

The Use of Tools and Checklists to Assess the Risk of Child Sexual Exploitation: Lessons From UK Practice

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Abstract

Tools to assess the risk of becoming a victim of child sexual exploitation (CSE) have been developed by UK CSE practitioners based on their professional experiences, with little evidence underpinning their development, and no evaluation/validation. Little is known about how they are used in practice. This paper summarises two studies. The first study consisted of a rapid review to identify factors associated with increased, or decreased risk of vulnerability to becoming a victim of CSE and the assessment of ten tools being used in the UK. The second study undertook interviews and on-line survey with professionals across multi-agencies to establish the use of tools. Results illustrate the context and processes in which the tools are being used and identify concerns regarding their ability to identify and protect children.

Keywords: Children, Child sexual exploitation, Screening tools, Vulnerability, Sexual Abuse, Risk Assessment, Child Protection, Young people

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The Use of Tools and Checklists to Assess the Risk of Child Sexual Exploitation: Lessons From UK Practice

In the UK, significant attention has been directed towards child sexual exploitation (CSE) in the last decade although this is not a new “issue”. High profile national scandals, which identified the failures of child protection services to protect thousands of children and young people who were victims of CSE, have been the focus of media attention prompting significant public and political outcry, and debate. Independent inquiries and service inspection reports undertaken by national governmental bodies have raised concerns about professionals’ awareness and understanding of CSE and highlighted their misinterpretation of risk and misunderstandings of vulnerability in children and young people (Jay, 2014: Ofsted, 2014).

Child sexual exploitation is a form of child sexual abuse (CSA); however, in the UK prior to 2009, sexually exploited children were not recognised as victims of abuse, but rather deemed to be involved in prostitution (Department of Health, 2000). Following lobbying and advocating by survivors and voluntary sector, non governmental organisations, children and young people involved in the “exchange” of sex were recognised as victims with a subsequent reframing of policy, guidance and legislation to recognise the coercive and controlling nature of CSE.

Although there is not a globally recognised definition of CSE or indeed one definition across the four nations of the UK, English Government guidance defines CSE as:

a form of child sexual abuse. It occurs when 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

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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, p. 5).

The complexity of defining and delineating CSE within wider definitions of CSA creates difficulties in being able to measure the scale and changing nature of CSE in the UK, and as yet there are no general population prevalence studies on CSE (Kelly & Karsna, 2017). Multiple interpretations and conflating contexts and circumstances have led to inconsistent data collection and conceptual challenges. Figures collected from local authorities in England indicate that in 2015/16, approximately 17,600 children were identified at risk of sexual exploitation (Kelly & Karsna, 2017). This figure is similar to other estimates (see for example, Berelowitz, Firmin, Edwards and Gulyurtlu, 2012; Association of Directors of Children's Services, 2016). Although caution must be adopted given the difficulties with definition, recording and identification and the overlap between different forms and models and the way in which abuse and/or exploitation is categorised.

In the UK it is important to note the historical and political context of CSE as this has influenced and framed current practice development. The nature of the high-profile cases that have involved, in the main, large gangs of male perpetrators targeting vulnerable girls, has led to CSE being predominantly synonymised with "grooming and pimping". Subsequently, the identification of risk in children and young people to being groomed by adult male gangs has dominated practice (Melrose, 2012). Such a narrow focus has to some extent persisted despite increasing evidence which recognises that CSE is vastly complex, manifests in multiple ways and through multiple mechanisms, and cannot be separated from wider societal

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factors (Appleton, 2014). As Hallett argued (2016), CSE statistics highlight the vulnerability of young people in the state care system, yet attention has often been placed on this as a risk factor for these young people, rather than placing attention on how the care system might exacerbate the problem of CSE. Similarly, others have argued that the responses developed to identify and protect children from sexual exploitation have led to the stereotyping of vulnerability in which the children and young people have often been viewed as *a* risk rather than *at* risk (Jago, Arocha, Brodie, Melrose, Pearce, & Warrington, 2011). The focus on identifying the “risky child” rather than those most at risk has also meant that attention has been diverted from child populations that are “hidden” (Fox, 2016). For example, despite figures suggesting that disabled children are three to four times more at risk of violence, including sexual violence, little focus has been placed on the sexual exploitation of this group (Franklin & Smeaton, 2017).

