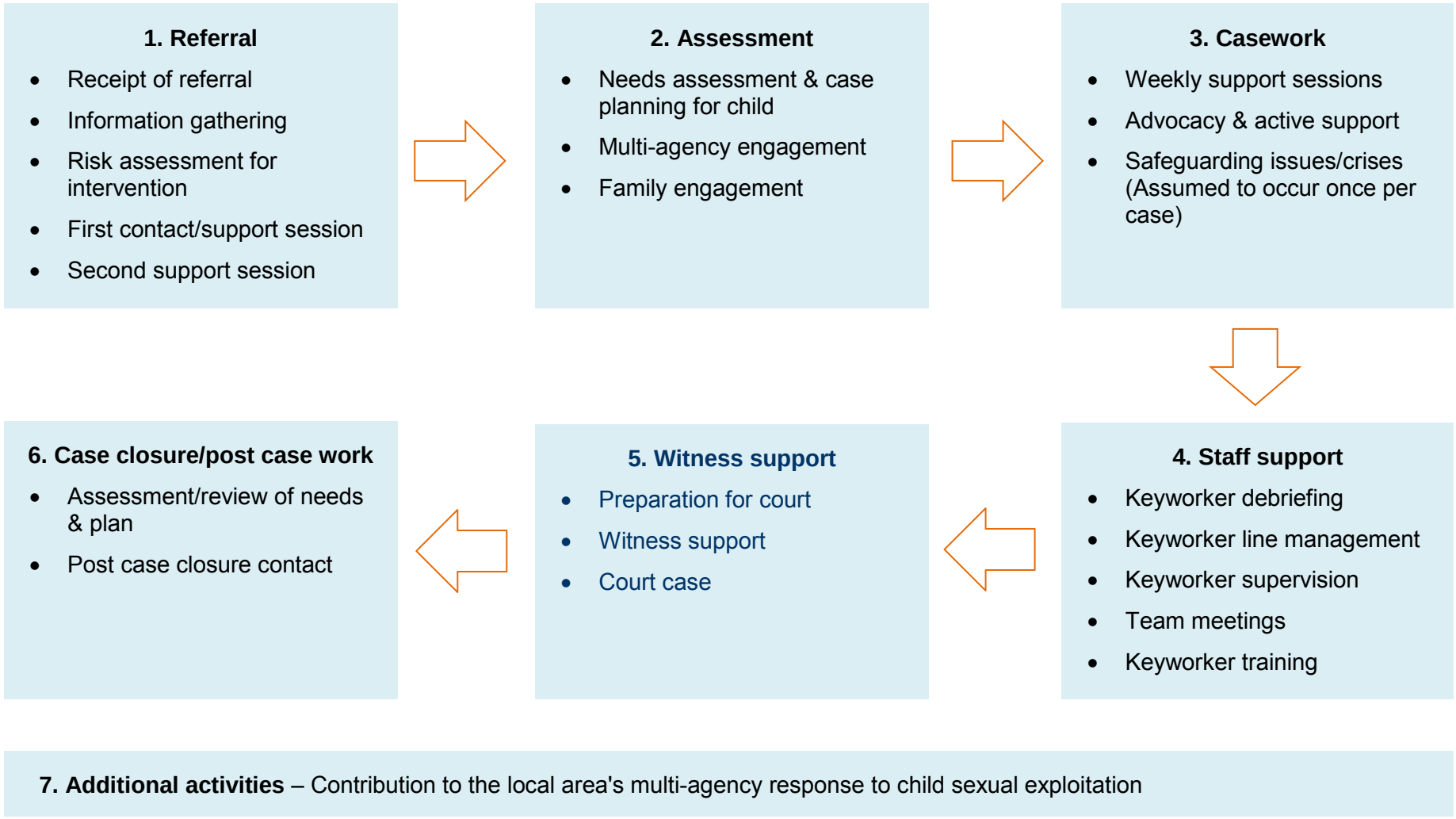
3.2.1 Recovery service activities

The activities for a trauma-informed recovery service for young people who have experienced sexual abuse and exploitation are summarised in Diagram 4. They follow a care pathway which includes referral, assessment, casework, staff support, witness support and case closure/post case-work. A minimal amount of additional activity is suggested, representing a contribution to the local area's multi-agency response to child sexual exploitation. The witness support activities have also been identified, though these will not be relevant to all cases.

