Rotherham Metropolitan Borough Council

Rotherham Child Sexual Exploitation Needs Analysis

CSE Joint Intelligence Working Group

LSCB CSE sub-group

December 2015

FINAL

Contents

Introduction

The abuse of children and vulnerable people is an abhorrent crime, no matter when or where it occurs. Partners within Rotherham are committed to tackling it. It is important that we learn the lessons from the Jay (2014), Ofsted (2014) and Casey report (2015) when addressing Child Sexual Exploitation (CSE). In the past we know that we have failed to listen to the voices of children and their families.

Collecting accurate data about Child Sexual Exploitation is an evolving process. At this stage we have used available data taken at a snap shot in time, but as time goes by it is anticipated the data will "firm up" and become more reflective of the true needs of victims and survivors of CSE. It is hoped this analysis will provide a good proxy of services that are required and assist commissioners in securing appropriate services for victims and survivors of CSE.

This report must be read alongside the:

- Salford University voice and influence work (due Autumn 2015)
- Monthly police figures: http://www.southyorks.police.uk/help-and-advice/child-sexual-exploitation

The scope for the Child Sexual Exploitation (CSE) needs analysis was endorsed by the LSCB CSE subgroup in November 2014, as follows:

- To understand the scale and nature of child sexual exploitation in Rotherham
- To understand the needs of victims (child and adult, current and historic)
- To understand the triggers, motivations and needs of perpetrators
- To make evidence based recommendations to inform the development, provision and commissioning of services and programmes to prevent CSE, protect victims and pursue perpetrators

How is CSE defined?

Rotherham has adopted the national agreed definition of Child Sexual Exploitation (CSE).

Sexual Exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where the young person (or third person/s) receive "something" (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money)as a result of them performing and/or other/others performing on them, sexual activities.
Child Sexual Exploitation can occur through the use of technology without the Childs immediate recognition; for example being persuaded to post sexual images on the internet/ mobile phones without immediate payment or gain. In all cases, those exploiting the child/ young person have power over them by virtue of their age, gender, intellect, physical strength and/ or economic or other resources.

www.nwgnetwork.org

Understanding CSE: learning from recent literature

- Estimates of the proportion of adults who have been sexually abused in childhood vary from 4-8% (involving penetration) to 20-30% (including no contact) (Radford et al 2011) ; there are no reliable national estimates on the prevalence of child sexual exploitation (CSE) (Brodie & Pearce 2012) .

- Modelling from national research on childhood sexual abuse suggests that there is an estimated 17,834 survivors of sexual abuse aged 18-64 years , within Rotherham's population, 70% of whom are female (www.pansi.org.uk).

- Linkage between experience of sexual exploitation/abuse in childhood and subsequent experience of domestic violence is well documented (The Lancet 2014).

- CSE takes many forms: inappropriate age relationship; familial; peer on peer; on line; organised group/gang; grooming an adult to gain access to a child; lone perpetrator (Barnados 2011).

- Peer on peer and online CSE continue to receive less attention than organised group CSE (Jago et al 2011).

- The process of grooming is well studied and described, although understanding remains limited in parts of children's workforce and the wider public (Childline 2012).

- Physical, psychological, behavioural signs of CSE are well described, as are risk factors associated with deprivation and multiple disadvantage ('Push' factors) (Berelowitz et al 2012).

- 'Pull' factors are also recognised: gifts, excitement, adolescent risk taking, seeking transition to adulthood (Berelowitz et al 2012).

- Under-reporting of CSE and additional barriers to disclosure and action are recognised with respect to girls and young women in Asian communities (Gohir 2013) and boys/young men (Barnados 2014).

- Consent: it is still not universally understood that **a child under 18 cannot consent to their own abuse**; victims continue to be blamed for the harm they experience (DH 2014).

- Some young people assume that sexual violence is 'normal' and inevitable; this normalisation also leads to lack of reporting and disclosure (Beckett at al 2013).

- Gender inequality underpins violence against girls and women. Young men are given freedom to be sexually active and receive credibility for this, while young women are judged for, and frequently harmed as a result of, the same (Beckett et al 2013).

- Responses to CSE understandably have had a strong safeguarding /children's social care focus; less attention has been given to youth and community outreach and victim/survivor and family support, especially for the over 16s/18s (Casey 2015).

- Health impacts of CSE are wide ranging and psychological impact of unresolved trauma due to sexual abuse is significant and lifelong; 85% of sexually exploited children interviewed as part of the CCSEGG inquiry had self-harmed or attempted suicide (Berelowitz et al 2012& Kirtley 2013).

- Effective therapeutic interventions: several systematic reviews have concluded that there is no magic bullet/intervention; a key success factor is quality of practitioner-client relationship (Macdonald et al 2012 & Parker & Turner 2013).

- Many victims/survivors of undisclosed abuse are receiving support in mental health, drugs and alcohol, domestic violence and criminal justice services: for

some, services may tend to respond to presenting issues/diagnosis but be less effective in identifying and addressing underlying trauma (Academy of Medical Royal Colleges 2014).

- Fragmentation of victims/survivors and their families can be exacerbated by fragmented and sometimes re-traumatising services and disjointed partnership action (Berelowitz et al 2012 & Ofsted 2014).

- Vicarious trauma for workers and organisations also requires attention in order to create a resilient system which can provide consistent, enduring support (Berelowitz et al 2013 & Jay 2014).

Understanding CSE in Rotherham: local learning

- Operation Central (2010): Recognised complexity of investigation. The relationships built up between youth workers (Risky Business), police officers and the victims was 'highly beneficial and instrumental' in success of the operation. A specialist multiagency CSE team and CSE multiagency training is recommended. Supportive youth services should be sustained. Staff dealing with CSE should be offered emotional support.

- Barnardos report (Oct 13) 'best practice has demonstrated to engage young people and families where CSE exists requires a different approach to traditional policing and social work' ; commended IYSS routine involvement in community, school and assertive outreach into hot spot areas and stressed the need for this to link back to specialist collocated CSE service.

- Her Majesties Inspection of Constabulary Review (2013): Commended strategic commitment, partnership working to prevent CSE, and staff training, but found not translated into operational activity, no operational targets, consequently lack of resources allocated.

- Jay report (2014): 66 CSE case files; found that majority had multiple missing episodes (63% missing more than once), 50% had misused drugs and/or alcohol, one third had mental health problems, two thirds emotional health difficulties; parental drug addiction was present in 20% of cases and parental mental health problems in over a third of cases. Just over a third were previously known to services due to safeguarding concerns. There was a history of domestic violence in 46% of cases, truancy and school refusal in 63%. Recommendations made on risk assessment, LAC, youth and community outreach, joint CSE team, early intervention, enduring victim support, and BME communities.

- Both LSCB (Dec 13) and Ofsted (Nov 14) reports stressed the need for greater clarity in strategic direction, leadership and governance and robust performance management.

- Ofsted (2014) called for authorities to make the links between CSE with other key strategies e.g. on gangs, licensing, and quality of PSHE in schools.

Ofsted stressed the importance of children both missing and persistently absent from schools and for the police (with assistance of shared intelligence from partners) to make full use of all powers to disrupt.

- Casey (2015) pointed to failings of a 'social care' approach and compartmentalising' of CSE; tension between youth outreach and social care approaches; concern re transition to adulthood, social care responsibility ending at 18; lack of identification of who and where the victims are and their current and future needs.

Risk and vulnerability to CSE in Rotherham's young people: how do we compare with our statistical neighbours?

CSE Needs Analysis

(DRAFT4)

Indicators from Public Health England Profiles

Position compared to England

Better	Lower		
Similar	Similar		
Worse	Higher		
	N/C Not compared		

Prev Period Key:

Better	Higher
Similar	Lower
Worse	

Data Group	Indicator (Data quality in brackets, A-C)	Rate	Period	Sex	Age	Rotherham Value	Count	Prev Period	Roth Trend	Close Statistical Neighbours (SN) Barnsley	Doncaster	Redc&Clev	Wigan	All SN (SN10)	Yorkshire & Humber	England	Note
1	Domestic Abuse (B)	(1)	2013/14	P	16+ yrs	30.4	n/a	▲		30.4	30.4	25.5	23.5	23.2*	22.8	19.4	N/C
1	Violent crime (including sexual violence) - hospital admissions for violence	(2)	2011/12 - 13/14	P	All ages	70.0	540	▲		73.6	73.5	76.8	84.6	69.2*	68.0	52.4	
1	Violent crime (including sexual violence) - violence offences per 1,000 population	(1)	2013/14	P	All ages	8.1	2,093	▲		8.1	12.8	7.4	8.6	10.2	10.0	11.1	N/C
1	Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	(1)	2013/14	P	All ages	0.82	212	▲		0.94	1.62	0.83	0.76	1.12	1.10	1.01	N/C
1	Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years) (B)	(3)	2013/14	P	<15 yrs	106.2	493	▼		100.1	129.5	154.1	144.2	128.1	121.0	112.2	
1	Hospital admissions caused by unintentional and deliberate injuries in young people (15-24) (B)	(3)	2013/14	P	15-24 yrs	115.8	357	▲		163.5	158.8	220.3	221.3	182.5	150.7	136.7	
2	Young people hospital admissions due to substance misuse: rate aged 15 - 24 (B)	(2)	2011/12 - 13/14	P	15-24 yrs	94.8	88	▼		124.2	119.0	215.8	186.4	136.8*	92.1	81.3	
2	Child hospital admissions due to alcohol specific conditions: rate per 100,000 aged under 18 (B)	(4)	2011/12 - 13/14	P	<18 yrs	29.1	50	▲		49.5	43.1	77.4	59.0	52.4	38.1	40.1	
3	Children in need: Rate of children in need during the year, per 10,000 (A)	(3)	2013/14	P	<18 yrs	824.0	4,625	▼		472.7	1185.1	899.1	545.3	834.1	755.0	679.0	YH N/C
3	New cases of children in need: Rate of new cases identified during the year (A)	(3)	2013/14	P	<18 yrs	499.8	2,804	▼		233.3	677.9	401.8	233.1	442.4	401.8	371.7	YH N/C
3	Children in need for more than 2 years: % of children in need (A)	(5)	2013/14	P	<18 yrs	27.3	506	n/a		29.3	35.6	30.5	35.0	32.9	31.8	31.6	YH N/C
3	Children in need due to abuse, neglect or family dysfunction: % of children in need (A)	(5)	2014	P	<18 yrs	69.4	1,285	n/a		54.6	80.6	56.7	74.5	73.8	71.3	65.8	YH N/C
3	Children in need referrals: Rate of children in need referrals during the year, per 10,000 aged <18 (A)	(3)	2013/14	P	<18 yrs	720.1	4,040	▲		354.6	1043.8	609.0	663.5	734.3	671.0	572	YH N/C
3	Assessment of children in need referrals: % of referrals with a completed initial assessment (B)	(5)	2013/14	P	<18 yrs	38.0	1,537	▼		23.1	63.9	79.7	3.0	36.3	43.0	46.9	YH N/C