English government guidance recognises the complexity and challenge for those working with children to identify risk factors for CSE. In response, a plethora of tools and checklists have been developed and are used widely across the UK to help identify risk of CSE. These tools have largely been developed by CSE practitioners based on their practitioner experiences and, although well-intentioned, the evidence on which these tools are based is questionable. Equally concerning is that they have not been evaluated and/or validated and are being used outside of well-established social work assessment processes. Little is known about how they are being used in practice to identify and/or assess potential victims of CSE and the outcomes they determine for vulnerable children. To address this gap in understanding, the UK Home Office funded two studies to explore the use of tools and checklists to assess risk of CSE.

The objectives of the first study, which was commissioned via the Early Intervention Foundation (EIF), were to establish what was known about indicators that suggest a child

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under the age of 18 is at heightened or reduced risk of becoming a victim of CSA or CSE in its various forms; and based on these findings, the suitability of assessment tools and checklists to identify future potential victims of CSE. Overall the aim was to help support early intervention and better protect children and young people.

Following publication of the first study, the newly established Centre of Expertise on Child Sexual Abuse (CECSA, for more information, see <https://www.csacentre.org.uk>), funded by the Home Office, commissioned a second study with the specific aims to: determine the circumstances in which the tools are used; understand how children/situations are identified that require assessment; investigate how different professional teams use the tools and how these teams work together to draw conclusions; see how practice varies between locations and with the use of different tools/checklists; and understand the strengths and limitations of shared multi-agency risk assessment tools. The overall aim was to make recommendations for the development of tools, checklists and practice in this area of work with children and young people. This paper presents the key findings across these two studies.

Method: Rapid Evidence Assessment

We conducted a rapid evidence assessment to identify what is known about the indicators that suggest a child under the age of 18 is at heightened or reduced risk of becoming a victim of CSA or CSE in its various forms. The following online databases were searched in October and November 2015: National Institute for Health and Care Excellence (NICE), Cochrane Systematic Review, Applied Social Science Index and Abstracts (ASSIA), PsychINFO, Social Sciences Citation Index, and Google Scholar. We also searched the grey literature via the charities of government and third sector organisations in the UK, such as the Home Office, Barnardo's, NSPCC, Office of the Children's Commissioner, BASPCAN. The search terms used to identify indicators of heightened risk are listed in Table 1 and

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indicators of reduced risk in Table 2. The reference lists of the papers that were retrieved were also searched.

TABLES 1 AND 2 ABOUT HERE

We included original empirical studies with samples from the UK, Europe, North America or Australasia to ensure similarity to UK contexts, systems and environments; and reviews, meta-analyses and meta-syntheses in which factors meeting the criteria had been examined. Studies published in English since January 1, 2000 and obtainable within two weeks of being identified were selected. We excluded studies in which the focus was solely on intra-familial CSA/E, as per the terms of the commissioners/funders and studies that exclusively included factors that could not be identified in individuals under the age of 18.

The risk indicators search revealed 18,327 items that were screened using the titles and abstracts. This led to 53 papers being retrieved and reviewed, 34 of these were excluded and 19 papers included in the review. The protective indicators search revealed 20,739 items that were screened using the titles and abstracts. Thirty-seven papers were retrieved and reviewed with 33 being excluded and 4 included in the review. See [Anonymous for Review] for a full list of the excluded and included items and a summary of each of the included studies.

Findings: Rapid Evidence Assessment

We found no studies in which indicators of reduced risk of becoming a victim of CSA/E had been examined. Many studies have been conducted to examine post-abuse resilience and we can theorise that the absence of the risk indicators outlined below indicate reduced risk of victimisation; however, currently, we are not able to identify any variables that specifically and/or independently indicate reduced risk or protective factors.

In relation to indicators of increased risk, we found a lack of methodological rigour with many studies that were small-scale and qualitative in nature and/or examining factors

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only in groups of victims, i.e., they lacked suitable control or comparison groups.

Consequently, only three studies were identified with methodological designs that allow us to be confident that the variables are associated with increased risk, which revealed two risk indicators: children with disabilities and residential care.

