

The use of tools and checklists to assess risk of child sexual exploitation

An exploratory study

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About the Centre of expertise on child sexual abuse

The Centre of expertise on child sexual abuse has been established to help bring about significant and system-wide change in how child sexual abuse is responded to locally and nationally.

We will do this by identifying, generating and sharing high-quality evidence of what works to prevent and tackle child sexual abuse (including child sexual exploitation), to inform both policy and practice.

The Centre is funded by the Home Office, led by Barnardo's, and works closely with key partners from academic institutions, local authorities, health, education, police and the voluntary sector.

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Summary

In a recent research study (Brown et al, 2016), we identified many issues with the tools and checklists used throughout England and Wales to identify young people at risk of child sexual exploitation (CSE): in particular, that risk indicators varied considerably across the large number of tools being used. We raised serious concerns that some indicators were actual signs of sexual abuse and exploitation rather than risk of abuse. The threshold for being identified as a potential victim was very high in some tools, resulting in differences in practice and responses across local authorities and agencies.

The current study builds directly on that previous study, exploring the use of screening and risk assessment tools relating to CSE in England and Wales with professional groups who currently use such tools.

Professionals working in this area are very keen to improve practice and the tools they use, and to do this quickly. This project aimed to identify how and when the current tools and checklists are being used, and provide research evidence, in order to make recommendations for the development of tools/checklists and practice.

Method

An online survey was completed by 42 professionals, and a further 17 professionals were interviewed. The professionals worked in a range of agencies and services, with the central focus of the majority being child protection and safeguarding. Participants shared the tools and checklists that they used with the research team. The data were analysed using thematic analysis.

Key findings

- A wide range of tools and checklists are being used across England – with one tool, the Sexual Exploitation Risk Assessment Framework (SERAF), used throughout Wales. (A separate review of the SERAF in Wales was taking place at the time of this study. It will be an important complement to this study, and provide a specific view of the Welsh context.)
- The data gathered from 42 online survey participants identified at least 19 different screening or assessment tools.
- There is variation in practice as to who completes the tools, the processes around their completion, and actions that result from the conclusions/risk categorisations obtained through their use. Some practitioners have undertaken training and are in specific CSE-related roles; others are less familiar and may encounter CSE less frequently. This results in young people being assessed differently in different geographical areas and by different services.
- There is sometimes confusion as to whether screening or risk assessment is being carried out, with debate amongst professionals as to whether one tool for both these purposes is required, or different tools for different purposes.

- Screening tools can ‘screen out’ some young people inappropriately if completed by one professional or single agency with limited information about the young person; other professionals may have information that might show an increased risk if all the information is pooled as part of the screening process. There is general support for the use of tools/checklists to guide practice in assessing whether young people are at risk of CSE, although there were differences in opinion between preferences for a single national tool or a range of tools tailored to localities and different professional needs.
- There is a conflation of risk and actual harm in the screening tools and checklists, and a variety of definitions of high, medium and low risk – with potentially serious consequences for the safeguarding of children and young people. Indicators included in tools and checklists and the method of overall assessment vary widely across each tool/checklist, service/organisation and service area.
- Meeting a threshold that triggers support from Children’s Services is not always achievable: some participants stated that the tools appeared to be used to assign resources rather than identify vulnerabilities.
- Some tools do not allow or encourage the inclusion of narrative information to explain indicators, risk and protective factors – yet the information contained in such narratives is important in enabling professionals to understand the nature of the risk and protective indicators.
- Scored tools are especially problematic, and tension can arise when scores differ between professionals/agencies, or do not indicate a level of response that some professionals feel is most appropriate.
- Existing tools are generally less appropriate for boys, younger children and disabled children, as they do not include risk indicators or vulnerabilities relevant to these populations.
- Some potential indicators of risk are often not included, e.g. online/social media communication, gaming, drug and/or gang involvement, deprivation/poverty, disability, and sexual interests and attitudes.
- There is little emphasis on protective factors or strengths of young people, their families and the immediate environment, and the potential to blame victims by narrowly linking experiences of victimisation to behaviours.
- There is a lack of situational, environmental and perpetrator/potential perpetrator factors in the tools/checklists.
- Some professionals stated that there is too strong a focus on young people who are potential victims and working with them to reduce their risk. Although a great deal of work is done to identify risk profile, high-risk areas and individuals as potential perpetrators, this is often carried out by different teams and different services, so it can appear that much of the work to prevent CSE places the emphasis on potential victims.
- Although the inclusion of young people and their families in assessing risk of CSE is generally supported, this does not always happen or is not appropriately managed and prepared for. Involving young people in thinking through adults’ concerns regarding exploitation could lead to more meaningful engagement. Increased discussion of the push and pull factors around CSE would help to ensure that this was addressed.

- The question of whether special CSE procedures are actually needed, or whether this should form part of generic child protection (because CSE is a form of child sexual abuse), was raised, leading to questions on whether separate tools are needed for CSE, or a more general risk indicators tool, and/or whether there should be a more general response to children and young people in need of support.

Gaps in research knowledge

- There is limited research evidence on which to identify the indicators (risk and protective factors) that should be included in the tools.
- Although professional judgement was generally favoured, and a number of limitations and difficulties were identified with the use of 'scored' tools, no research has been conducted, and expertise in the broader forensic risk assessment research/practitioner knowledge and experience has not been used to assess or evaluate the best approach(es) to use in identifying potential victims.

Implications and recommendations

These findings raise a number of implications for practice, but it is important to note that there are no simple solutions and 'quick fixes' in relation to this work, not least because there is a lack of research evidence on which to draw in order to develop evidence-based tools. A number of recommendations are listed in the report; here we list seven guiding principles, derived from our findings, that should be considered in the development and use of tools/checklists.