Liddle M., Boswell G., Wright S., Francis, V. with Perry, R. *Trauma and Young Offenders: A Review of the Research and Practice Literature* (2016) Beyond Youth Custody. Nacro, ARCS (UK) Ltd, University of Salford, University of Bedfordshire

[118] *In-brief: Trauma-informed Youth Justice.* Effective Practice In Youth Justice (September 2017) Youth Justice Board; P2. Available at: https://yjresourcehub.uk/our...for.../588_5e9a4cdcfa738eb6db35fbaaac85d872.html. Accessed on: 8 February 2018

Diagram 4: Summary trauma-informed recovery service model activities



4.2.2 Recovery service costs

The cost of the trauma-informed recovery service model activities summarised in Diagram 4, above has been calculated at £3,300. The case length over which the costs have been calculated is nine months. This represents the average length in recent years for cases in a current child sexual exploitation recovery service.

Excluded costs

Critically, these costs do not include the management and other organisational overheads needed, by either a statutory or a voluntary and community sector organisation, to provide a robust and safe 'personal care service'. They also do not include training for the specialist team practitioners and managers or environmental improvement initiatives. The latter are likely to include local authority and partner agency involvement (as described in the case study under the heading Addressing the environmental influences on young people's lives, in subsection 3.2.5 Supports for practitioners to give of themselves, above).

The Project focus on frontline engagement costs only, has been deliberate in order to allow for the variation in strategic planning and activity and in operational structures and service arrangements in the different local statutory and voluntary and community sector organisations who may (be commissioned to) provide the service.

Return on investment

The cost of the frontline engagement to provide recovery support for a young person of £3,500 is likely to appear low in the light of the likely cost to the individual and the public purse over the life course of each of these young people. Urgently needed is research into:

a) The longitudinal benefits of full implementation of a best practice Trauma-informed recovery service for young people following child sexual abuse and exploitation; and

b) The costs of life course impact for the significant minority of the UK population who have experienced child sexual abuse and exploitation to the public purse.

Over the course of the coming year funding will be sought for a Project designed to address, the costs to the public purse of the life course impact of child sexual abuse and exploitation. A key objective for this follow-on work is that it should provide estimates which can be used at a local area level to assist health and social care decision-making at strategic and operational levels – about trauma-informed service aims, resourcing and delivery.

4.2.3 Exemplar service core elements and delivery method

A summary of the core elements and delivery method for an exemplar trauma-informed recovery service for young people following child sexual abuse and exploitation are presented in Table 4.2.2. This is the service for which activities and costs have been identified, above.

Table 4.2.2 Summary of the core elements and delivery method for an exemplar trauma-informed recovery service model

Trauma-informed recovery service model					
	Generic evidence-base	Specific underpinning theory	Core service elements	Keyworker method of engagement with service user	Treatment content detail
Frontline engagement	All the psychological models and approaches Research conclusions (since mid-nineties) from within the 'Trauma stress field'	• Pedagogic approach • Humanistic therapy • Ecological theories • ACEs • DESNOS, C-PTSD & Developmental Trauma Disorder theories	1. <u>The young person trusts their keyworker</u> (one keyworker throughout, weekly sessions with contact between & average of 9 months of support) 2. <u>The keywork support is young person-centred</u> (relationship & activity is bi-directional, co-produced & at young person's pace) 3. <u>The keywork support addresses the whole-child's needs</u> (incl. associative life & environment) 4. <u>The keyworker gives of themself</u> (persistent/assertive outreach & personal commitment) 5. <u>The support is strengths-based</u> (assessment & progress identified, built-on & recorded in terms young person's qualities, abilities & goals)	a) One-to-one trusting relationship, including: o Befriending* o Advocacy o Advice o Counselling b) The keyworker receiving expert advice and co-working to avoid referring outside the service c) These activities to be delivered wherever/however is most comfortable for the young person (i.e. to include smartphone & Skype communication), however, an optimally effective service will offer a 'drop-in' service, which is open to young people after their case is closed	For treatment content detail see section 4.2.4 An exemplar treatment model