Children with Disabilities

Two studies demonstrated that disability is a risk indicator for sexual violence/abuse. In a systematic review and meta-analysis of research published between 1990 and 2010 examining the prevalence and risk of violence including sexual violence, Jones et al. (2012) concluded that children with disabilities in all settings are a high-risk group, with children with intellectual or mental disabilities having a higher risk than children with other disabilities such as a physical disability. Roberts, Koenan, Lyall, Robinson, and Weisskopf (2015) found associations between adult autistic traits and lifetime experience of abuse, trauma and Post Traumatic Stress Disorder in a retrospective study of the link between Autism Spectrum Disorder and experiences of abuse in a sample of 1,247 mothers. Women with the highest levels of autistic traits had one to five times the prevalence rates of sexual abuse, compared to women with the lowest levels of autistic traits, but Roberts and colleagues noted that even subtle difficulties in information processing in children may increase risk. This can be explained by Franklin, Raws, and Smeaton (2015) who also highlighted the ways in which some impairments, such as limited understanding of social cues and social interaction, can make some young people more at risk of exploitation. Social isolation can also potentially make disabled young people more vulnerable to grooming and exploitation.

Residential Care

Euser, Alink, Tharner, van Ijzendoorn, and Bakermans-Kranenburg (2013) examined the prevalence of CSA in residential and foster care in the Netherlands and found higher

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prevalence rates of sexual abuse in residential care compared to foster care and the general population. The reason for this is difficult to establish as residential care is characterised by a flow of children and care givers and large groups of peers, including children with behavioural and/or attachment issues and experiences of maltreatment. Consequently, children in residential care may differ and be more vulnerable to abuse compared to children in foster care or the general population, or the increased risk could be caused by the characteristics of residential care arrangements (Euser, et al., 2013).

Two qualitative studies conducted in the UK help to explain why residential care is associated with an increased risk of sexual victimisation. The experiences of 14 women of living in state care were examined by Coy (2009). The women interviewed by Coy reported multiple placement moves that were destabilising and limited their capacities to develop trusting relationships. This made them vulnerable to coercive pressure and exploitation. Numerous incidents of peer sexual abuse were identified by Green and Masson (2002), who examined residential care in two local authorities. They noted that such behaviour was normalised and accepted by children. Many of the young women had been previously sexually abused and were unable to either resist unwanted sexual advances, or emotionally juxtaposed sexuality and love and were unable to differentiate between the two. Several overtly or covertly exchanged sex for money, drugs or cigarettes. Many young men (some of whom had been previously sexually abused), saw sex as a form of physical conquest and a means of gaining power over their peers. These studies indicate that the histories of the children and the features and cultures of residential settings combine to increase risk of victimisation of sexual violence.

Potential Indicators

The remainder of the studies included in the review did not have methodological designs that enabled us to be confident that the indicators discussed were related to increased

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risk of CSE or CSA. For example, many examined case files or interviews with victims and survivors and did not compare these to individuals who had not been abused or exploited, so we could not identify whether the indicators were more frequent in the CSE/A populations compared to other groups. That is not to say that these might not be indicators of risk, rather that the research evidence is currently unable to demonstrate this. Hence, the indicators that were frequently identified in these studies were discussed as *potential* indicators of increased risk of CSE. However, it is important to recognise that no young person is immune from CSE and many victims do not have factors that have been typically identified as vulnerabilities.

Alcohol and drug abuse, involvement with gangs and groups, young age of first sexual experience, going “missing”, running away and escaping from abuse or family difficulties were frequently associated with risk of CSE. Although these factors were frequently present in the histories and experiences of CSE victims, the relationship to increasing *risk* of CSE was difficult to determine. For example, although alcohol/substance misuse was identified as a factor in many CSE cases (Davies & Jones, 2013; Klatt, Cavner, & Egan, 2014), it was rarely specified whether drinking alcohol or abusing drugs was part of a child’s behaviour prior to becoming a victim that increased the risk of victimisation, whether it was used as self-medication following abuse/exploitation, or was supplied by perpetrators in order to abuse or exploit the children. Similarly, although being missing (running away) is frequently associated with risk of CSE (e.g., Klatt et al., 2014), this could be an indicator of abuse and exploitation rather than something prior that increases risk. More research is needed to develop a clearer understanding of the link between these indicators and the pathways that lead to CSE and CSA.