1. The purpose and use of any tool/checklist or assessment should be clear to all professionals involved in the process (including those developing it) – for example, is the tool/checklist designed/used to screen a large number of individuals and identify those most at risk, or to complete a comprehensive assessment? Tools should be used for the purposes for which they have been developed.
2. Tools/checklists designed to assess potential risk of harm should not include actual indicators of harm; if it is likely that indicators of harm will be identified in assessments using the tool, then separating actual indicators of harm from risk and protective indicators would enable the clearer identification of victims from potential victims, and enable the most appropriate responses to follow the assessments.
3. Professional judgement should be encouraged, not only in the tools/checklists and associated guidance/training, but also in the processes and procedures in which the tools/checklists are embedded.
4. Narrative information should be collected, so that all professionals involved in assessment or later processes can be clear about the nature of the risk and protective indicators identified.
5. A focus on assessing an individual's risk of CSE can lead to victim-blaming, particularly where risks are narrowly linked to individual behaviours. Apart from having serious negative impacts on children, victim-blaming undermines good practice around CSE as it obscures important contextual factors and the role of perpetrators in manipulation and abuse. Assessment work with potential victims, victims and their families should be collaborative and supportive. Where risks are identified, the responsibility for preventing CSE should not be placed on potential victims and their families.

6. Scoring should be avoided, but lists of potential indicators (risk and protective) can be helpful, particularly for professionals who have less knowledge and training in relation to CSE and/or are newly qualified, and to encourage consistency in the indicators used in decision-making. The structured professional judgement approach developed to assess the risk of offenders is an example of how indicators can be used in combination with professional judgement.
7. Support, guidance and training is required not only in respect of the completion of tools and checklists, but also in relation to using these tools to support and underpin decision-making and best practice in order to prevent CSE. Consideration should be given to meeting the needs of, and supporting, newly qualified professionals and those with limited CSE training/knowledge. This is relevant to some groups of professionals, e.g. GPs, health workers and some social workers.

1. Introduction

This research was commissioned by the Centre of expertise on child sexual abuse to support increased understanding and awareness of the protocols and procedures used in the prevention of child sexual exploitation (CSE). This report focuses on the use of screening tools and checklists, exploring those that are in current use, the purposes for which they are used and the ways in which they do or do not support good practice in the developing field of CSE prevention.

The findings will be of interest to frontline practitioners, service providers, commissioners of services and policy-makers.

1.1. Background

In a recent research study conducted for the Early Intervention Foundation (EIF) and funded by the Home Office (Brown et al, 2016), we identified many issues with the tools and checklists that have been developed in the last five to 10 years and used throughout England and Wales to identify young people at risk of CSE. These findings reflected concerns that have been raised and discussed for some time amongst practitioners.

In particular, we found that the risk indicators being used varied considerably across the large number of tools in operation. An examination of 10 tools identified 110 different indicators, with each tool having a different combination of these. Across the tools there was variability as to how many, and which, indicators needed to be identified at various levels of risk to facilitate a particular service response. Concerns were also raised that some indicators were signs of actual sexual exploitation and abuse rather than risk of abuse, and that the threshold for being identified as a potential victim was very high in some tools.

Additionally, the 2016 study identified different patterns of scoring and reaching conclusions across the tools, leading to potentially different decisions for the same child if they were assessed using different tools; thus, there were differences in practice and responses across authorities and agencies. A reliance on scoring or tick boxes was identified, which discouraged or eliminated professional judgement. Conversations and anecdotal evidence from frontline workers suggested that the tools were being used in ways that generated tension and concern.

Professionals working in this area are very keen to improve practice and the tools they use, and to do this quickly. An important first step to improving practice is to ascertain how the current tools and checklists are being used. For example, for what purpose are tools being used, and under what circumstances? What are the differences between a screening tool and an assessment tool? What happens when the outcome of using a tool raises concerns about a child, but the 'threshold of risk' is not reached? What processes are adopted when different thresholds of risk are identified? To what extent is professional judgement used? Are risk assessment tools necessary in the field of CSE practice?

1.2. Aims

In order to make recommendations for the development of tools/checklists and practice in this area of work with children and young people, the current project's aims were to:

- determine the circumstances in which the tools are used
- understand how children and young people/situations requiring assessment are identified
- investigate how different teams of professionals 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
- determine the best course of action once the tools/checklists have been completed
- understand the strengths and limitations of shared multi-agency risk assessment tools.

1.3. Key definitions

The most recent practice guidance from the Department for Education states (DfE, 2017:6):

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

The DfE goes on to acknowledge the difficulty that those working with children may have in identifying CSE, stressing the difficulty in interpreting signs and symptoms and differentiating ‘normal’ young people behaviours from indicators of CSE. In particular the guidance states (DfE, 2017:6):

“It requires knowledge, skills, professional curiosity and an assessment which analyses the risk factors and personal circumstances of individual children to ensure that the signs and symptoms are interpreted correctly and appropriate support is given.”

In both England and Wales, CSE is regarded as a form of child sexual abuse, although policy and practice frameworks differ between the two nations and between local authority areas. The development of screening tools and checklists has grown out of a concern to identify children and young people at risk of CSE, in order to respond to need and provide support or intervention. It is beyond the scope of this exploratory study to trace this development: that is a topic for further research, and this study had a focus on finding out the current experience of such practice.

2. Method and sample

Professionals' experiences of using risk assessment tools and checklists were sought via both an online survey and semi-structured interviews. Both quantitative and qualitative data were generated through this process. Ethical approval for the study was granted by Coventry University, with permissions being provided to promote the online survey through Barnardo's and the National Working Group on CSE (NWG).

2.1. Online survey

The online survey was developed by the project team, based on their findings from the previous EIF project and in consultation with staff in the Centre of expertise on child sexual abuse. The draft survey was reviewed by the NWG and piloted with a small number of professionals (Barnardo's service manager, a CSE Police lead, a social worker with voluntary sector experience and the Director of Research for the Centre of expertise). 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, and what types of decisions are made using them), any challenges and difficulties in using the tools, and the respondents' views about the value and use of the tools.

Hosted on Bristol Online Surveys, the survey was available from 3 March to 22 March 2017. It was advertised within NWG's newsletter (emailed to all 13,000 members) and its social media channels, by Barnardo's via an email to its service managers, and via emails from CSE regional crime unit leads to their networks of contacts. It was also shared via social media: for example, organisations and CSE professionals distributed the link via Twitter. Full information was provided about the purpose of the study and what taking part involved. The fixed-choice responses were analysed descriptively. The open-ended responses were analysed using thematic analysis in combination with the interview transcripts.

Survey participants

The survey was completed by 42 individuals from a wide range of areas, as shown in Figure 1. Their professions are displayed in Table 1.