	As described in section 2. of this Report	As described in section 2. of this Report	As described in section 3. of this Report	As described in section 3. of this Report	As described in section 3. of this Report
	Generic evidence-base	Specific underpinning theory	Core service elements	Manager and commissioner method of support for frontline worker	Treatment support detail
Support for frontline service		Social pedagogy	1. Offering practitioners space for reflective practice (regular one-to-one & group clinical supervision) 2. Providing managerial and team support (regular one-to-one & group line-management supervision) 3. Allowing enough time for individual contact and overall progress (low caseloads & flexible, average 9 months, case lengths) 4. Making appropriate practice tools available (provision of an eclectic menu of evidence-based practice tools & techniques) *5.* Addressing the environmental influences on young people's lives (management/senior management activity & arrangements re. environment) 6. Promoting flexible, multi-agency joint-working (management & organisational arrangements to support whole-child incl. associative life)	a) Line management supervision b) Clinical supervision c) Child sexual abuse and exploitation team commissioning specifies & budgets for appropriate caseloads & case lengths d) (Training) ** e) Environment improvement activity f) Good multi-agency working g) Recognised, appropriately specified & resourced care pathway	a) Commissioning – Child sexual abuse and exploitation Specialist service commissioning specifications and budgets to support points 1 – 4 of the core service elements supporting the frontline service b) Strategic – agreement & arrangements between local statutory partners to address environmental issues c) Operational – agreement & arrangements between local

			7. Developing and maintaining effective care pathways (services appropriately resourced to meet need)		statutory partners to address multi-agency working issues
		As described in section 2. of this Report	As described in section 3. of this Report	As described in section 3. of this Report	As described in section 3. of this Report

* The term 'befriending' is used here to describe the trusting relationship in which the service user is working on feeling secure in the relationship, initially or intermittently taking precedence over direct work with the trauma or any other aspect of the service users lived experience.

** Training was not addressed in this Project. However, working with young people who have experienced child sexual abuse and exploitation is challenging and requires resilient workers who are adequately trained and supported to provide the consistent and ongoing relationships young people need (Webb and Holmes 2015). Evidence suggests that workers who have received training and engage in regular reflective supervision are more able to deal with the high demands of complex CSE cases (Webb and Holmes 2015; Scott et al 2017a; Williams et al 2017).

4.2.4 An exemplar treatment model

As noted in subsection 3.5.2 Treatment implications, above for traumatised young people with histories of early abuse and DESNOS (Disorders of Extreme Stress, not otherwise specified), the treatment of problems, such as loss of emotion regulation, dissociation and interpersonal problems, may be the first priority because they cause more functional impairment than the PTSD symptoms.

Loss of emotion regulation

In promoting trauma sensitive practice with children Furnival and Grant (2014)[119] note that many traumatised children struggle to regulate their emotions, attention and behaviour. Furthermore, that adults address this with verbal approaches or counselling. Difficulties with basic self-regulation, however, reflect a disorganised and over-responsive lower brain that is unaffected by approaches relying on a functioning cortex. This finding is supported by Bovarnick S., Scott S., Pearce J. (2017)[120] who recognise that there is limited scope within talking therapies, such as Cognitive Behavioural Therapy (CBT) for personal exploration and examination of emotions or of understanding and looking at troubling issues from a variety of perspectives. This includes situations where a child or young person has severe behavioural problems that existed prior to the trauma (see Adverse Childhood Experiences in subsection 3.5.4)[121].