We also examined the limited research into social media and online communication and what we called “prosocial” activities. These studies showed that there was a complex interplay between a range of factors. For example, in a qualitative study of 14 athletes, Cense

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and Brackenridge (2001) found that some young people engaging in sporting activities may be more vulnerable than others. Those with few friends, poor relationships with their parents or negative home experiences, in isolated positions on teams (such as being an outstanding performer) or socially isolated were more vulnerable than their peers. Whittle, Hamilton-Giachristis Beech and Collings (2013) reported that children who show vulnerabilities offline may also show vulnerabilities online, but that children who did not have vulnerabilities in one or other of these environments might have vulnerabilities in the other. They concluded, therefore, that the aim of research into children's use of the internet should not be to categorise or profile potential victims, but to note influencing vulnerabilities and risk factors should be explored.

The media coverage of high profile cases has drawn attention to specific types of abuse and exploitation that had previously been overlooked in the UK. More recent coverage has shone a light on abuse within sporting contexts; however, given the hidden notion of this crime, there could be many other types of abuse and exploitation, and/or many other victims that have not been identified. This means that there may be many other factors associated with increased risk of CSA/CSE that we have not yet considered and/or researched. For example, some types of variables have rarely been examined in relation to CSE, since most of the variables that have been considered related to the victims and some aspects of their families. Broader issues such as poverty and features of the environments in which the victims live have not been considered; neither has the interplay between potential victims and potential offenders. Hence, there is still a great deal that we do not understand about the factors that increase or decrease risk of CSE victimisation, which makes it difficult to develop evidence-based tools to identify individuals who may be most at risk. Nevertheless, many tools have been developed and are used in the UK, which were the focus of the second part of our first study and our follow-up study exploring professionals' experiences and

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perceptions of the tools. These are discussed together below, since many of the findings overlap and the aims were to assess the tools, given the evidence-base, and explore how they were used in practice in England and Wales.

Method: Review of Tools and Checklists

In our first study [Anonymous for Review] ten tools or checklists, which are listed in Table 3, were identified by the EIF and the steering group in November 2015. These tools were assessed by identifying the risk indicators that were included in each tool and comparing these with the risk and potential indicators identified in the rapid evidence assessment. The methods of reaching decisions (e.g., scoring) and the evidence/research that was used to develop the study were also compiled and reviewed. In the second study (see below), participants were asked to send us copies of the tools and checklists that they used. We received 12 and since the aim of this study was not to review the tools in detail again, we used these to understand what the participants were telling us and to illustrate key points. In many instances, the issues that we identified in the first study, were present in many of the tools that we received in the second study.

TABLE 3 ABOUT HERE

Professionals' Experiences and Perceptions of Tools and Checklists

Design

A qualitative design was employed to canvas the perspectives and experiences of professionals across England and Wales in March/April 2017.

Participants

Forty-two professionals completed the survey from a wide range of areas including social care ($n = 17$), voluntary organisations ($n = 11$), police ($n = 9$), health care ($n = 8$), youth justice/service ($n = 1$), child and adolescent mental health service ($n = 1$), education ($n = 1$) and residential care ($n = 1$). For most of the sample ($n = 35$) their primary role related to

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child protection and safeguarding. For those who responded that this was not their primary role ($n = 6$), they stated their roles included: Child risk assessment and vulnerabilities intervention; managing a team of social work professionals; lead consultant in department for safeguarding; passing on concerns/assessing risks; training safeguarding professionals; both safeguarding and investigating crime; and previous role was working directly with children at risk of CSE or those being subjected to CSE.

Seventeen professionals were interviewed. These were a CSE coordinator and CSE service manager (interviewed together at their request), a Chief Executive Officer and manager of a missing service (interviewed together), a Head of PSHE (secondary school) and a special school teacher (interviewed together), a youth justice team leader, a police officer CSE representative, a CSE service manager, a missing service manager, a Local Safeguarding Children Board Chair, a local authority strategic lead CSE, a CSE worker in the voluntary sector, a social worker, a CSE worker, a CSE trainer and a designated nurse.

Measures

The online survey and interview schedule were developed by the authors based on the findings from the previous study and in consultation with staff in the CECSA. The draft survey and schedule were reviewed by the National Working Group (a charitable UK network of over 14,000 practitioners involved in child protection) and the Director of Research for the CECSA. The survey was piloted with a small number of professionals (a voluntary organisation CSE service manager, a CSE Police lead, and a social worker with voluntary sector experience).