Figure 1. Online survey participants' areas of employment

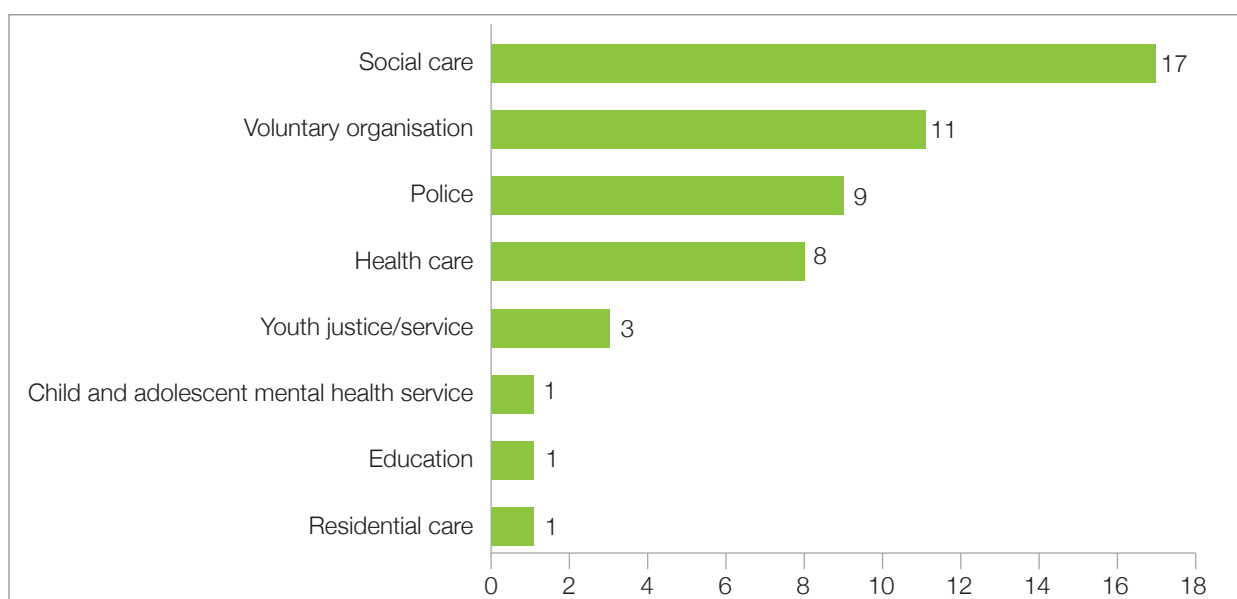


Table 1. Online survey participants by profession

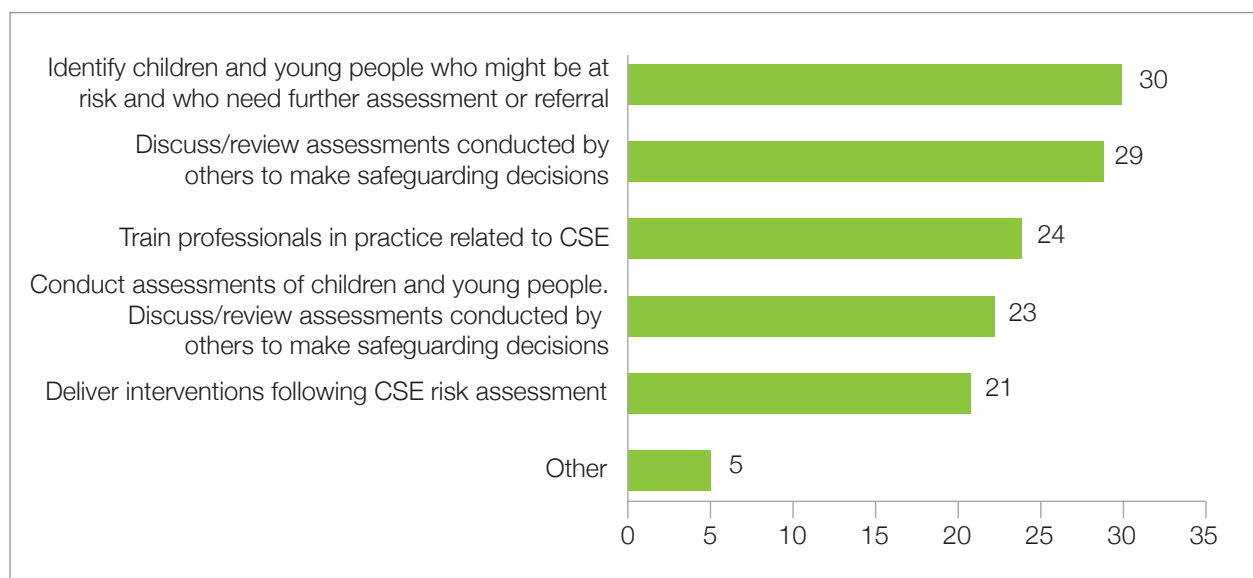
Profession	Number
CSE project worker, practitioner, or youth worker	9
CSE project, service or operational lead or regional coordinator	6
CSE social worker	4
Detective Constable/Detective Sergeant	3
Nurse practitioner or designated safeguarding children nurse	3
Service manager	3
Senior or team manager, or operational manager	3
Family support worker	2
Team manager of a Missing, Exploited and Trafficked Children Team	1
Service practitioner	1
Head of an integrated Safeguarding Service	1
Consultant in sexual health/genitourinary medicine	1
Multi Agency Team personal adviser	1
Intelligence analyst, CSE Hub	1
Designated safeguarding lead	1
CSE trainer	1

Note: One participant listed multiple professional roles.

For the majority of the sample (n=35), their primary role related to child protection and safeguarding. Those who responded that this was not their primary role (n=6) stated their roles, which 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.

All of the survey participants stated they used CSE risk assessment tools/checklists within their professional role, for the purposes outlined in Figure 2.

Figure 2. Use of CSE risk assessment tools/checklists by survey participants



Source: online survey.

Note: For those who selected 'other', responses included: Deliver longer term intervention to children and young people at risk of or exposed to CSE following assessment; Discuss during training sessions with safeguarding professionals and have previously used it during assessments of children; Oversee commissioned services in health care who safeguard children – acute and community trusts. CCG health re on CSE subgroup of LSCB; conduct daily scan of police systems regarding those at risk/victims of CSE ensure they are flagged on police systems; and contribute to the development of strategies and policy.