The most critical of perspectives is that of the young person themselves. Social pedagogy describes this as, a need for the practitioner/keyworker to inhabit the same life-space as the child, focussing on the child as a whole person and their overall development and incorporating the young person's associative life (see social pedagogy in subsection 2.4.8, above). This is because understanding the specific experiences of each individual young person is key to providing safety for them – trauma responses and re-traumatising triggers become obvious when the practitioner understands more of the child's history[122] and the meaning of events for the child. As can be seen in the findings from the fieldwork in this project, being in a safe, trusting relationship is a prerequisite for this:

> *'The first thing traumatised children need is to be safe and secondly to feel safe. Being safe and feeling safe are not always the same thing. For instance, we might be ensuring that a child is safe from harm but s/he might not trust us….A child will only communicate something important in a straightforward way when s/he believes and trusts that there may be a positive and caring response. Until s/he has experienced this from us consistently over time s/he has no reason to believe that we are any different from adults who have hurt and failed to protect him or her in the past.'*

[119] Furnivall J., Grant E. (2014) Trauma Sensitive Practice with Children in Care Glasgow: IRISS Insights 27 http://www.iriss.org.uk/category/resource-categories/iriss-insights. Accessed on: 22 July 2017

[120] Bovarnick S., Scott S., Pearce J. *Direct work with sexually exploited or at risk children and young people: A rapid evidence assessment* (2017). P40 Available at: http://www.barnardos.org.uk/resources/research_and_publications/rapid-evidence-assessments-child-sexual-exploitation/publication-view.jsp?pid=PUB-2960. Accessed on: 13 June 2017.

[121] Ibid. P38

[122] Furnivall J., Grant E. (2014) Trauma Sensitive Practice with Children in Care Glasgow: IRISS Insights 27 http://www.iriss.org.uk/category/resource-categories/iriss-insights. Accessed on: 22 July 2017

Tomlinson P. (2013)[123]

In consequence, any therapeutic techniques exploring the origins and triggers of emotions and addressing emotional regulation with a child or young person can only be safely negotiated within the containment of a trusting relationship, careful, empathic observation and listening:

> *'In simple terms the foundations of trust are only built through a consistent relationship over time. Without such a foundation to build from, the benefits of therapy or clinical intervention are very unlikely to be relatable or sustainable. This is because the real learning and resilience comes from how as human beings we utilize the insight that these clinical tools and skills provide in times of adversity to respond well. Experiential learning is core to this approach and the relationship of trust is the key to being and feeling safe enough to try.'*
>
> *Quote from Claire Rigby*[124]

Dissociation

> *'I would disconnect myself from being in the room where the abuse was happening. I almost felt like I was watching it happen to me but I wasn't feeling it or wasn't part of it. It became something that happened automatically.'*
>
> *Quote from Mind webpage*[125]

This dissociative response is the 'freeze' response when 'fight' (resisting) or 'flight' (running away) is not possible. When people experience extreme terror and danger they are capable of an overwhelmingly violent response or can completely cut off from bodily and psychological experience (Perry et al.,1995)[126] In situations such as sexual assault, where physical escape is impossible, dissociation is the most adaptive response a child or adult can employ[127]. It is protective physiologically and psychologically, allowing trauma to be experienced at a distance. The more serious and long lasting the threat the more intense is the response. Individual to each traumatised young person will be the demonstration of both hyperarousal and dissociation at different times to manage their distress and anxiety. Often this difficult behaviour results in an excessive focus by [parents/carers and] professionals on control of the young person rather than understanding meaning. A relational and attachment-promoting approach is needed requiring personal commitment to the young person from an individual practitioner.