The survey used a combination of fixed-choice questions and open response questions, exploring the tool(s) used by each respondent, the use of the tools in practice (e.g., who completes them, what type of information is used, what types of decisions are made using them), any challenges and difficulties in using the tools, and the respondents' views

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about the value and use of the tools. A semi-structured approach was used to explore questions addressing similar areas as the survey but allowing for a more detailed, in depth discussion.

Procedure

Ethical approval for the study was granted by [Anonymous for Review] University. Permission was provided to promote the online survey through Barnardo's and the National Working Group on CSE (NWG). The survey was hosted on Bristol Online Surveys and was available for 20 days in March 2017. It was advertised within the NWG's newsletter emailed to all members and social media, Barnardo's via an email to its Service Managers, and via emails to networks of contacts by CSE regional crime unit leads. It was also shared via social media. Full information was provided about the purpose of the study and what taking part involved.

Due to the short timescale of the project, the networks of the authors, their colleagues and the CECSA approached professionals to be interviewed for the study. Requests were sent by email and some people were asked in person. Full information about the aims and purpose of the study were provided. Interviews were conducted face-to-face or by telephone and took between 27 and 80 minutes and were digitally recorded. Most participants were interviewed alone by one of the authors and three interviews were conducted with two professionals and one of the authors. Interviews were transcribed verbatim by professional transcribers. Five transcripts were reviewed and quality assured. Since these transcripts were accurate, no further transcripts were reviewed. Care was taken to ensure that transcripts maintained the anonymity of individuals and cases.

The fixed-choice responses of the survey were analysed descriptively. The open-ended responses of the survey and the interview transcripts were analysed in combination using thematic analysis.

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Findings: Use of Tools and Checklists

Tools for screening and assessment of sexual exploitation are used in common practice in England and Wales. The majority of survey participants regarded screening and assessment tools as useful and valuable; for example, as they focused workers' minds and support staff on problems/concerns and helped them map out risk and level of risk so they could plan how to reduce risk, guided decision making, interviews and professional thinking and were useful to let children and families see the concerns that were highlighted. Despite recognised limitations (as discussed in more detail below), the majority of survey participants ($n = 38$) reported that tools and checklists should continue to be used for CSE safeguarding as they inform practitioners' decision making, support the collection of information and help with assessing risk of sexual exploitation of young people. Participants also gave a wide range of responses in terms of how they would like to see them used in future. For example, suggestions were made for developing a standardised tool to be used across the country with all agencies; a tool which could be used with confidence and a good understanding of CSE; used to make referrals and to be able to monitor a child's progress and assess whether risks were reducing. Thus, there was general support, in principle, for the use of tools and checklists.

Large Number of Tools Being Used

There are a very wide range of tools in use across England and one used consistently in Wales (known as the Sexual Exploitation Risk Assessment Framework, SERAF, developed from Clutton & Coles (2007) study). Some tools were developed locally, others nationally and many have been adapted to meet local need. The 42 professionals who responded to the survey identified at least 19 tools used in their practice, with potentially up to 28 being used. Since the participants were self-selecting, it is also highly likely that there are a large number of tools being used in addition to the ones that were listed in our survey.

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Most used a checklist approach listing indicators and/or warning signs and/or vulnerability factors. However, in both studies, we found that the tools and checklists varied in a number of ways including in the language used, indicators included, descriptions and categorisation of indicators, methods of scoring or reaching conclusions, the extent to which narrative information describing risk indicators was included, and in the suggested pathways for different risk levels. In addition, there was also variability in how much scope is allowed for professionals to provide narrative responses which incorporate their professional judgement and help to situate the scoring of indicators of risk within a context. The outcome of this variability is that children with similar vulnerabilities and risks are being assessed differently depending on the tool that is being used. In addition, in the majority of cases, it was not clear how the tools have been developed and most have not been evaluated or validated.