2.2. Interviews

An interview schedule was developed by the project team, based on their findings from the EIF project and in consultation with staff at the Centre of expertise on child sexual abuse. The draft schedule was reviewed by the NWG and the Centre's Director of Research. A semi-structured approach was used to explore similar areas as the survey but allow a more detailed, in-depth discussion. Interviews took between 27 and 80 minutes and 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 transcripts were analysed using thematic analysis.

Given the short timescale of the project, the networks of the project team, their colleagues and the Centre of expertise approached professionals to take part in the study. (See section 4.1 for a discussion of the implications of purposive sampling.) Requests were sent by email, and some people were asked in person. Full information about the aims and purpose of the study were provided.

Interview participants

Seventeen professionals were interviewed from the following professions/organisations across England and Wales.

- CSE coordinator and CSE service manager
- CEO and manager of a missing service
- Head of Personal, Social, Health and Economic (PSHE) education in a secondary school, and teacher at a special school
- Youth justice team leader
- Police CSE representative
- CSE service manager
- Manager of a missing service
- Local Safeguarding Children Board (LSCB) Chair
- Strategic lead CSE (local authority)
- CSE worker voluntary sector
- Social worker
- CSE worker
- CSE trainer
- Designated nurse

Three of the interviews involved two people being interviewed jointly.

3. Findings

3.1. Range of tools and checklists

The wide range and number of tools and checklists used across England and Wales is demonstrated in Table 2, although it is important to note that the Sexual Exploitation Risk Assessment Framework (SERAF) is used consistently throughout Wales. The 42 professionals who completed the survey identified at least 19 different tools, with the total potentially being 28 (if each of the 'own tools' and 'screening tools' identified in responses, and the 'unknown' tool, is different from one another and those listed). Copies of tools were requested, and 12 were emailed to the team by survey and interview participants. Since the aim of this study was not assess tools/checklists directly, these tools were used to understand what participants had told us in the interviews/survey, and to illustrate key findings.

Table 2. Risk assessment tools/checklists currently being used

Risk assessment tools/checklists	Number
SERAF	7
Own tool/risk indicator checklist	4
Screening Tool	4
LSCB screening tool and risk assessment	3
NWG risk assessment and screening tool	3
Project Phoenix CSE measurement tool	3
Rotherham Council's/Rotherham Screening Tool	3
Spotting the signs	2
Vulnerability Checklist – Swindon	2
West Midlands Regional Screening tool/West Midlands CSE Tool	2
West Yorkshire Police Multi Agency Risk Assessment Tool	2
Aide Memoire	1
Buckinghamshire CSE Aide Memoire	1
CSE assessment tool on Early Help Module (EHM)	1
DASH risk assessment	1
Distance travelled tool	1
HEADSS assessment tool	1
Matrix	1

Relationship Psychometrics	1
Safety and disruption plan	1
SERAF Step Assessment Protective Factors	1
Warwickshire Safeguarding Board CSE Screening Tool and CSE Assessment	1
West Mercia Consortium toolkit	1
Unknown	1

Source: online survey.

Note: The names of tools listed in the table are reported directly as recorded by the survey participants. Where multiple participants used exactly the same wording, these have been summed. In many cases, no further details were supplied; thus, assumptions have not been made that respondents were referring to the same tool. Some respondents reported using more than one tool/checklist, each of which is listed separately.

It is important to note that participants who took part in the survey were a self-selecting sample, so the tools featured in the study are not necessarily representative of all those used. Although we have indicated the area of employment of the people who made the comments, and in the discussion below will indicate the tools used by them, we did not systematically review all the tools used across England and Wales.

Many additional tools/checklists, and multiple versions of some of these referred to in Table 2, were described by those interviewed. In many areas more than one tool was used, and with varying geographic borders of services across different professions (because police regions encompass a number of local authorities and services, for example), some professionals had to work with a large number of different tools. To illustrate the complexity of the situation, the police CSE representative interviewed described how their two local police forces cover multiple local authorities:

“Each area will have a different pathway, different referral process, different risk assessments within that. Some areas may also use screening tools prior to referring through the referral pathway.”

3.2. Adaptation of existing tools and checklists

We were interested to know whether existing screening and assessment tools were used, or whether tools had been tailored to meet local or service need. When asked whether the tool or checklist had been adapted from the original in their area or service, 18 survey participants said yes, 10 said no, and the remaining 14 did not know.

Both the survey respondents and the professionals who were interviewed spoke about tools changing over time, and being adapted to fit in with local services and referral pathways. Others said that changes were made in light of a better understanding of CSE, or changes in how CSE manifested within their local areas. A couple of very experienced social workers, however, raised concerns that it was not always clear why decisions to adapt tools were made and where the evidence base for such decisions had come from. A number mentioned that, to overcome a tick-box process, an open-response box had been added to the end of their form to allow professionals to disagree with the scoring system used and the overall score generated by the tool, and to argue the risk level. This is explored further on the next page.

3.3. How tools and checklists are used

Survey participants listed a range of circumstances in which professionals use tools and checklists with young people, as illustrated in Table 3.