Risk and vulnerability in Rotherham's young people: how do we compare with our statistical neighbours?

Data Group	Indicator (Data quality in brackets, A-C)	Rate	Period	Sex	Age	Rotherham Value	Count	Prev Period	Roth Trend	Close Statistical Neighbours				All SN (SN10)	Yorkshire & Humber	England	Note
										Barnsley	Doncaster	Redc&Clev	Wigan				
3	Child protection cases: Rate of children the subject of a CP plan at the end of the year (31 March) (A)	(3)	2013/14	P	<18 yrs	69.2	388	▲	—	42.5	50.9	79.0	31.4	49.1	44.4	42.0	YH N/C
3	New child protection cases: Rate of children the subject of a CP plan during the year (A)	(3)	2013/14	P	<18 yrs	72.4	406	▲	—	44.9	64.8	100.1	56.1	63.6	51.7	52.0	YH N/C
3	Repeat child protection cases: % of children the subject of a 2nd or subsequent CP plan (A)	(5)	2014	P	<18 yrs	11.3	46	n/a		19.4	17.6	9.1	10.8	14.3	14.9	15.8	YH N/C
3	Looked after children: Rate per 10,000 <18 population (A)	(3)	2013/14	P	<18 yrs	70.4	395	▬	—	46.5	77.0	63.7	73.0	75.8	64.7	59.8	YH N/C
3	Children leaving care: Rate per 10,000 <18 population (A)	(3)	2013/14	P	<18 yrs	23.2	130	▼	—	18.2	36.2	27.3	23.6	26.2	24.8	26.4	YH N/C
3	Spend (£000s) on Children looked after: rate per 10,000 0-17 (A)	(3)	2013/14	P	<18 yrs	4,025	22,579	▲	—	2,696	4,059	3,704	3,617	3,662	3,199	3,182	N/C
3	Spend (£000s) on Safeguarding children and young people's services: rate per 10,000 0-17 (A)	(3)	2013/14	P	<18 yrs	1,974	11,073	▼	—	2,101	1,734	1,959	1,159	1,718	1,750	1,761	N/C
3	Spend (£000s) on Local Authority children and young people's services (excl. education) (A)	(3)	2013/14	P	<18 yrs	9,500	53,297	▼	—	8,479	9,272	9,574	8,233	8,773	8,236	7,811	N/C
4	New sexually transmitted infections (including chlamydia)	(3)	2013	P	15-24 yrs	4,940	1,550	n/a		3,697	3,958	2,751	4,618	3,723	3,430	3,433	N/C
4	Chlamydia detection (15-24 year olds) - CTAD	(4)	2014	F	15-24 yrs	2,141	660	⇩	—	2,272	2,809	1,471	2,192	2,407	2,244	2,012	
4	Under 18 conceptions (A)	(1)	2013	F	<18 yrs	24.3	115	⇧	—	40.9	34.7	33.2	27.1	32.9	28.5	24.3	
4	Under 18 conceptions: conceptions in those aged under 16 (A)	(1)	2013	F	<16 yrs	3.4	16	⇧	—	9.6	7.8	9.7	5.6	6.8	6.0	4.8	
5	Young people hospital admissions for self-harm: per 100,000 aged 10 - 24 (B)	(2)	2013/14	P	10-24 yrs	268.1	122	⇩	—	508.1	433.7	733.2	784.1	525.0*	394.7	412.1	
5	Prevalence of potential eating disorders among young people: Est. no. of 16 - 24 year olds (C)	(6)	2013	P	16+ yrs	3,616	3,616	n/a		3,314	4,346	1,917	4,485	3,337	n/a	n/a	N/C
6	All entered to the youth justice system: rate per 1,000 aged 10 - 18 (A)	(1)	2013/14	P	10-18 yrs	7.6	211	▼	—	10.8	9.6	14.6	6.0	7.5	7.7	7.0	
6	First time entrants to the youth justice system (A)	(4)	2013	P	10-17 yrs	534.7	134	⇩	—	703.4	580.5	608.9	321.7	453.6	459	441	
7	State funded total persistent absence rates	(5)	2014	P	5-15 yrs	4.4	n/a	▼	—	4.9	4.2	4.0	3.7	3.9	3.8	3.6	N/C
7	Children in Need who are persistent absentees	(5)	2014	P	5-16 yrs	15.4	n/a	▼	—	18.6	17.2	10.1	13.6	13.9	n/a	13.8	N/C
7	Children in Need subject to a Child Protection Plan who are persistent absentees	(5)	2014	P	5-16 yrs	13.7	n/a	▼	—	21.0	16.5	9.4	14.4	15.2	n/a	15.2	N/C

Risk and vulnerability in Rotherham's young people: how do we compare with our statistical neighbours?

Data Group	Indicator (Data quality in brackets, A-C)	Rate	Period	Sex	Age	Rotherham Value	Count	Prev Period	Roth Trend	Close Statistical Neighbours: Barnsley	Doncaster	Rdc&Clev	Wigan	All SN (SN10)	Yorkshire & Humber	England	Note
8	Primary school pupil absence: % of half days missed (A)	(5)	2014	P	Primary	4.3	n/a	▼		4.4	4.2	4.0	3.9	4.0	3.9	3.9	N/C
8	Secondary school pupil absence: % of half days missed (A)	(5)	2014	P	Second-ary	5.7	n/a	▼		6.3	5.9	5.9	5.2	5.5	5.4	5.2	N/C
8	Pupil absence (A)	(5)	2014	P	5-15 yrs	5.0	n/a	▼		5.2	4.9	4.9	4.5	4.7	4.6	4.5	N/C
8	Secondary school fixed period exclusions: % of school pupils (A)	(5)	2012/13	P	Second-ary	10.1	1,855	n/a		8.5	13.4	7.9	7.2	9.9	8.5	6.8	
8	16-18 year olds not in education employment or training (A)	(5)	2014	P	16-18 yrs	5.9	n/a	▼		5.4	5.3	8.4	4.9	5.7	5.1	4.7	N/C
9	Child admissions for mental health: rate per 100,000 aged 0 -17 years (B)	(4)	2013/14	P	<18 yrs	37.4	21	▲		62.7	53.9	87.4	106.2	84.2	62.1	87.2	
9	Children who require Tier 3 CAMHS: estimated number 0-17 years (C)	(6)	2012	P	<18 yrs	1,040	1,040	n/a		910	1,205	510	1,255	933*	n/a	n/a	N/C
9	Children who require Tier 4 CAMHS: estimated number 0-17 years (C)	(6)	2012	P	<18 yrs	45	45	n/a		40	50	25	55	41*	n/a	n/a	N/C
9	Emotional well-being of looked after children (A)	(7)	2013/14	P	5-16 yrs	13.9	n/a	▼		14.3	15.0	14.3	15.2	14.3	14.0	13.9	N/C
9	Emotional and behavioural health outcome for LAC: % eligible children considered 'of concern' (A)	(5)	2012/13	P	School age	44.0	99	▲		35.0	39.0	41.0	31.0	34.8	38.0	38.0	
9	Estimated prevalence of any mental health disorder: % population aged 5-16 (B)	(5)	2013	P	5-16 yrs	10.2	3,742	n/a		10.3	10.3	10.5	9.9	10.1	9.7	9.6	N/C
9	Estimated prevalence of emotional disorders: % population aged 5-16 (B)	(5)	2013	P	5-16 yrs	4.0	1,456	n/a		4.0	4.0	4.1	3.8	3.9	3.8	3.7	N/C
10	Family homelessness: rate per 1,000 households (A)	(1)	2012/13	P	n/a	0.6	69	n/a		0.2	0.3	0.1	1.0	0.7	1.3	1.7	

Notes

Rates
(1) Crude rate per 1,000
(2) Directly standardised rate per 100,000
(3) Crude rate per 10,000
(4) Crude rate per 100,000
(5) Proportion (%)
(6) Count
(7) Score

Data quality:
(A) Robust
(B) Some concerns
(C) Significant concerns

Data Group
1. Domestic violence/sexual violence
2. Drugs and alcohol
3. Children in need/child protection/in care
4. Sexual health
5. Self harm
6. Youth justice
7. Persistent absence from education
8. Missing from home/care/education
9. Mental health services
10. Youth homelessness

n/a - not available/applicable
P - Persons, M - Males, F - Females
Prev. period = change over last year/period
N/C - Not Compared (no RAG-rating)

Data from Mental Health Children and Young Peoples Profile only compares to England in terms of 'Lower', 'Higher' or 'Similar'

SN10 = Average for all 10 Statistical Neighbours of Rotherham. Source: Children's Services Statistical Neighbour Benchmarking Tool (CSSNBT)(2014 Update), Department for Education.