Risk Indicators

As highlighted by our rapid evidence review, it is difficult to identify the indicators that should be used, since the research evidence is so limited. However, our assessment raised a number of concerns regarding the items that were included in the tools and the variability across the tools. In our first study, 110 indicators were present in the 10 tools that we reviewed (see [Anonymous for Review](#)] for a full list of the indicators included across the 10 tools), although many were related and some were similar with slightly nuanced meaning given the differences in words/approaches used. Nevertheless, this represents a large number of indicators, many of which were not supported by the evidence and for which in some instances it was difficult to determine why they had been included, e.g., “chronic fatigue”. Some, such as “poor self-image/low self-esteem”, although might be relevant to CSE victims, are also likely to apply to a much larger population and so might not be useful differentiators of risk. In addition, given the lack of evidence, some of the indicators could be

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discriminatory, e.g., “ethnicity” or “sexuality”. The indicators used and the poor link to the evidenced indicators and potential indicators raised concerns about the quality of the assessments that could be made based on the indicators. Moreover, the range of indicators across tools means that children with similar vulnerabilities would be assessed differently depending on the tool that was being used, leading to inappropriate differences in practice.

Risk or Harm

Running throughout the tools and practice was a frequent conflation of risk and harm. Many of the indicators used in tools and checklists were indicators of actual harm, rather than risk. For example, “Disclosure of serious sexual assault”, “Child under 13 involved or coerced into sexual activity”. Some of these indicated CSE or CSA, while others indicated other types of harm, “Abduction and forced imprisonment” or “Disclosure of physical assault ...”. Each of the tools reviewed in our first study included at least one indicator of harm. In one of the tools we were sent in our second study, “receiving a reward for recruiting other peers to CSE” and “reports of involvement in CSE” were indicators of “Medium risk”, while a “child meeting different adults and exchanging or selling sexual activity” was a “High risk” indicator.

In addition, the participants in our second study revealed that in many geographical areas, the concepts of “risk” and “harm” were being conflated, with many tools/checklists and the processes/policies identifying abuse and harm, rather than risk. In one area, for example, “high risk” was defined as evidence that a child is being sexually abused; “medium risk” evidence that a child may be being abused; and “low risk” that a child has the potential to be abused. Whilst it is clearly important to identify children and young people who are being sexually exploited and abused, the focus of screening and assessment here is on the identification of harm but the language and terminology of “risk” (potential harm) is being used. This can lead to children being categorised as “high risk” or at “serious risk of harm”

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when in reality they are already being coerced, controlled and entrenched in sexual exploitation. There were numerous examples of this across the tools gathered and reported by participants. Problematically, this may mean that children who are being exploited are receiving a service response which is more in line with risk reduction, rather than an immediate child protection and safeguarding response. The implications of this will further be discussed later in the paper.

Range in Methods of Scoring and Reaching Conclusions

In the majority of tools we reviewed and received, the number of indicators identified as being present is used to determine the overall risk category. However, there was significant variability between the tools in how this was done. Some tools are highly specific, with direct actions based on the number of identified indicators or scores within each section. Others are less clear about the way in which information informs action. The descriptions of risks and vulnerabilities varies and the scoring method too. Whilst not all tools use risk levels, they do primarily still adopt the language of risk in describing the case and the pathways of action are informed by perceptions of risk.

When a threshold for serious risk of harm is not reached through the method of scoring yet professionals have significant concerns for a young person, interview participants reported that they may discuss this further with their wider teams, involve other professionals, and/or refer to more senior managers for decisions. In some cases, it was also possible to over-rule the mandated threshold for a response and to emphasise the outstanding needs of the young person, although this was not made explicit on the instruments.

At a basic level, the information gathered to inform this initial assessment differed, depending on the agency, the professional and practice in the geographical area. When a single agency assessed risk, it may not be in possession of all of the information needed, which may mean that the level of concern appears to be at a low level. This then affects the

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decision taken to refer to support services, or to a multi-agency assessment or to take no further action. As one participant explained:

A school could fill it out (the screening tool) about the information they have but what about if the police hold information about that young person or what about if youth justice hold information or health – that would significantly change the outlook of that screening tool but without that information it might not look that concerning [...] CSE worker

Practice Varies

Alongside the wide range and variety of screening and assessment tools in use, practice also varied widely in terms of completing the tools and the meaning of the outcome in terms of a service response. There was no standard way in which this was managed across different regions or areas of operation. In some areas one service takes the lead in completing assessments. In others, multiple tools are used by different agencies:

So it's even more complicated than just saying 'This area do this and another area do that' [...] they (agencies) could in theory do what they want, but my question is what are they using and who's validated it and how is it being used because if it's just a form that you access on your internal system and print off and tick some boxes then would it be safer to refer any concerns through to a central safeguarding lead and allow them to make a decision [...]? Police CSE representative