Table 3. Circumstances in which tools are used, by type of profession

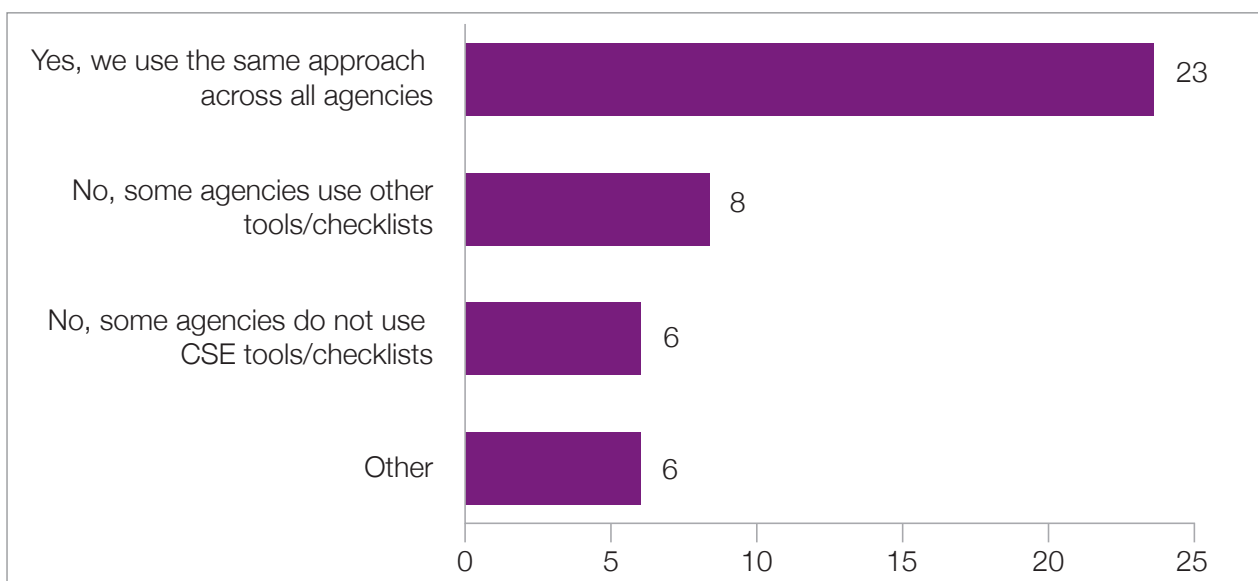
Circumstance	Type of profession
1 Children/young people at risk or suspected to be at risk, and to highlight risks.	Social care (4) Voluntary organisation (2) Health care (2) Police (3)
2 At point of referral to service. Identify level of risk.	Social care (7) Voluntary organisation (6) Police (3) Youth justice/service (2) Education (1)
3 Identified areas for concern.	Social care (3) Multi-agency 1
4 At CSE Strategy meetings/Multi-Agency Safeguarding Hub/Triage meetings/Multi-Agency Strategy discussions and CSE network meetings.	Social care (3) Voluntary organisation (2) Health care (1) Child and adolescent mental health services (1) Police (2) Youth justice/service (1)
5 Throughout any intervention carried out with the child/young adult. Tools/checklists reviewed anywhere between six weeks and six months. Administered when there has been a significant change.	Social care (4) Voluntary organisation (4) Police (2) Youth justice/service (2) Health care (1) Residential care (1)
6 Used when child presents in emergency settings with alcohol/substance misuse, self-harm.	Health
7 Young person under 18 attending sexual health clinic.	Health
8 Audit only.	Health

Source: online survey.

Reflecting on the development and journey of such tools, some professionals acknowledged during interviews that generally knowledge of CSE had previously been relatively limited and something was needed to guide professionals in their identification of CSE. There was general agreement that professionals need guidance and some sort of framework, and that having a visual prompt is useful. Despite the consistent use of a single tool across Wales, views were mixed on whether a single standard tool should be used across England and Wales, or a range of tools used that are locally tailored. This is explored further below.

The majority of the tools are used by multiple agencies in the survey participants' areas (see Figure 3).

Figure 3. Are the tools used by multiple agencies in your area?



Source: online survey.

Although a multi-agency approach is most common, the interviews revealed that there is no standard way in which this is managed across areas/regions, particularly in relation to the completion of the checklists. In some areas, a particular service (e.g. a CSE specialist team) takes responsibility or the lead for completing the assessment; in others, multiple tools/checklists (e.g. one completed by each agency) are discussed, which can be problematic:

“So it’s even more complicated than just saying, ‘This area do this and another area do that.’ It’s actually within an area what the agencies themselves are doing, because they can do what they want, can’t they? Nobody’s governing, saying, ‘Well, health, you’re not allowed to have your own separate screening tool, and the SARC [sexual assault referral centre], you’re not allowed to have a screening tool of your own,’ so they 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 actually be safer to refer any concerns through to a central safeguarding lead and allow them to make a decision about what happens to that? Because at least they’re trained and up to date in theory.” *Police CSE representative*

Even when using the same tool, agencies may have different approaches and views about 'risk':

"I think over-completion of the tool is very unhelpful, and I know that the tool has been criticised in child practice reviews for that, where the child has been subject to other concerning events which has led to a number of agencies independently completing tools all with different scores; actually that's very unhelpful for the agencies involved, but the child as well. If we all have a different review on risk and where the risk is and what the risk is and we're all in danger of working in silos with the child not coming together, then the tool I think can be unhelpful."

CSE service manager

3.4. Screening versus risk assessment: issues with conflation of purpose

A number of issues arose when discussing what professionals see as the purpose of using tools with children and young people. When asked directly in interviews 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 to identify and raise initial concerns and a thorough assessment of risk:

"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 such as the SERAF one... Predominantly, and I'm not saying that this is in all cases, but 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, because in order to do that, that's really the purpose of having a MACE meeting is to get the key players round the table in relation to an individual young person to fully share all of the information that's held about that young person, look at it in context to enable you to assess risk and look at risk reduction."

Police CSE representative

This conflation of the two processes and forms was recognised as problematic by a large number of the interviewees. One talked of the 'danger' of the tool (in this case, the SERAF) being seen as a robust assessment tool rather than a 'screening tool of likelihood'; the next step to the use of the tool, the participant felt, should be to assess a child that is referred onto a service, not to take the score of the tool as the assessment.

Others were concerned that tools are not always helpful and, whilst designed to act as a prompt for conversation, have become too prescriptive: "We're becoming far too

reductionist and we seem to be ticking boxes for everything.” This ‘tick-box culture’ could be said to have grown out of fear of not complying or of missing an opportunity to recognise when a young person needs to be safeguarded.

“When you are 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.” *LSCB Chair*

Amongst some, there was a sense that screening tools may act to screen out rather than screen in, particularly as highlighted above when they are completed with a limited or narrow range of information (see also section 3.8).

Agencies with a remit for undertaking return interviews with young people who have been ‘missing’ from home or from care used a screening tool for CSE. It was made clear that this was not a risk assessment. Return interview staff may have 20–30 minutes to make a quick judgement on an initial screening:

“There is not a child in this country that would not tick low risk... I don’t want to look at making thresholds higher but at the moment the way we use our screening tool ... it could be that they’ve been late, they’ve had a missing episode or they might have missed the bus. But have we dug down deep enough or have we just ticked everything? There’s got to be a bigger context to what we are doing.” *Manager of a missing service*

Others felt that the use of screening tools could lead professionals to be risk-averse and include more factors than necessary.