Interpersonal problems

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[123] Tomlinson P. *Communicating with Traumatised Children: Lecture for Foster and Residential Carers in Japan*, October 2013. The goodenoughcaring Journal, Vol. 14, December 2013, www.goodenoughcaring.com. P2 & P4

[124] Claire Rigby, Partnership Lead for Forward Thinking Birmingham 0-25 Mental Health Services (2018)

[125] https://www.mind.org.uk/information-support/types-of-mental-health-problems/dissociative-disorders/causes/#.WsIa_HtFwdU

[126] Perry B.D., Pollard R., Blakely T., Baker W., Vigilante D. *Childhood trauma, the neurobiology of adaptation and 'use-dependent' development of the brain: how "states" become "traits"'.* Infant Mental Health Journal 16 (4): 271-291, 1995

[127] Furnivall J., Grant E. (2014) Trauma Sensitive Practice with Children in Care Glasgow: IRISS Insights 27 http://www.iriss.org.uk/category/resource-categories/iriss-insights. Accessed on: 22 July 2017

Developmental trauma can leave a young person without a template for positive social interactions. This can mean that human contact, rather than being reassuring, may be a source of stress and anxiety. Many young people misinterpret the intentions or feelings of others as hostile which can lead to them being ignored or excluded by their peers (Streeck-Fischer, 2000). Some fail to understand normal rules of interaction or overreact to the inevitable frustrations and difficulties in making and maintaining friendships. Traumatised children may find being in group situations with peers or others particularly stressful as they are often highly stimulating and can quickly overwhelm children's fragile coping mechanisms. In this context a child or young person can feel much safer in a one-to-one relationship with a trusted practitioner.

The young people in this Project talked about learning to represent themselves socially and to negotiate with others, through interaction with, and observation of their keyworkers. Research supports the positive effect on adolescent development of mentors or important non-parental adults, supporting and inspiring the young people, and modelling positive behaviours (Beam, Chen, & Greenberger, 2002; Hamilton & Darling, 1996; Hirsch, Mickus, & Boerger, 2002; Rhodes, Ebert & Fischer, 1992). These and other studies have found that non-parental adults have both parent- and peerlike qualities, and may serve as better role models (e.g., lower levels of psychological and behavioural problems) for adolescents than do parents and peers (Beam et al. 2002). Non-parental adults were found to often provide more social support (e.g., higher levels of warmth and acceptance) than parents and peers (Chen et al. 2003). Furthermore, the warmth and acceptance moderated young people's problem behaviours such as misconduct and depressive symptoms (Chang et al. in press; Greenberger et al. 1998).

Treatment content detail

In consequence, of the above, the treatment content in an exemplar Trauma-informed recovery service, **Tier 1 of the service model** needs to:

a) Commence with the **establishment of a safe, trusting relationship** with a positive adult (practitioner); as described in the 'Frontline' section of Table 4.2.2 Summary of the core elements and delivery method for an exemplar trauma-informed recovery service model. Within this relationship the collaboration necessary for recovery can be negotiated.

Alexander et al. (1998)[128] describe the attachment relationship as *'therapy itself… interpreted as the attachment relationship whose purpose is to alter negative models of the self and others by providing the child with a secure base from which to explore his or her inner world and actual relationships.'*

b) Be **'modelled' by the keyworker** . The young people in this Project talked about learning to represent themselves socially and to negotiate with others, through interaction with, and observation of their keyworkers. positive effect on adolescent development of mentors or important non-parental adults, supporting and inspiring the young people, and modelling positive behaviours

c) Be **holistic** – addressing the young person's mind, body, spirit and emotions in the healing process. This comprises a wide variety of therapeutic and supportive interventions tailored in each case to the needs of the individual child. This includes counselling and talking therapies, symbolic play, solution-focused brief therapy,

[128] Alexander P.C., Anderson C.I., Brand B., Schaeffer C.M., Grelling B.Z., Kretz L. *Adult attachment and long term effects in survivors of incest* (1998). Child Abuse and neglect 22,1 P45-62 in *Effective Ways of Working with Children and their Families* Ed Hill M. (1999) P222

somatic therapy[129], work on awareness and management of feelings, activity therapy and a variety of creative therapies.