Purpose of Tools and Assessment Not Always Clear – Screening or Assessment

A number of issues arose when discussing what professionals see as the purpose of using screening and assessment tools with young people. When asked directly about the purpose, some professionals were at pains to point out that it was important to retain a distinction between a tool used for screening a young person and for assessment of risk:

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there's a distinct difference between screening tools and risk assessment, and I think that it's become too blurred and I think people are referring to screening tools as risk assessments, and that's quite dangerous because if you've got a frontline practitioner that's using a screening tool [...] predominantly that will then become a single agency information gathering exercise, and what you will have is a professional filling that out and generally the screening tools are very simplistic so they tend to be just a list of vulnerability factors and risk indicators that they will tick, and sometimes they're colour coded and depending on how many ticks you get in each colour equals how high the risk is, but predominantly at that very first stage that is not going to be multi-agency, truly multi-agency. Police CSE Representative

This conflation of the two processes was recognised as problematic by a number of the interview participants. For example, one participant talked of the “danger” of the tool being seen as a robust assessment tool rather than a “screening tool of likelihood”. Following the use of a screening tool such as SERAF, this participant felt that a child should be assessed and referred on to a service. The score of the screening should not be taken as the assessment.

Whilst there was generally support for using tools, practitioners liked to have guidance and often exercised caution, stating that professional judgement was important too and that professionals should not be overly confident in the risk indicators. Since there is a lack of strong research evidence, that limits the validity of such tools and they should not be used as a stand-alone mechanism to determine decision-making.

Concern with Over-Compliance and Limited Support for Professional Judgement

An over-reliance on screening tools to assess a child's needs or risk of being a victim of CSE was raised as a concern by experienced specialist practitioners:

I think if it's an experienced practitioner using the tool, and it can be, not experienced in social care, it can be within education, health, social work, then they're much more

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likely to use professional judgement, but if you've got a newer qualified worker then the score fairly much becomes the holy grail, so it's the score that's relied upon which is something that again over the past 12 months we're trying to say to our partners don't get hung up on the score, it's a guide, it's meant to create a certain safeguarding response, but whether the child's at 13 or 23, the child still is likely to need safeguarding. If you're scoring 13 then there's still enough concern there that increased safeguarding needs to be considered...there's still a need but, yeah, if they don't get to that magic 16 sometimes it is a case of oh well, they're not at risk. (CSE Service Manager)

Referred to as a "tick box" culture, this practice could be said to have emerged out of professionals' fear of not complying or of missing an opportunity to safeguard: "when you're feeling vulnerable the easiest solution is to be about a compliance focus and a compliance focus is about a process and in a process you lose the child." (Local Safeguarding Children's Board Chair). This is a very real fear as there have been numerous high-profile cases where CSE was not recognised at an early stage and children were not properly protected. However, within this culture of speedy assessment and scoring of indicators or risk, professional judgement was not always encouraged and in some cases was discouraged, as an experienced CSE trainer said:

I'm getting delegates saying the toolkit comes out medium risk but they are absolutely sure the child is currently being exploited and they're writing on the bottom of it 'This is what I think is happening, this is my professional judgement [...]', they're getting emails back saying 'Do not write on this tool, I've taken off your comments. (CSE Trainer)

When asked if the tools allowed for use of professional judgement sufficiently, a large proportion of the survey participants ($n = 33$) felt that they did, with only nine participants

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feeling otherwise. However, the majority of participants ($n = 32$) reported that tensions arise often, sometimes or occasionally, between professional judgement and the use of these tools. Open-ended response boxes to encourage professional judgement had been added to some assessments used within and across agencies.

there wasn't a professional judgement box, and so again what we said was that actually they might come out as low risk but people may have a professional say for example, or they might come out as no risk of CSE, but what we were finding was that people were using the tool and there was lots of those indicators that fit for young girls and boys that may be involved in gang activity, and so we were saying actually whilst there may be no risk of CSE, the professional judgement box would allow people to say: whilst this isn't a concern actually, there may be other concerns associated with exploitation in other forms, so we've asked for it to be adapted a few times. CSE Service Manager

Survey participants aided understanding of the process relating to screening and assessment tools: they said that if there was any conflict with information, or professionals' levels of concerns, they were able to challenge the score or ask for more information; tools were there to aid professional judgement, further discussion would take place to raise concerns and that it was important to continue to gather information from family and other professionals. However, this was not without its challenges and some professionals interviewed were concerned that either inexperience, and/or an over reliance on tick boxes impinged upon the use of professional judgement.