3.5. Value of tools and checklists

When asked about the value of CSE tools/checklists, most survey participants thought they were valuable and useful because:

- they focus workers’ minds and support staff on problems/concerns and help them map out risk and level of risk so they can plan how to reduce risk (n=12; range of employment areas)
- they guide interviews and professional thinking (n=5; range of employment areas)
- they are useful to let child/families see the concerns highlighted (n=3; police, social care, health care)
- they guide decision-making (n=2; police)
- information that comes to light from the assessment can be used in police intelligence and trigger plans for consideration if the young person goes missing on a regular basis (n=2; social care and police)
- they are needed and give a black/white idea to services rather than emotive narrative (n=1; voluntary organisation)
- they are how most of the information is gathered (n= 1; voluntary organisation).

(The comments listed above and in the rest of this section are the survey participants' responses to open-ended questions; these have been analysed and grouped together, sometimes drawing on the wording of multiple responses to summarise each point raised.)

Two respondents noted that tools needed to be completed in a multi-agency format, and that they should be evidence-based.

The merits identified by the participants might also apply to other tools; we did not ask each participant to consider the value of the tool(s) they used on each of these issues. This should also be borne in mind in the following discussion.

When describing what is helpful about the tools and checklists they use, the survey participants' responses noted that they:

- give an indication of areas for concern/areas of vulnerability/risk – identify areas which could otherwise be missed (n=16; wide range of tools)
 - o can focus intervention/social workers can target behaviours and risks
 - o provide indication of risk level
- are accurate and embedded in practice/supports clinical opinion (n=10; wide range of tools)
- provide context around family issues/risk to a child (n=6; range of tools)
- are clear and concise/easily accessible for non-professionals/easy to understand language/incorporates different issues/short, quick and easy to use (n=4; SERAF, Screening tool, LSCB tool)
- provide the basis of knowledge to start 1:1 intervention/supports staff when gathering information (n=2; Matrix, Rotherham Council)
- are tailored to service issues (n=1; SERAF, Distance travelled tool)
- are based on research (n=1; SERAF, Distance travelled tool)
- are accessible to the child/young person – use phrases they can understand/what they are experiencing (n=1; Buckinghamshire CSE Aide Memoire).

However, some who thought they were valuable also had concerns:

- Useful but should not override professional judgement or common sense (n=1; Aide Memoire)
- Tick-box tools difficult – want to encourage conversations with the child/YP (n=1; Spotting the signs, SERAF)
- I'm not convinced this is the way to go (n=1; West Midlands screening tool)
- I do not like screening tools. They are generally carried out single agency by relatively low-skilled and untrained professionals (n=1; LSCB tool)
- Not great but best they have right now (n=1; Aide Memoire)

For those who stated that these tools/checklists should not be continued, the reasons included:

- Relationship-based working has always been difficult and not sure what the answer is (n=1; NWG risk assessment and screening tool safety and disruption plan)
- More of an emphasis on social workers' understanding and considering behaviours (don't need checklists for this) (n=1; West Midlands Regional Screening tool)
- Follow normal child protection procedures and assessments, and not seeing CSE as something other than sexual abuse (n=1; LSCB tool, Spotting the signs)
- Needs to be a way to assess online grooming (n=2; LSCB tool, nursing team checklist)
- CSE 'risk' needs to be considered as part of everyday safeguarding business in CP assessments (n=1; LSCB tool)
- Should involve child – 'done with' approach rather than 'done to' (n=1; West Mercia Consortium toolkit)

Various factors were identified as not being helpful: for example, neighbouring areas using different tools. Several responses concerned the layout of the form, lack of space to include explanations/narratives, or missing information/indicators:

- Layout of the assessment they use is lengthy and inaccessible – needs to allow for more free-flowing information (n=4; NWG tool, SERAF, locally designed tool, West Yorkshire Police Multi Agency Risk Assessment Tool)
- Out of date with regards to online grooming/image distribution (n=2; SERAF, West Yorkshire Police Multi Agency Risk Assessment Tool)
- No room for narrative or explanation/straightforward tick boxes (n=1; Buckinghamshire CSE Aide Memoire)
- Doesn't reflect boys'/young men's issues very well (n=1; SERAF)
- Wording very professional and doesn't easily lead to the next question (n=1; LSCB tool, nursing team checklist)
- Some of it can be repetitive (n=1; Rotherham Council)
- Thresholds don't accurately reflect risk (n=1; SERAF, SERAF Step Assessment Protective Factors, Relationship Psychometrics)

Some of the concerns were more procedural, in terms of lack of time to complete the assessment or concerns over professionals' use of tools:

- Practitioners in acute setting (i.e. A&E) may struggle to find time to complete (n=1; health care)
 - o Length of time it takes to complete inhibits end user

- Professionals can ‘over-exaggerate’ the concerns (n=1; voluntary organisation)
- Can be difficult to de-escalate cases where there are other child protection concerns, as this keeps the CSE risk artificially high (n= 1; social care)
- People don’t think outside the box/may not be intuitive (n=1; social care).

One survey participant stressed:

“We should remember that child protection procedures should be followed and not see CSE as something outside of this just because there is a specific tool.” *Safeguarding children nurse*

Despite these concerns, the majority of survey participants (n=38) reported that these tools and checklists should continue to be used for preventing CSE. The reasons for continuing to use them included that they inform practitioners’ decision-making and support the collection of information. Participants gave a wide range of responses in terms of how they would like to see them used in future:

- Standardised tool would make sense across the country for all agencies (n=1)
- To make referrals and assess that a child’s risk is reducing/monitor their progress (n=1)
- To be used as often as necessary (n=1)
- Used with confidence and a good understanding of the topic (n=1)
- As an educational tool that demonstrates the known CSE indicators, vulnerability factors and symptoms of trauma to aid assessment (n=1)
- Short, easy to complete, and accessible to all (n=1).

One participant noted that more CSE training was required.

In the interviews, participants were asked about the need for screening tools. It was generally agreed that a baseline measure was needed, along with consistency (a way to first identify and record any concerns identified by any professional who might come into contact with a child). Participants identified that, following this, what was needed was a thorough assessment and a way to record and review the reduction in risk and to gauge a young person’s progress. There was concern that different authorities and agencies seemed to be ‘doing their own thing’ or not doing anything:

“How do they know what the risk is, we need to have something to baseline, we need to have something to move cases on so we can make sure the risk is being reduced, otherwise we could leave kids endlessly on plans forever and not have any sort of changes.” *Team manager, Children’s Services*

3.6. Tools and checklists recommended by participants

We wished to identify examples of good practice that could be shared more widely. When asked whether they were aware of a tool or checklist they deemed appropriate or suitable to use in CSE risk assessment, only 13 participants responded ‘yes’. See Table 4 for a list of their answers. In addition, one participant stated that the “Wolak and Finkelhor typology” should be incorporated and used alongside the current checklists in cases that involve online communication.