* Crude average only (sum of SN10 values/10)

Sources: Public Health England (Profiles data), Department for Education (Local Authority Interactive Tool)

Analysis

CSE Needs Analysis – Indicators from Public Health England Profiles

Areas highlighted based on data updated as at July 2015

Indicators rated significantly worse than England:

- Violent crime (including sexual violence) - hospital admissions for violence (All ages). However, similar to the Statistical Neighbour (SN) average and Yorkshire and the Humber (YH) region average and rates are decreasing recently.
- First time entrants to the Youth Justice System (10-17 yrs.) Rotherham higher than England, YH and SN. Its rate had been decreasing until the latest year (2013) but has now increased.
  However, in terms of 'All entrants to the Youth Justice System', Rotherham's rate for 2013/14 is similar to SN and YH averages and only slightly higher than England. The rate has also been decreasing year-on-year.

Indicators rated significantly higher than England:

- Children in need (CIN): rate during the year. (However, rate decreasing recently)
- New cases of children in need identified during the year. (However, rate decreasing recently)
- Children in need due to abuse, neglect or family dysfunction.
- Children in need referrals during the year.
  Coupled with this the percentage of CIN referrals with the initial assessment completed was significantly lower than England (although slightly higher than the SN average)
- Looked after children. Rate per 10,000 <18.
  However, spend on looked after children also higher than England and SN/YH.
- Secondary school fixed period exclusions: % of school pupils.

Indicators higher than the England average (but not measured for significance):

- Domestic abuse (16+) (Also higher than YH/SN and trend is increasing)
- New sexually transmitted infections (15-24yrs) (Highest in YH region)
- State funded total persistent absence.
- Children in Need who are persistent absentees
  However , Children in Need subject to a Child Protection Plan who are persistent absentees was lower than England. Also, all persistent absentee percentages have decreased recently.

- Pupil absence (primary and secondary). (However, percentage decreasing over time)
- 16-18 year olds not in education employment or training. (However, similar to SN and the percentage is decreasing over time)

What does Rotherham's local Children and Young People lifestyle survey tell us?

- 25% in Y10 reported they had had sex; of these 46% reported this was after drinking alcohol; 22%, of those that reported sexual activity, did not use any method of contraception: these findings indicate a *lowe*r level of u-16 sexual activity and *greater* use of safe sex by Rotherham young people than nationally.

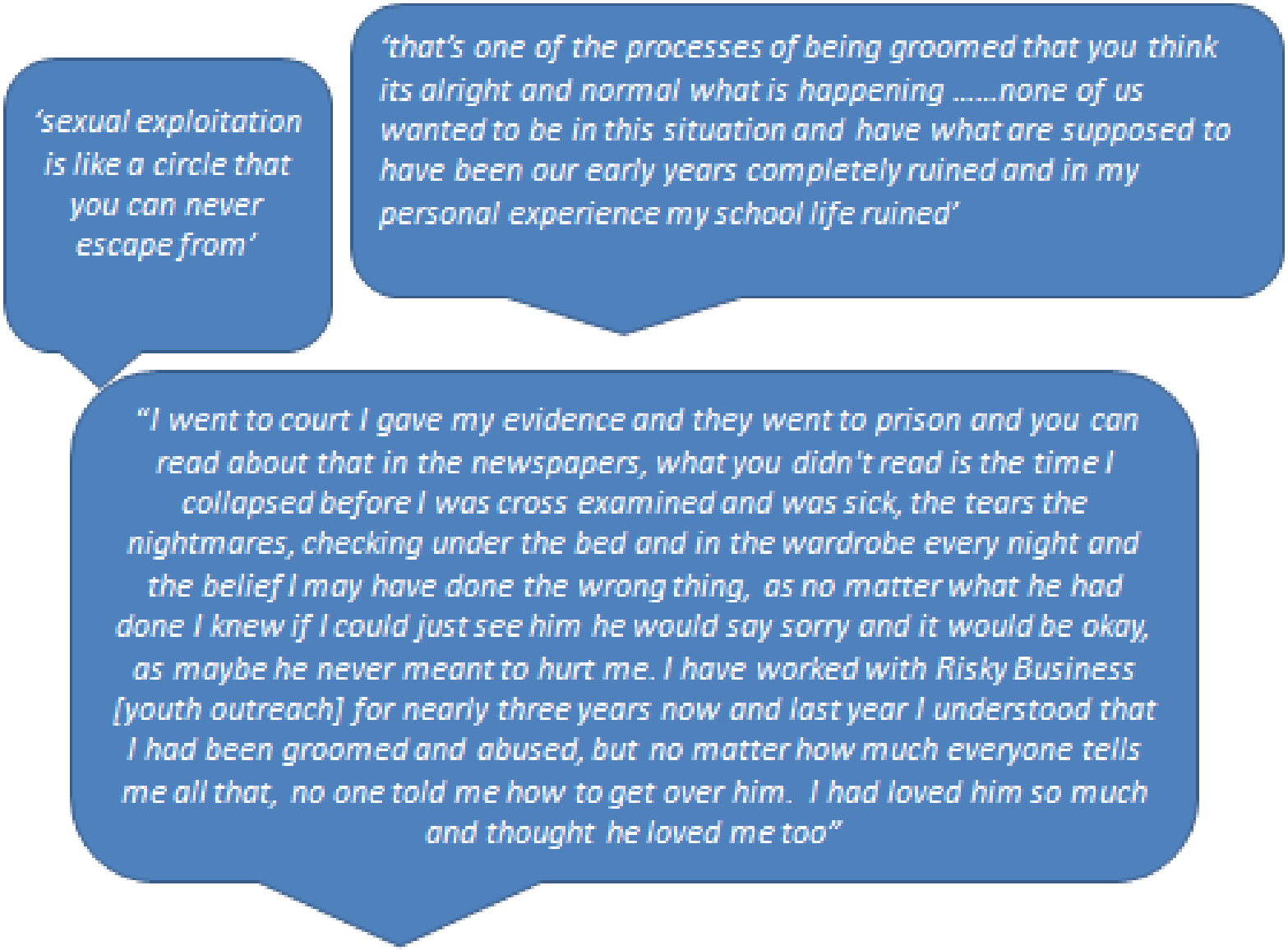
- Reductions in smoking and alcohol use among young people in Rotherham mirror national trends.

- Of concern, locally as nationally, is the increasing proportion of young people who report negative feelings about themselves and their relationships with friends and family.

- 60% report that they had been taught in school about child sexual exploitation and about being a parent.

Drugs and alcohol & CSE: There is a significantly higher proportion of opiate users and experience of CSE in young people supported by drug treatment services in Rotherham, compared with nationally.

Appendi



Victims Quotes

What prevention and early intervention activity has happened/is planned?

- Multiagency training and awareness raising: 1552 workers have attended CSE training and/or events (up from 320 in 13/14).

- CSE prevention work in schools and youth-work settings 2014/15:
  - CSE sessions offered to Y8s in all secondary schools: 1330 students attended 41% of total Y8s (up from 1320 in 2013/14)
  - CSE sessions delivered by IYSS as part of informal curriculum (targeting more vulnerable young people): 341 sessions (up from 252 in 13/14)
  - 3 Pilot CSE Theatre in Education (TiE) performances:

    a) 'Chelsie's Choice' (Wingfield)

    b)'*Working for Marcus'* (Dinnington)

    c)'Somebody's Sister, Somebody's Daughter' (Wales High School).

- Future plans re CSE TiE: Funding secured from RCCG and RMBC Public Health; planning for implementation in all secondary schools, rolling programme over 2-3 years depending on costings. Likely to use performances from a) & b) *(result of evaluation of performance/value for money/company flexibility)* Consultation summer term with PSHE Leads regarding timing of performances and year group focus. Planning to include one performance for special/PRU/vulnerable students in day time and one evening performances for vulnerable young people and workers/families as appropriate, in addition to a year group performance in each secondary school.