Tier 2 of the service model provides support for the keyworker to make the service 'self-contained'. That is, the keyworker can deliver the range of therapeutic and s upportive interventions by relying on expert advice and co-working to avoid referring the child or young person outside the service.

This was the model for much of the work undertaken by the keyworkers in the services reviewed in the fieldwork for this Project

[129] Somatic therapy aims to safely release traumatic shock 'frozen' in the body at times of overwhelm, allowing for a nat ural transformation of both PTSD and the wounds of emotional and early childhood trauma. SE offers a w ay to explore where a per son is "stuck" in the stressful fight, flight or freeze responses, and provides practical clinical tools to resolve these fixated physiological states. See www.seauk.org.uk/.

5. Observations and recommendations

5.1 Observations

The objectives for this Project were to inform interested health and care commissioners in relation to the child sexual abuse and exploitation recovery services that they commission, by explaining why a tailored, trauma-informed approach needs to be taken; and coming to a judgement about both what an exemplar service might look like and whether such services are currently being delivered in the UK.

The Project fieldwork yielded data suggesting that exemplar child sexual abuse and exploitation services are being delivered in the UK, albeit in selected areas and at a relatively small scale. Based on these findings the Project has sought to provide information for commissioners to benchmark the child sexual abuse and exploitation recovery services that they commission; and, to this end, this report identifies the core elements and approach, the frontline activities and costs of an exemplar trauma-informed recovery service for young people following child sexual abuse and exploitation.

The sense in which the service needs to be 'tailored', is that it needs to offer each young person the opportunity to develop a trusting relationship with a single, constant practitioner (keyworker), the basis for recovery work needs to be the young person's strengths and the relationship between the young person and their keyworker needs to be pedagogic.

The sense in which the service is 'trauma-informed', is that it needs to take into account, for each young person, the trauma responses that that young person may be experiencing which reflect not just the most recent trauma or series of traumas they have experienced, but also past traumas. These are currently variously described in this report as Disorders of Extreme Stress, not otherwise specified (DESNOS)/Complex Trauma/C-PTSD or Developmental Trauma Disorder.

As noted earlier, recognising the whole-life impact of past and present trauma on an individual and understanding their whole lived experience is essential to working effectively with them to achieve a measure of recovery. Importantly, this will facilitate the practitioner's understanding and accommodation of the pace the survivor is able to sustain and the 'distance he or she is able to travel' towards recovery, within the period of an intervention (case length).

The negative consequences of trauma in childhood is supported by the adverse Childhood Experiences (ACEs) Study which predicts increased risk of disease and death for individuals who have four or more untreated ACEs. This is distressing on a personal level for the individuals concerned; the cost of medical and psychological support for them over their lifetimes also represents a significant drain on the public purse.

It is anticipated that should research be undertaken to identify the cost to the public purse of the life course impact of child sexual abuse and exploitation, the large scale delivery of the service across the country will represent a very good return on investment for the Government.

5.2 Recommendations

This report makes four recommendations based on the findings from this Project.

1) The first recommendation – or invitation – is for health and care commissioners responsible for services seeking to support young people to recover following child sexual abuse and exploitation to review the services to benchmark them against:

a) the criteria encompassed in the descriptions of ‘a trusting relationship’, ‘building on the young person’s strengths’ and using ‘a pedagogic approach’

b) the exemplar service frontline (practitioner) and service support activities

c) the exemplar service frontline costs (including case length).

2) The second recommendation – or invitation – is that, where possible, health and care commissioners monitor or dip sample their child sexual abuse and exploitation services using the criteria set out in this Project in order to build the evidence-base started through this research.

3) The third recommendation – or invitation – is for health and care commissioners to support the collection and analysis of data on the Adverse Childhood Experiences (ACEs) experiences of the children and young people who receive support from their services (as per this Project).

4) The fourth recommendation is that the Department of Health and Social Care commission research to be undertaken to identify the cost to the public purse in the UK of the life course impact of child sexual abuse and exploitation.