Table 4. Tools/checklists recommended by participants that are suitable/appropriate to use in CSE risk assessment

Risk assessment tool/checklist	Number
SERAF	4
Oxford risk assessment tool	1
Evolve risk assessment	1
Brook – Traffic Light Tool	1
My world triangle	1
Spotting the signs	1

Source: online survey.

These tools or checklists were deemed suitable or appropriate because:

- The SERAF is less complex and more accessible/understandable, and having a single form makes multi-agency communication more effective when crossing geographical boundaries to other counties.
- The use of the Wolak and Finkelhor typology in addition to the SERAF was specific to online concerns.
- The Oxford risk assessment tool provides a more comprehensive overview of concerns, levels of concern and overall risk to help those identified as higher risk.
- The Evolve risk assessment looks at indicators in terms of low, medium and high risk.

One survey participant highlighted a new toolkit that was about to be launched by the West Mercia Consortium:

“to make it easier for professionals to make assessments and to move away from a ‘scoring’ method. The new toolkit requires a multi-agency approach to the referral to ensure that all agencies that are currently working with that child have input into the risk assessment. It also requires that the parents and the child are involved in the assessment; in the previous toolkit we always required consent from parents, but agencies did not always involve the child in the conversation and this

could hamper engagement with the work to reduce risks if the child didn't know that concerns were being raised or that they were not consulted for their opinion of what is occurring for them. It is important that the focus is a 'done with' approach as opposed to a 'done to' process."

CSE/missing operational lead

3.7. Guidance and training in use of tools and checklists

Most survey participants (n=36) stated that guidance on how to use the tool/checklist is available for professionals. Of these, 27 said they had read the guidance whereas seven said they had not. Professionals in interviews spoke about the need for guidance and good-quality training to go hand in hand, especially giving the complexity of CSE:

"It's always down to how good the training is. I would argue that the training's just as important as any guidance that you can write, because it requires much wider knowledge than you could ever condense down into some written guidance. So I see them going hand in hand, not just 'There's your guidance, read that and then you'll be able to do the risk assessment,' it should be 'Here's your training,' and then directed to the guidance after the training so that you've got a proper understanding of the wider implications of risk assessment, child protection, the crossovers between other services in child protection issues – which you just can't condense into guidance because it would just be too long and then people won't read it properly." *Police CSE representative*

When training was explored within the interviews, the need for more multi-agency training and awareness-raising of CSE was a reoccurring issue, with a number of respondents explaining that a lack of training affected the quality of screening/assessments being undertaken. Multi-agency training was seen to be the best, particularly for topics such as CSE:

"The approach to CSE needs] to be multi-agency because what you get then is a different group of professionals in the room that bring something different to it; that leads on to discussion and leads on to better understanding of what each other's role is, because if you just train everybody in silos then social workers don't understand police roles and police don't understand social workers and then they don't know how that links in with health, and that's what the risk assessment process is all about, multi-agency information sharing. I believe that needs to start at the training stage, so that by the time you get through to the multi-agency meeting there's a better understanding of what we're all there to achieve for that young person when we're sat in that meeting." *Police CSE representative*

In addition, a lack of understanding meant that professionals did not consider risk and identified the need to consider possible CSE of a child.

"We do need to do some more because we're finding that people aren't, not necessarily not just filling in the forms, but aren't being mindful around CSE or any exploitation so hence why we want to go back and revisit that really." *CSE coordinator*

Another respondent highlighted that some professionals needed even basic training and understanding of child abuse, as they were missing possible signs and indicators of abuse and presuming that a child would disclose.

“What we find is, unless the child is making a disclosure, sexual abuse didn’t happen, so the behaviour being presented by the child is clearly indicative that this child has seen something or has had something happen, but the response we get from professionals consistently against health, education, social care, is ‘Well, they haven’t said it, or they’ve said then they’ve retracted,’ so there is definitely something about education around adults working with children in a professional arena. We need to get better at interpreting this behaviour, and being able to raise concerns because we’ve interpreted something – you can’t rely on disclosure from a five/six/seven/eight-year-old... if we waited for children to tell us then we’d be waiting until they’re adults, we know that, we need to help them more when there’s those early behavioural concerns and factors that should include our awareness really that there’s a risk around this child.”
CSE service manager

Other professionals had concerns that, without adequate training, not only would risk of or actual CSE be missed, but misconceptions and victim-blaming would be allowed to continue.

“If we don’t put enough training into teachers, into social workers, and I’m going to say the word ‘police’, there’s a fear, for me, that victim-blaming from their own culture, their own understanding and what they’re seeing, will come through. And that’s not what we want. But if they’re not getting quality training and they’re not getting quality line management, who’s looking after that young person who decides, ‘I’ll go to my teacher. I trust my teacher. I’m going to speak to my teacher about what’s happening to me,’ at five to four on a Friday afternoon? What will that teacher do with that information? I question that all the time. That teacher will probably be as afraid as the kid, and then who does that teacher go to if they haven’t had the training, and how open are their lines of enquiry, their designated safeguarding leads, and how does it carry forward from there? Or is the young person told – and I believe this happens – ‘Take the weekend, I’m sure it will be alright. Speak to you next week,’ and we leave it.” *Manager of a missing service*

Others reported that their local authority had invested in training around CSE, but questioned whether this was adequate and gave professionals enough confidence:

“It’s rolled out as a programme. It’s not rolled out to all new staff. And I will say, it probably forms part of the last three or four slides on the CSE training day and it’s just ‘This is what it looks like, this is where you download your procedures from, and this is where you fill it in.’ I don’t think, locally, we train in how to use the tool.” *Manager of a missing service*

“If I was a frontline social worker who’d had a day’s training and then didn’t use that tool for three or four months and then I used it, and then I didn’t use it again for three or four months, I think I’d probably lose confidence.” *CSE service manager*

The interaction of training, continuing professional development and the use of the screening and assessment tools were seen by participants as fundamental to the development of effective practice that leads to positive outcomes for young people.