- Community awareness raising Nov 14 – March 15: 375 community members have attended the Child Sexual Exploitation Awareness training; in addition 113 participants of the conference launch in Nov 14 received an awareness raising session. 8 staff from member organisations within the Children, Young People and Families Consortium have been trained as trainers for the programme. Of those completing the training, the following is a result of the evaluations of the training;
  - 85% recorded an increase in understanding of what makes a child or young person at risk of being sexually exploited
  - 87% recorded an increased understanding of what action to take if worried a child or young person is being sexually exploited
  - 100% recorded an increased understanding of what they and other community members can do to prevent child sexual exploitation
  - 99% recorded an understanding of how to access the free online child sexual exploitation training resource for family, friends or colleagues

Appendix One

Analysis of 'CSE cohort' young people involved with CSE team i.e. at risk of or currently experiencing sexual exploitation 1.10.12-31.10.14

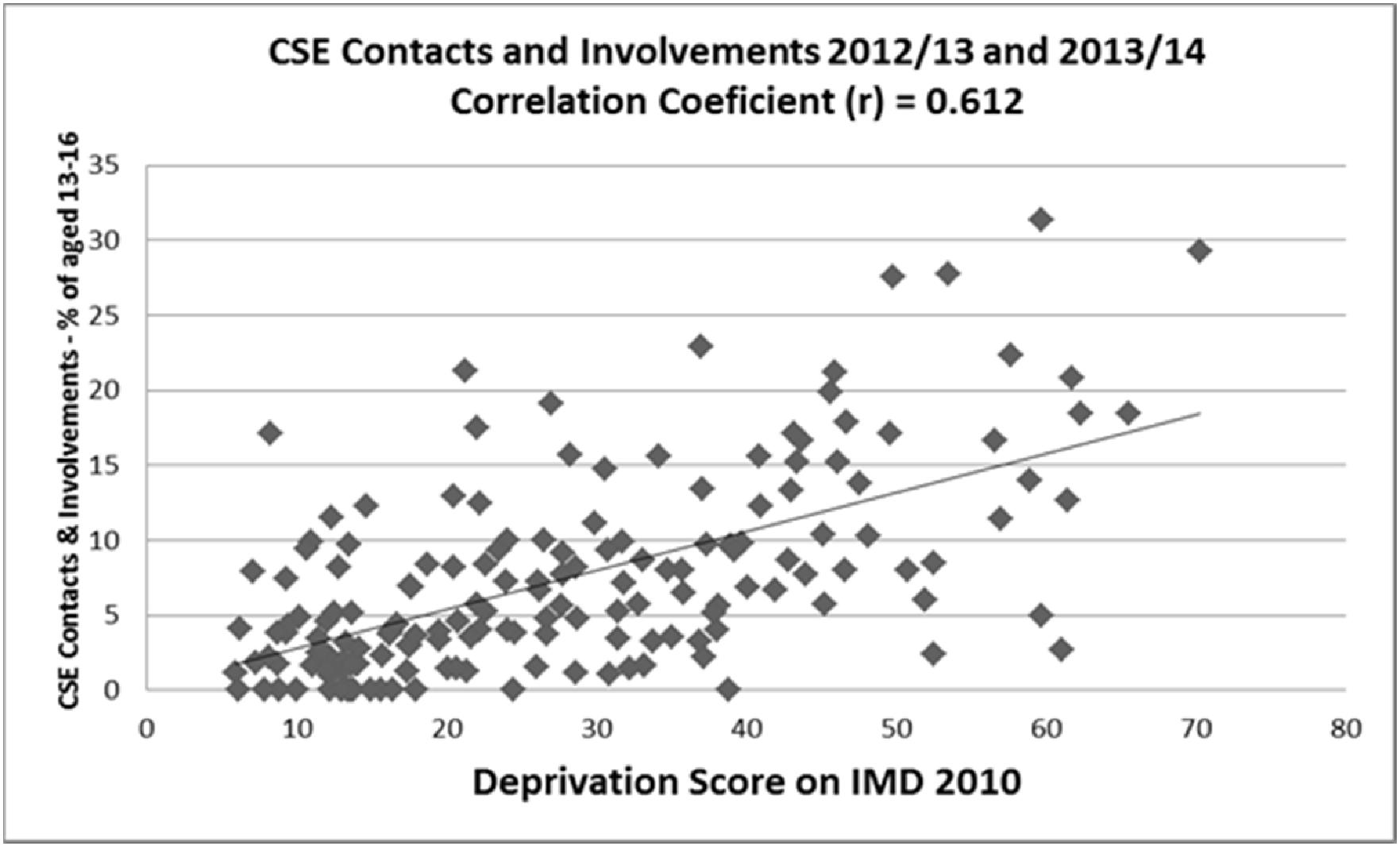
AGE AT THE DATE OF THE EARLIEST INVOLVEMENT WITH THE CSE TEAM	Female	Male	TOTAL
6	<5		<5
7		<5	<5
8		<5	<5
9	<5	<5	<5
10	<5	<5	<5
11	9	<5	11
12	17	<5	20
13	60	<5	62
14	85	<5	87
15	72	7	79
16	44	<5	46
17	13	<5	15
18	<5		<5
Grand Total	306	24	330

Ethnicity	Female	Male	TOTAL
White -British	222	21	243
Gypsy/Roma	25	<5	26
Asian – Other	<5		<5
Asian - Pakistani	6		6
Black - African	<5		<5
Dual Heritage – White and Black Caribbean	<5		<5
Dual Heritage - Other	<5		<5
Dual Heritage – White and Asian	<5		<5
Mixed - Other	<5		<5
Mixed – White and Asian	<5		<5
White – Other	<5		<5
Other - Any	12		12
Not Obtained/Refused	25	<5	27
Grand Total	306	24	330
TOTAL BME	59	<5	60

Most of the 'CSE cohort' (81%) are under 16 years; most (93%) are female; most are white British. Nearly one in 5 (18%) are from a BME community overall, but within that; there is under-representation of Asian communities and significant over-representation of the Gypsy/Roma community.

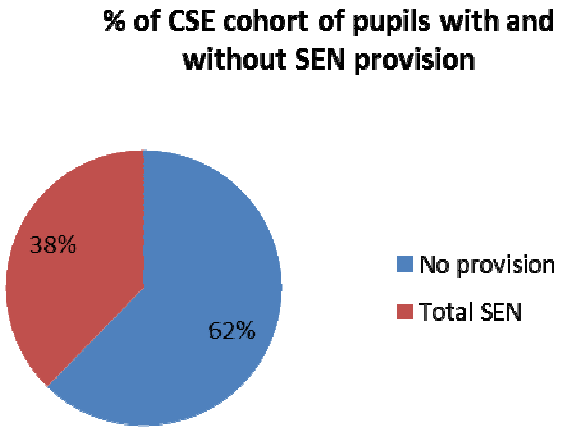
Please note these figures come with a "health warning". The data used is based on cases that went through the CSE team and the thresholds were not always clear but it provides a good proxy. The threshold has now been tightened up and agreed.

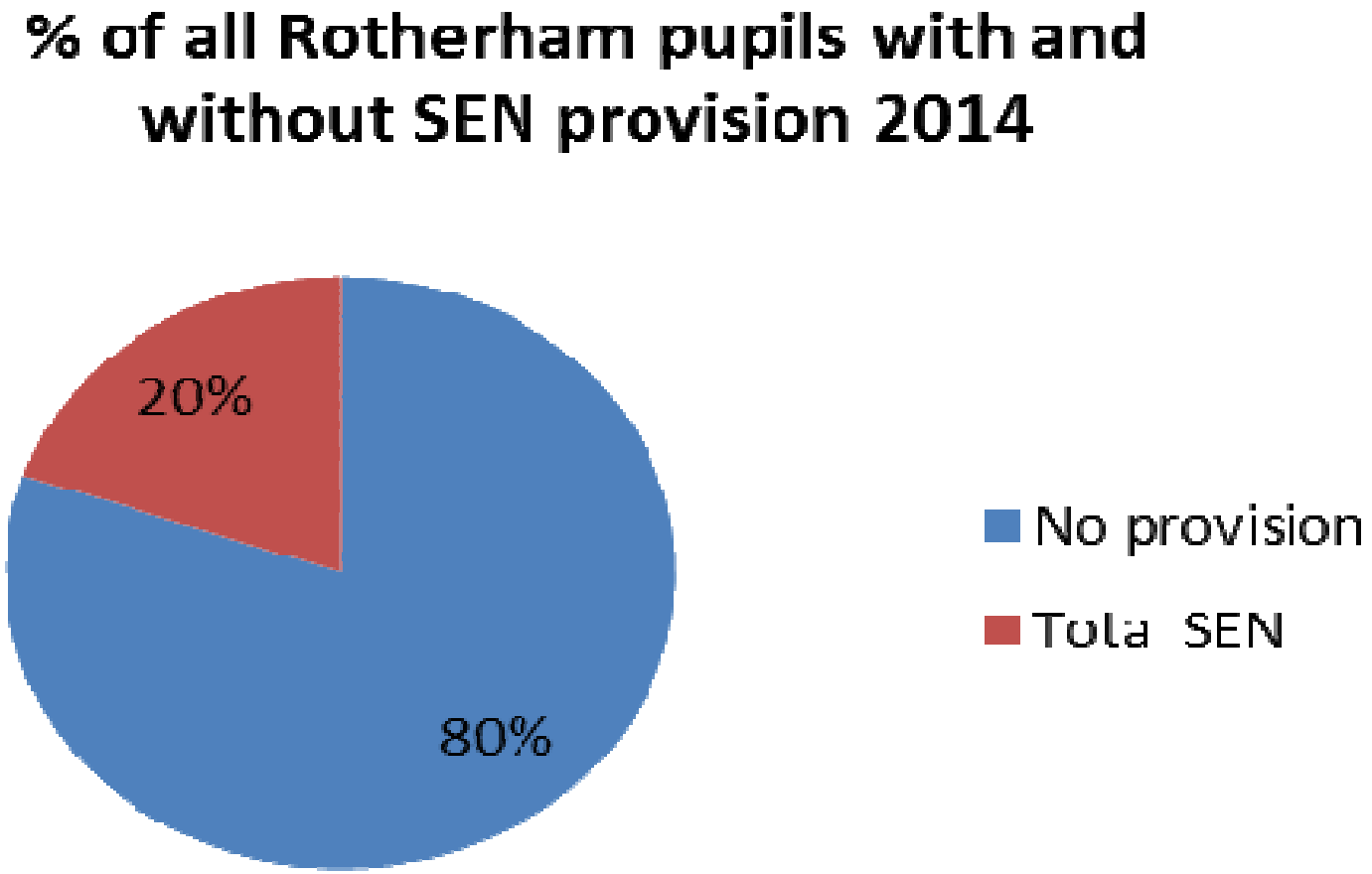
Appendix One



Young people identified in the 'CSE cohort' have a lower level of educational achievement at age 11 yrs (KS2) than the Rotherham average, and are almost twice as likely to have Special Education Needs (SEN), categorised at School Action or School Action Plus; however the CSE cohort is half as likely to have a Statement of SEN when compared to the general school population.