Discussion

These two government funded studies aimed to establish what is known about indicators that suggest a child under the age of 18 is at heightened or reduced risk of becoming a victim of CSE in its various forms, and to explore the suitability and use of risk

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assessment tools and checklists to identify potential victims. Overall the aim was to help support early intervention and better protect children and young people. Our findings have illustrated the lack of research evidence on which UK CSE risk assessment practice is currently based. CSE practice has responded to incidents by developing tools/guidelines with the methodological limitations highlighted above (e.g., case file reviews, small samples and no comparison groups). None of the tools has been assessed for test-retest reliability or consistency in rating between professionals, and/or validated to assess if they identify children who are at most risk and whether the high, medium and low risk categories relate to level of risk of harm of CSE.

In addition, our findings raise concerns about how existing tools and checklists are being used to determine responses for children who might be, or are, at risk of CSE. Our reporting of a lack of clarity and evidence is a highly pertinent message for those with a remit for identifying CSE and raises questions over; what have ideas of “risk” been based on? How can we talk of “risky lifestyles”, “risky behaviours” and “risky choices” of children and young people if we do not know what the link between any of the above and being abused or exploited actually is? Crucially, all of the above explanations focus on the behaviour of the child or young person, which can lead to victim blaming, and attention solely being placed on the child at risk, or labelled as “risky”, rather than focusing on perpetrators, their identification and activities to disrupt and prevent their offending.

Although these studies have highlighted significant concerns over current practice, the limitations of the studies must be noted. Most notably the exclusion of studies that examined sexual abuse within families in the first study and the exploratory nature of the second study which was a snapshot undertaken over a short period of a few months and with an opportunistic, small self-selecting sample of, albeit very experienced, professionals. Despite

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this, the consistency in responses and concerns raised across the survey and interviews should be noted.

These studies have indicated the need for further research in this area and specifically the need for large scale studies identifying risk and protective factors, comparing indicators in those who have experienced CSE as well as in those who have not in order to create an evidence base from which to base tools and checklist. We would also suggest that where screening and assessment tools are to be used there should be rationalisation and development of tools across all partners and stakeholders involved in safeguarding and protection of children and young people so that full information can be gathered to ensure an accurate picture of risk is made. The gap in reviewing the quality and validity of screening and assessment tools and testing their usefulness through evaluation needs to be addressed with some urgency in the UK. This is critical to ensuring that the pathways of action are effective at reducing likelihood of risk of CSE and also support children and young people and their families.

Given the inevitable delay in this research evidence becoming available and the daily, present need to protect children and young people from CSE, the following seven principles for practice are recommended to support practitioners and help to ensure the best possible protection of children:

1. The purpose and use of tools/checklists should be clear to all professionals involved in the protection of children and young people.
2. Tools used to identify risk of harm should not include actual indicators of harm. Any indicators of harm should facilitate an immediate child protection response.
3. Professional judgement and experience should be encouraged. Single agency/service and/or single professionals, undertaking risk assessments should be discouraged

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wherever possible, with a focus placed on multiagency assessments where fully, more comprehensive information could be gathered.

4. Scoring to determine a course of action should be avoided.
5. Narrative information should be valued, so that all pieces of evidence, however, small or seemingly inconsequential, can be gathered to inform a full picture of what is often a complex, changing picture of exploitation.
6. Narrowly linking risks to individual child behaviours, and focusing on “risky” behaviours can lead to victim-blaming and losing sight of the child who is at risk.
7. Professionals need training to understand the complexities of CSE, in addition to training in the use of tools and checklists in operation in their area. Given the changing nature of CSE and increasing evidence base such training needs to be regularly updated, and opportunities given to reflect on understanding and practice.

In conclusion, this study has raised a number of issues concerning the current evidence base and use of tools and checklists used in the UK to identify the risk of CSE in children. Attention must be placed on developing a solid evidence base and evaluating tools in order to better support frontline practitioners who face the daily reality of trying to protect vulnerable children and young people at risk of child sexual exploitation.

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