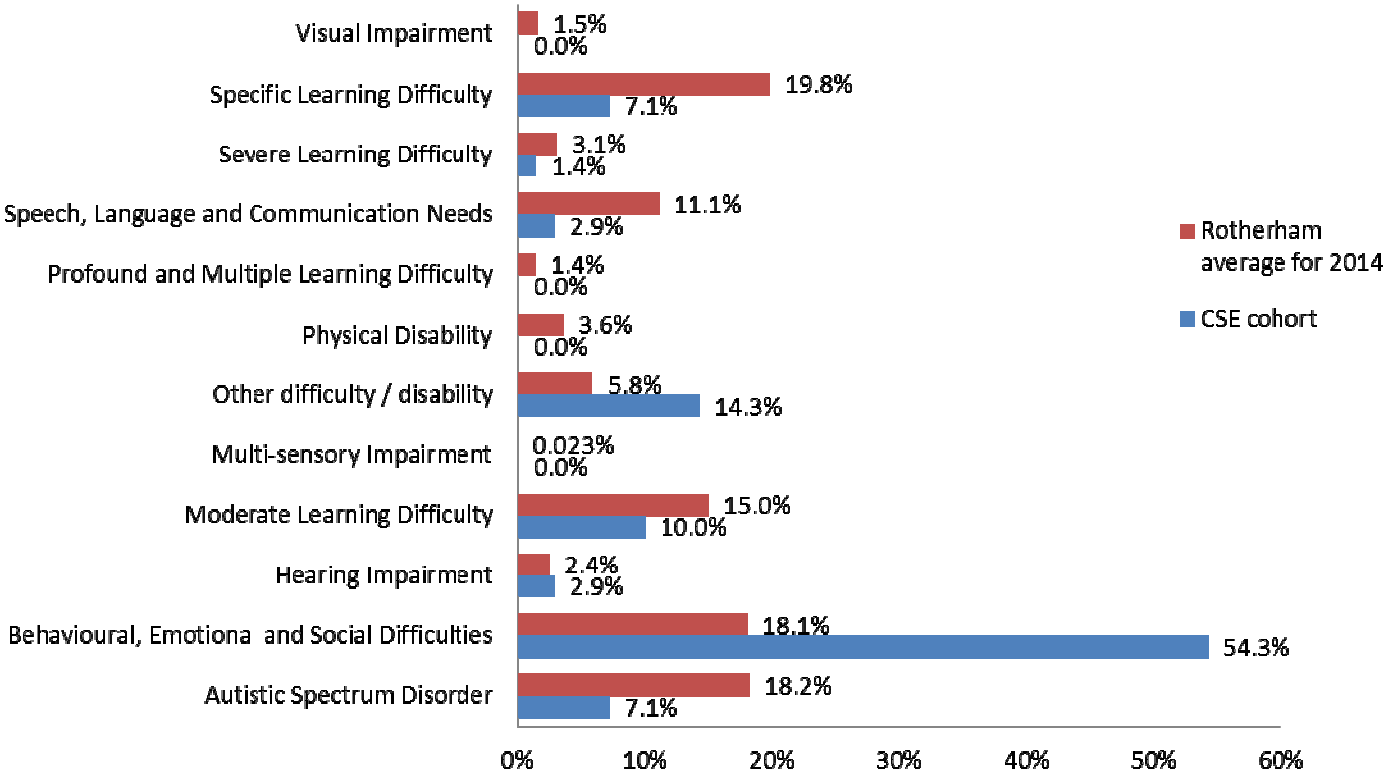
CSE cohort		
SEN provision	No.	%
No provision	203	62%
Total SEN	123	38%
Breakdown of total SEN		
School Action	53	43%
School Action Plus	63	51%
Statemented	7	6%
Total no. in cohort	326	
Rotherham average 2014		
SEN provision	No.	%
No provision	34936	80%
Total SEN	8578	20%
Breakdown of total SEN		
School Action	4241	49%
School Action Plus	3323	39%
Statemented	1014	12%
Total no. in cohort	43514	



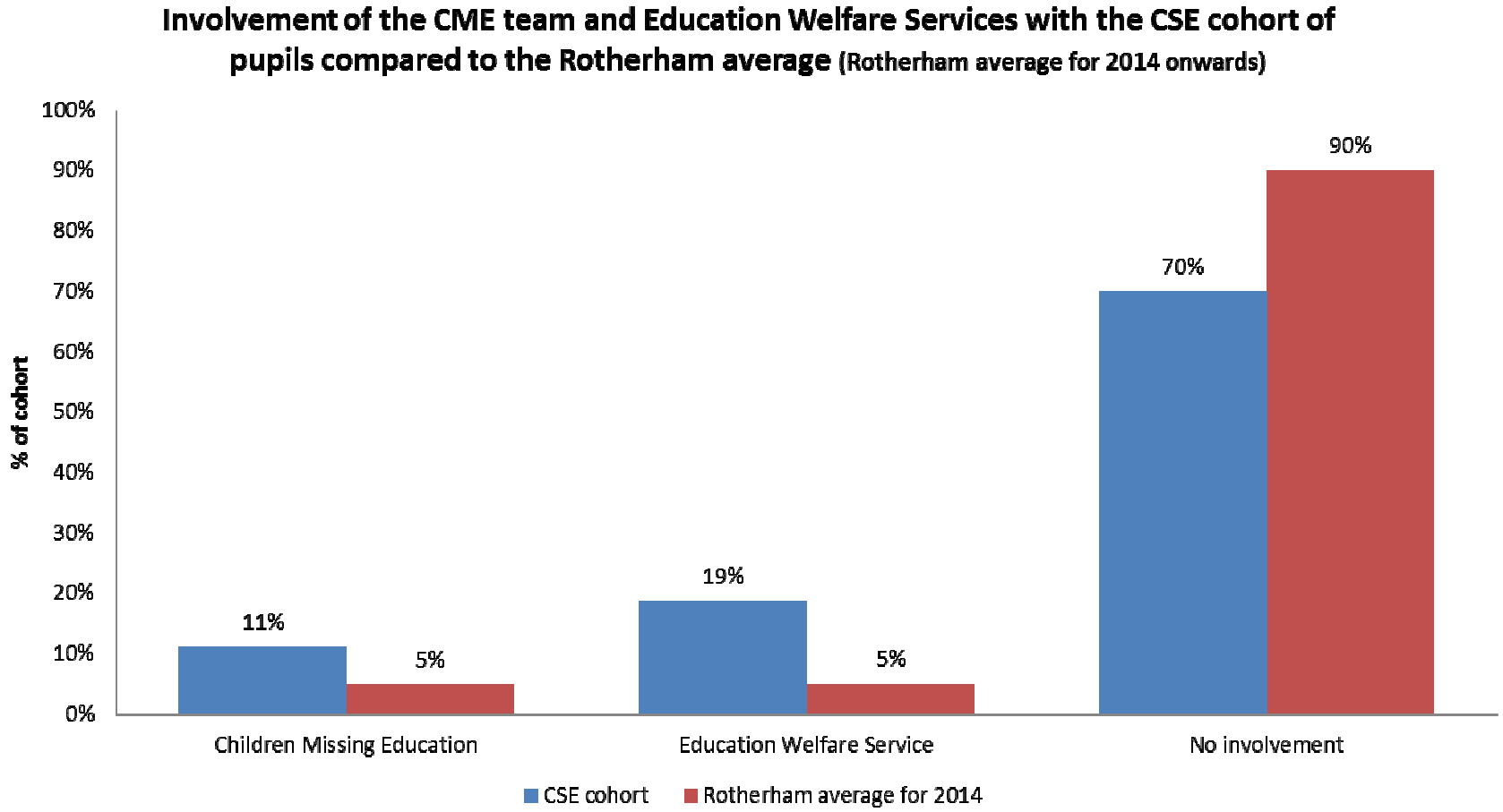


Over 50% of the 'CSE cohort' categorised with SEN have 'behavioural, emotional and social difficulties' as the primary need, compared to 18% of general SEN population: conversely under one fifth of 'CSE cohort' in receipt of SEN provision have 'learning difficulties' compared with over a third of the general SEN population.

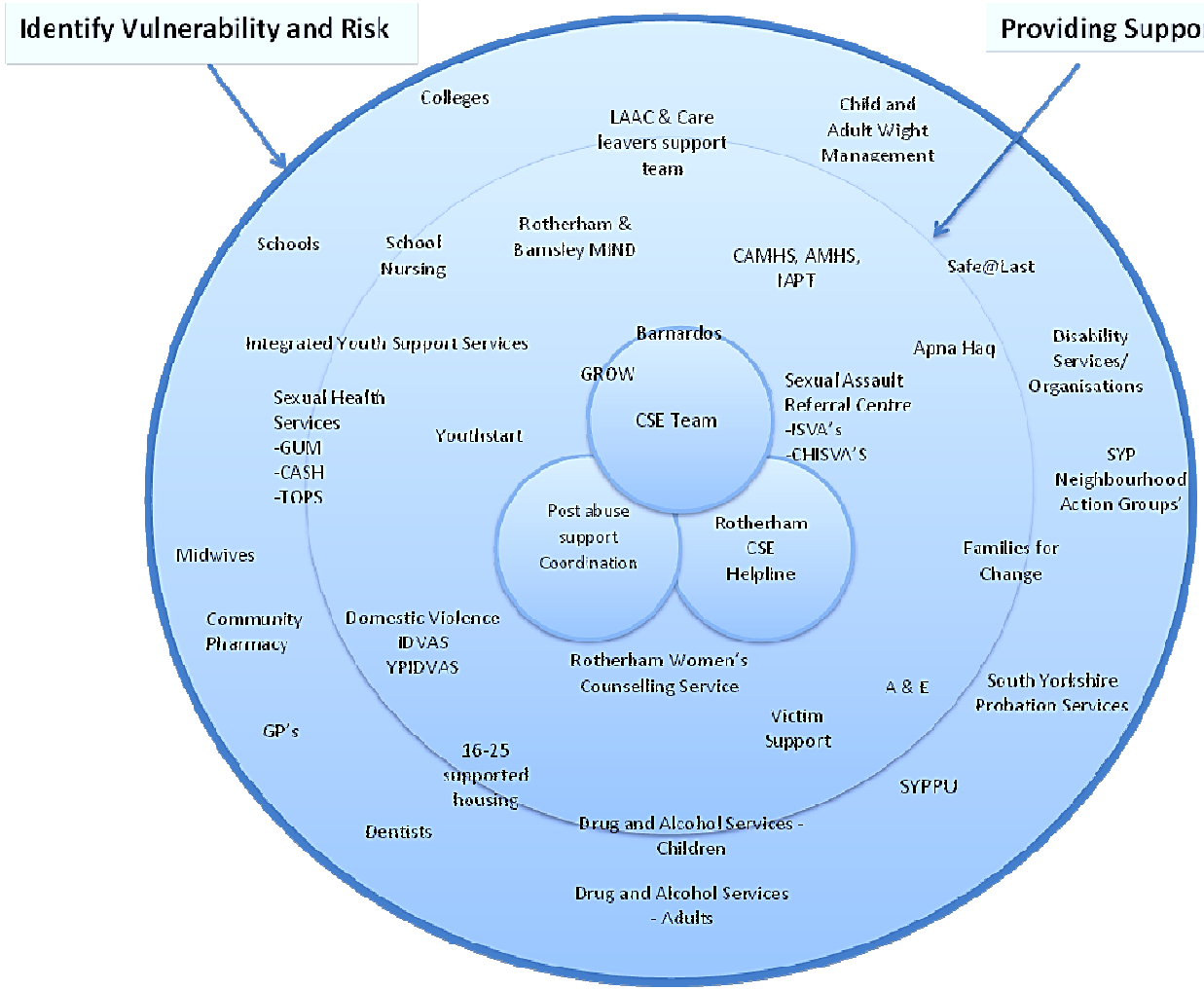
Breakdown of SEN primary needs for those pupils from the CSE cohort who are in receipt of SEN provision, compared to the Rotherham average



The association of risk/experience of CSE with absence from school and missing from education is demonstrated by the chart below; the CSE cohort is three times more likely to be known to either or both the CME and EWS teams.

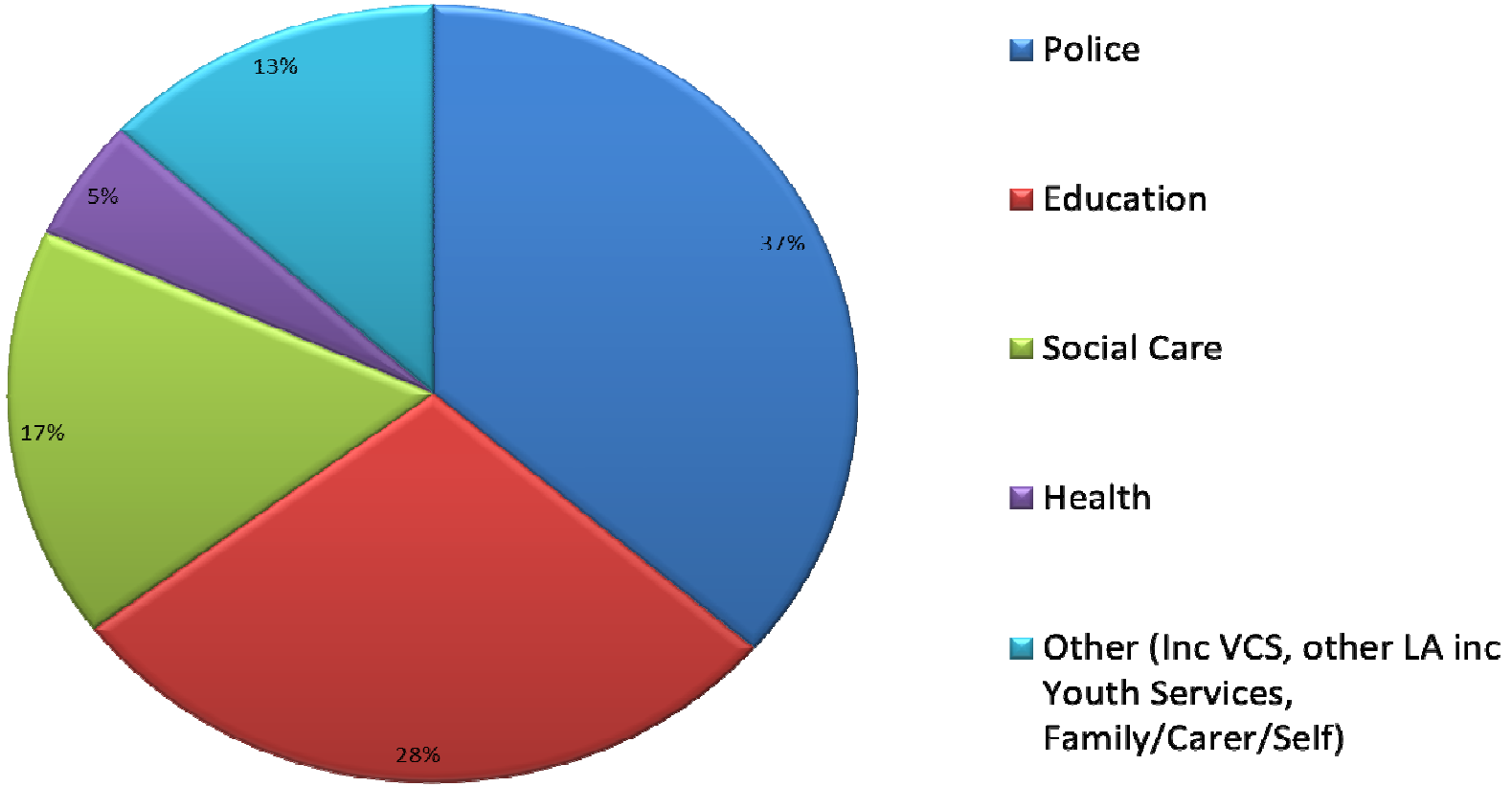


Which services are well placed to identify vulnerability and risk of CSE and which services are offering support to victims and survivors of CSE?



Where do referrals into the CSE team come from?

There is potential to further strengthen the contribution of health services eg GPs, A&E, Sexual Health Services, Drugs and Alcohol, School Nursing to the early identification of those at risk.



Are all services/agencies doing all they can to identify risk factors for CSE and enable early intervention to reduce risk?

- Currently education and police sectors provide the main 'early warning system' for CSE

- Total social care referrals from sexual health, young people's drugs and alcohol and school nursing services in last 12 months:

  - sexual health services 3; Know the Score 1; school nursing 6

- Services report that a high proportion of those they identify as at risk are already known to social care, Sexual Assault Referral Centre and/or police.

- CQC inspection (Feb 15) reported significantly more robust risk assessments taking place in Genito Urinary Medicine clinics than in Contraceptive and Sexual Health Services (both now part of a single Integrated Sexual Health Service).

- IT system to flag concerns and action across integrated sexual health services and drugs and alcohol services currently being improved.

- There is potential to further strengthen the contribution of health services (eg GPs, A&E, sexual health, drugs and alcohol, school nursing services) to the early identification of those at risk.

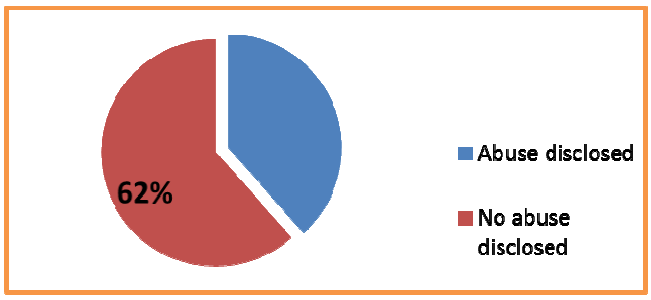
Where are the victims/survivors of CSE receiving support?

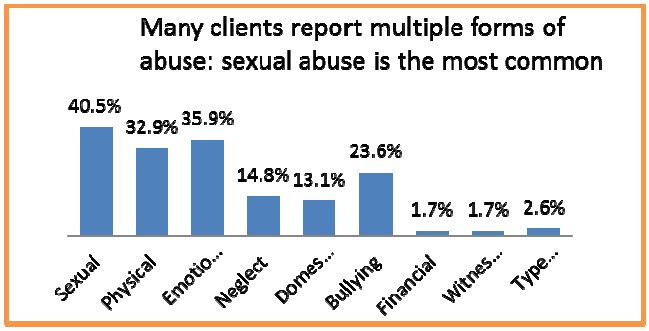
Service	Commissioner(s)	Activity 12 months period unless specified				Service Offer Detail
		<16 yrs.	16/17 yrs.	18-24 yrs.	25 yrs. and over	
GROW	SRP/PCC; RMBC	10 (8 Families)	13	14		Embedded in CSE team; Intensive care support: practical, emotional , advocacy; family support ; groupwork
Barnardos	Barnardos	20	10			Embedded in CSE team; Intensive care support: practical, emotional , advocacy; 3% male; 10% BME; 26% current CP Plan
Rotherham Women's Counselling Service	PCC; MoJ; Lottery; RDASH; CRT; RMBC; RCCG			146 (18 yrs. and over)		Specialist sexual abuse/violence counselling; 25% referral from NHS; 14% male; 8% BME; 50% approx sexual abuse in childhood
Rotherham Women's Refuge (3 months data)	RMBC	10		10		Outreach; practical, emotional, individual and family support; 10% male; 5% BME
Sexual Assault Referral Centre	NHS E; PCC	14	Approx. 198 (16 yrs. and over)			Sexual Assault forensic service; independent advocacy
Parliamentary Office of Sarah Champion MP (Sept 14- March 15)			19	38	57	Practical emotional support & advocacy with victims/survivors/family members; 17% male; 76% white
IYSS: Youth Start	RMBC	23	18	15		Outreach; practical , emotional support, advocacy, counselling; abuse disclosed on 5% of total caseload; 16% male; 16% BME; 25% referrals from NHS
Domestic Abuse Service IDVAs	RMBC; PCC		<5	<5		practical, emotional support and independent advocacy; 100% female white; CSE disclosed in 1% total caseload
RMBC Vulnerable Person's Unit	RMBC			9	5	Case assessment and signposting to services; CSE disclosed in 28% total caseload; 7% male ; 21% BME
CAMHS/AMHA	CCG (RMBC)	19		14		Treatment mental disorder; numbers refer to disclosed CSE reported/recorded
Adult and Young People's Substance Misuse Services, RDASH: Know the Score	RMBC	9				Treatment of young people's substance misuse; confirmed CSE cases; 27% state sexual exploitation compared with 5% nationally
Family Nurse Partnership	NHS E; RMBC	30 (<19 yrs.)				Intensive home visiting family support; numbers refer to those disclosing history of sexual abuse

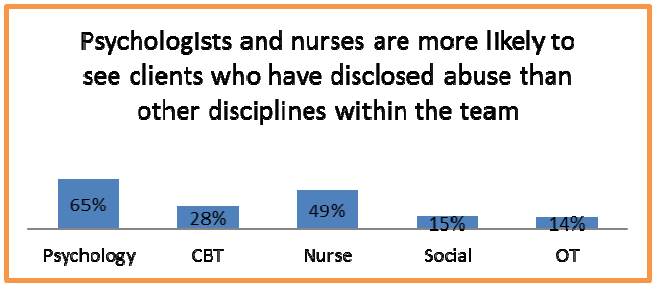
Under reporting and/or recording of CSE

- Evidence suggests, and practitioners in domestic violence, mental health and drug services also expressed the view that, a significant proportion of their clients are likely to have experience of sexual abuse/exploitation in childhood but that:
  - client does not disclose/is not asked
  - disclosure is inconsistently and variously recorded/coded;
  - numbers disclosing sexual abuse/exploitation not easily retrievable from electronic record
- Sexual abuse and, particularly exploitation, is likely to be significantly under-reported within these services
- Many victims/survivors are not being supported to access effective trauma focused support and therapeutic interventions

Learning from Rotherham Community Therapies audit







In response to the Jay Report, Rotherham Community Therapies Team (part of adult mental health services) conducted an audit into the prevalence of all forms of abuse, to highlight any potential cases of CSE and to help inform service development. The data used within this audit comprises of 617 patients, 41% being male and 59% female, who are currently on a waiting list for therapy, undergoing therapy or attending a group. A questionnaire was handed to all staff- capturing the information presented in the charts. The remaining data was systematically collected through the Silverlink Mental Health System, analysing full needs assessments to aid the completion of the questionnaire.

Of the 617 patients within the team, 38% (237) disclosed that at some point in their life they have suffered some form of abuse. However, since over half of patients within this audit were awaiting an initial assessment where abuse is routinely enquired about, this is likely to be a conservative estimate.

A conservative estimate of 8 cases of CSE were identified through this audit.

Learning from CSE psychotherapist role in CAMHS/AMHS Oct 14 to date

- The challenge of CSE for mental health services is an emerging picture of clinical complexity rather than insurmountable numbers; only a proportion of victims/survivors will access/need the support of mental health services.

- The number of cases currently identified with experience/disclosure of CSE in Child and Adolescent Mental Health Services (CAMHS) Improving Access to Psychological Therapies (IAPT) and Adult Mental Health Services (AMHS - see previous slide) is low, but growing with the understanding of CSE within the service.

- The Psychotherapist role has developed to provide:
  - Staff group consultation to AMHS Psychiatric Intensive Care Unit, Intensive Community Therapies and Community Therapies and to CAMHS

  - Specialist assessment and wrap around consultation/co-working on case by case basis.

  - Time limited individual psychodynamic psychotherapy for limited number of cases.

- There is potential for further development of consultation services for mental health staff groups and externally to the wider care/therapeutic community based upon the successful model for consultancy and support for supervision and reflective practice established in Family Nurse Partnership.

Providing support to survivors

As the numbers of CSE victims currently receiving mental health services is reported to be low work needs to be carried out “upstream” i.e. to PREVENT victims in the first place. This can be done through the tightening of licencing permits of taxi drivers and takeaways. School PSHE should address CSE, sexual health, drug and alcohol, healthy relationships and mental wellbeing messages using creative means such as theatre in education.

Casey praised the outreach work carried out by Integrated Youth Support Services (IYSS) and the police and such models should be built on and developed with services reaching out into schools, youth clubs and areas where children and young

people meet. Outreach workers can act as advocates for victims and potential victims and sign post them to appropriate services be they health services for Sexually Transmitted Infections, housing or benefits advice, or a safe place to stay such as the women's refuge. Support should be given to victims going through the court process and provide a gateway into a survivor framework.

Survivor support groups may be offered but thought must be given to how this is delivered without inadvertently putting people at risk ie perpetrators waiting outside an identified venue. Specialist mental health services should be offered by staff who have received some training in CSE.
(Clinical) supervision should be available to all staff working with CSE either in groups or individually.

"Its just like society innit? Like women don't get that much respect in society like a guy. Its just always that guys have the upper power.. Its just how society is, men naturally get more respect… men are just dominating it …A lot of people from other areas, like more classier areas than round here say, 'Oh the girls don't have no respect for themselves' blah blah, but that's just how girls get treated in the workplace. That's how girls get treated on the streets."
Beckett et al (2013) p24

What do victims, survivors & families affected by CSE say they want & need?

- Support on their own terms; non-judgemental; to be believed; opportunities for social support, open access, including evenings, drop in sessions, with childcare; group work, expressive activities (e.g. art therapy, poetry), and access to services e.g. benefits advice, employment skills, sexual health, counselling.

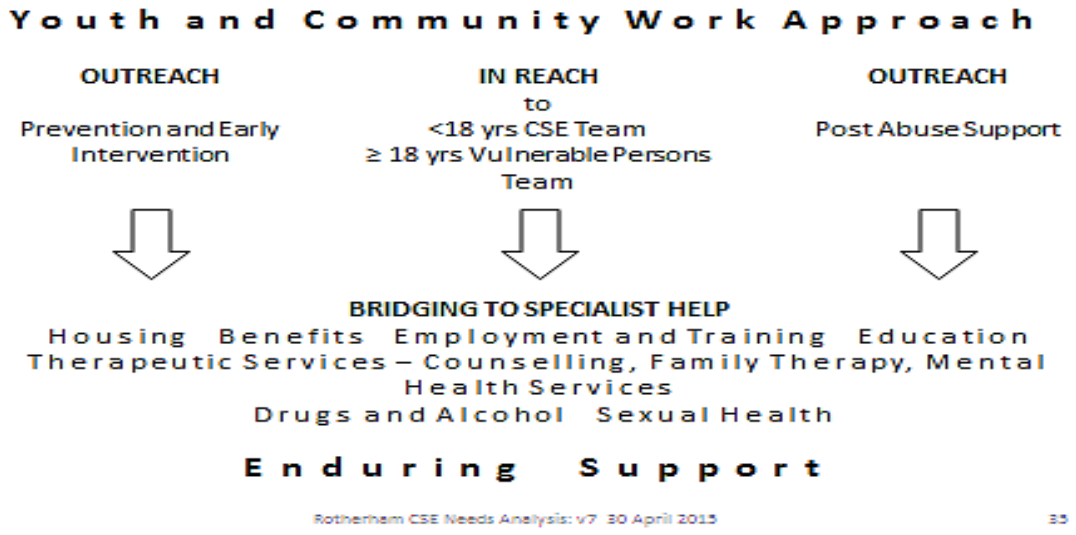
- Black & minority ethnic women's voices: victims/survivors may need considerable time to tell their story in a way that feels suitable to them; outreach work with trusted individuals within the community; many older women have experienced CSE; sexual abuse is a taboo subject and very 'hidden' in BME households & perpetrators use this to their advantage; important to recognise the impact on the wider family/community; CSE has destroyed community relations; shame and fear of retribution from families/communities act as barriers to disclosure; CSE victims may be beaten, forced into marriage, taken abroad; victims don't know who to tell & may not recognise they have been abused; awareness raising needed e.g. on process of grooming in schools, youth and community groups; targeted work needed eg with Asian young men, faith leaders, young Asian mothers; need to

publicise positive work; learn from best practice elsewhere; recognise the roots of violence against women and girls in racism and gender and class inequality; culture used as an excuse, but no culture 'allows' abuse or exploitation.

- Roma community: CSE community awareness raising presentation in Czech and English should be made available in schools; people fear retribution if they report concerns to the authorities; some parents turn a blind eye/do not challenge, may be pleased to receive gifts; more police action needed; why is this happening? Will/how can my identity be protected if I report something? Could police send children home after a certain hour?; what more can parents do? Questions to be explored at subsequent focus group session.

- Outreach and research work to listen to voices of diverse communities within Rotherham on CSE and service/actions needed, with particular focus upon young people & families, and on Roma and Pakistani communities, has been commissioned from University of Salford, working with local groups, Clifton Learning Partnership, Rotherham Women's Refuge, Apna Haq and Swinton Lock. A report with recommendations for action will be produced by 30 June 2015.

Towards a model for early intervention, risk management and post abuse support.



What service capacity is required to meet the support needs of historic victims/survivors of CSE?

Modelled age range of historic victims:
2015/16 20% u-18s ; 45% 18-24 yrs; 35% 25 yrs and over
2019/20: 47% u-18s; 30% 18-24 yrs; 23% 25 yrs and over

Modelled numbers needing support 2015-2020

Assumptions: legacy of 1600 requiring support of which 30% have accessed/do not seek/do not need further support; the remaining 30%, 20%, 10%, 5% and 5% seek help over the next 5 years

Year	Legacy	100 new cases 15/16	100 new cases 16/17	75 new cases 17/18	75 new cases 18/19	50 new cases 19/20	Total	Cases needing therapeutic support assuming 30% of total
2015/16	480	30					510	155
2016/17	320	20	30				370	111
2017/18	160	10	20	23			213	64
2018/19	80	5	10	15	23		133	40
2019/20	80	5	5	8	8	15	121	38

Recommendations

Prevent

- There should be greater clarity in strategic direction, leadership and governance relating to CSE (LSCB 2013 and Ofsted 2014).CSE Delivery plan (2015).
- Improve the links between CSE and other key strategies e.g. gangs, licencing, quality of PSHE (including sexual health and healthy relationships) in schools (Ofsted 2014).
- Awareness raising required in schools, youth and community groups on the process of grooming.
- Improve the mental wellbeing of children and young people (also links to the Health & wellbeing board “All children get the best start in life”)
- Improve links re transition into adulthood (Casey 2015)

Protect

- Requires routine involvement in community, school assertive outreach into hot spot areas (Barnardos 2013).
- The right multi agency and social care services are in place to meet the needs of children at risk from CSE
- Victims of CSE and their families are supported with holistic interventions that enhance the potential for a child or young person to stay safe within their family and community

Pursue

- The time and necessary resources will be committed so that perpetrators of CSE are arrested, successfully prosecuted, convicted and deterred from re offending.

Provide Support

- The physical, psychological and emotional damage caused by CSE and its victims is understood and recognised and victims and survivors have access to a wide range of support and aftercare from more specialist services, which will be clear and easy to access. This will include timely access to mental health services where required.
- Services commissioned to support victims and their families are informed by what thay want and need and are provided by specialists with the required skills, experience and leadership in the field of sexual violence.

Participation

- Obtain the views and experiences children and young people as well as their families to influence service development. This will include the views and experiences of adult survivors.

- Develop victim participation groups to gain the views of young people

The above list of recommendations is not exhaustive and may change as more local intelligence becomes available. CSE Needs Analysis is a dynamic process as we learn more about the needs victims, their families and perpetrators both locally and nationally.

This Needs Analysis will be reviewed in August 2016.

References

Academy of Medical Royal Colleges (2014) *Child sexual exploitation: Improving recognition and response in health settings* AMRC, London.

Ashley S (2013*) A review of the response to child sexual exploitation in Rotherham* Rotherham Local Safeguarding Children Board (Unpublished)

Barnardos (2011) *Puppet on a string: The urgent need to cut children free from sexual exploitation* Barnardos, London.

Barnardos (2013) *Rotherham Practice Review Report* (Unpublished)

Barnardos (2014) *Hidden in plain sight: a scoping study into sexual exploitation of boys and young men in the UK* Policy briefing August 2014, Barnardos, London.

Beckett H with Brodie I, Factor F, Melrose M, Pearce J, Pitts J, Shuker L and Warrington C (2013) '*It's wrong … but you get used to it' A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England* University of Bedfordshire, Luton/Office of the Children's Commissioner, London

Berelowitz, S, Firmin C, Edwards, G and Gulyurtlu S (2012) *I thought I was the only one. The only one in the world* Office of the Children's Commissioner Inquiry into Child Sexual Exploitation in Gangs and Groups. Interim Report.

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

Brodie I & Pearce J (2012) *Exploring the scale and nature of child sexual exploitation in Scotland* Scottish Government Social Research.

Casey L (2015) *Report of Inspection of Rotherham Metropolitan Borough Council* DCLG, London.

CEOP (2011) *Out of Mind, Out of Sight* CEOP Thematic Assessment, CEOP, London

Childline (2012) *Caught in a trap: the impact of grooming in 2012* NSPCC, London

Coffey A (2014) *Real Voices: Child Sexual Exploitation in Greater Manchester* Office of the Police and Crime Commissioner, Greater Manchester

DH (2014) *Health working Group Report on Child Sexual Exploitation* DH, London.

DH (2014) *Asking the question about violence and abuse in adult mental health assessments online training* DH, London

Gohir S (2013) *Unheard Voices: The Sexual Exploitation of Asian Girls and Young Women* Muslim Women's Network UK, Birmingham.

Jago S with Arocha L, Brodie I, Melrose M, Bernie J, Warrington C *what's going on to safeguard children and young people from sexual exploitation* University of Bedfordshire, Bedford

Jay A (2014*) Independent Inquiry into Child Sexual Exploitation in Rotherham* 1997-2013.

Kirtley P (2013) '*If you shine a light you will probably find it' Report of a grass roots survey of health professionals with regard to their experiences in dealing with child sexual exploitation* NWG Derby.

DH (2014) *Health Working Group Report on Child Sexual Exploitation* DH, London.

Office of the Children's Commissioner (2015) *"If it's not better, it's not the end" – Inquiry into Child Sexual Exploitation in Gangs and Groups: One year on.* London: Office of the Children's Commissioner.

Ofsted (2014) *The sexual exploitation of children: it couldn't happen here, could it?* Ofsted, London.

Macdonald G, Higgins JPT, Ramchandani P, Valentine JC, Bronger LP, Klein P, O'Daniel R, Pickering M, Rademaker B, Richardson G, Taylor M (2012) *Cognitive-behavioural interventions for children who have been sexually abused* Conchrane Database of Systematic Reviews Issue 5.

Parker B & Turner W (2013) *Psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused* Cochrane Database of Systematic Reviews Issue 7

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

RMBC (2014) *Children and Young People's Lifestyle Survey 2014*

Smeaton E (2013) *Running from hate to what you think is love: the relationship between running away and child sexual exploitation* Barnardos, London.

Stevens M (2010) *Report to Rotherham Local Safeguarding Children Board: Lessons learned review – Operation Central* JusticeCare Solutions (Confidential)

Contributors to the analysis.

Many thanks to the following people for their help in compiling this analysis:

Dr Sue Grieg , Locum Consultant in Public Health, RMBC
Jo Abbott, Acting Director of Public Health, RMBC
Ruth Fletcher-Brown, Public Health RMBC
Paul Theaker, Operational Commissioner RMBC
Jayne Parfrement, Director, Safeguarding Children and Families RMBC
Jo Smith, CSE Coordinator
Gill Haggie, Rotherham Women's Counselling Service
Paul Boyden, Youth Start
Jayne Senior, Senior Parliamentary Advisor to Sarah Champion (MP) Rotherham
Steven Gauntley, Social Care Consultant RMBC
Janet Wheatley, Voluntary Action Rotherham
Tracey McErlain-Burns, TRFT
Miles Crompton, RMBC
Marcus Williamson, Public Health RMBC
Deborah .Johnson, Performance & Improvement Officer RMBC
Kay Piearcey, South Yorkshire Police
Robin Carlisle, Deputy Chief Officer CCG
Sam Newton, Service Manager safeguarding Adults RMBC
Jan Bean, Safeguarding Adults and Domestic Abuse Manager RMBC
Katherine Wallis, South Yorkshire Police
Paul Grimwood, Manager (Youth Justice)
Sarah Mainwaring, South Yorkshire Police
Christine Brodhurst-Brown, Head of Children & Young People's Services RMBC
Bina Palmer NWG Network – Tackling Child Sexual Exploitation,
Sue Cassin, Chief Nurse CCG
Sue Barrett, GROW
Dr Helen Beckett, Deputy Director, the International Centre: Researching Child Sexual Exploitation, Violence and Trafficking, University of Bedfordshire
Zlakha Ahmed, Apna Haq
Janine Cherry-Swaine, Community Therapy RDASH