3.8. Information used in the completion of tools/ checklists

The interviews and survey responses revealed that a wide range of information is used to inform the completion of the tools and checklists, including:

- conversations with/information from peers and family of the child/young person
- professional input/information from other agencies – agencies such as police, social care, school and school files etc.; multi-agency discussions
- case file information, case history and referral details
- conversations/interviews/observations with the child/young person
- reviews at monthly meetings
- home and school visits
- psychometrics
- experience/‘gut feeling’.

The interviews revealed that, although a standard policy and approach had been adapted in Wales, there was no standard approach for similar types of assessments across England, with different types of information being used for different types of assessments and by different professionals or services using the same tools. Although the purpose of Multi-Agency Safeguarding Hub (MASH) and other information-sharing meetings was to draw this wide range of sources together to plan service responses, concern was expressed that in some instances a referral might not be made, or a case not progressed to a multi-agency level, if an assessment was done by a single agency/service using a limited range of information sources.

“Quite often you’ll come into contact with the young person as a result of something so it will be because of an incident that’s happened or a missing episode or a specific concern that’s been raised. So, for example, if a school is encouraged to fill out these SERAF screening tools, how much extra information do they actually gather in relation to that young person? A school could fill it out about the information that they know and the concerns that they have, but what about if the police hold information about that young person, or what about if youth justice hold information about that young person, or health – that would significantly change the outlook of that screening tool. But without that information it might not look that concerning, and it may be that the school decide it’s not that concerning and they’ll manage it in-house, and they may or may not share that information through to the MASH. Then you end up with a situation where every agency that’s individually in contact with the young

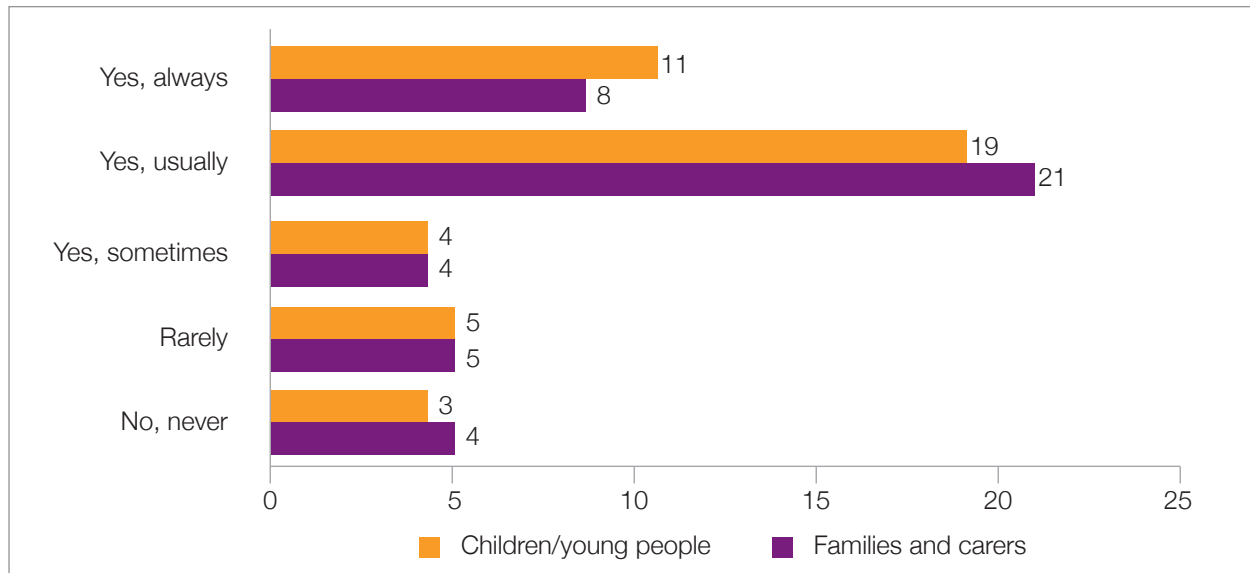
person thinks that there's no risk or it's low risk and they're all individually managing it, whereas if you pooled all of that information together you'd have something that we were all very worried about and should be sat in a MACE meeting. I worry that screening tools more often than not screen out rather than screen in." *CSE worker*

A very senior social worker and Chair of an LSCB also raised concerns that these multi-agency meetings were often used to complete basic risk assessment information rather than to focus on planning responses and reviewing children's needs and support, and that in some authorities these multi-agency meetings were being chaired by CSE coordinators without a social work background and/or in-depth understanding of abuse and trauma.

3.9. Young people and parent/carer involvement

Only 11 of the 42 survey participants reported that the children or young people being assessed are always consulted during the assessments, although almost half (n=19) stated that this usually happens. Similar figures were reported for the involvement of families and carers: half of participants (n=21) stated that the families of young people being assessed are usually consulted during these assessments, but only eight reported that this always happens. Four respondents reported never involving either the young person and/or their family/carers (see Figure 4).

Figure 4. Are the children/young people being assessed, and their families/carers, consulted during assessments?



Source: online survey.

Involving children and young people in the process of assessment and responding to need was regarded as important by all interview participants. Examples were given of the involvement of young people in initial screening, in the assessment process, at multi-agency meetings and in drawing up appropriate plans for intervention and management of risk. However, it was acknowledged that this was the ideal, and views varied on whether it was always appropriate to involve young people in certain aspects:

“Staff are always encouraged to capture the child’s voice, and my view is that really they should be doing [SERAF] with the child. However, circumstances aren’t always that easy: either children don’t always want to engage or they’re not willing to complete stuff, and actually some of the questions it’s not always appropriate to do that. With the DTT [Distance travelled tool] in my team, I would encourage that even more, because that is aimed at a child to complete, and the discussion, you know, we have a participation, we call it a star, so the star’s got seven points on it and each point again can be scored against the DTT. That’s more child-friendly, so the workers can talk openly with the children about the risk and about what risks they’re looking at taking.” *Manager of a missing service*

Timing emerged as an important consideration when considering the involvement of young people. Professionals reported in interviews that the timing had to be right or a young person may not perceive any risk, or may be unwilling to engage with professionals. A number of the procedures generally used were said not to be inclusive to young people, and the whole process was said to have been developed without the inclusion of young people or their parents/carers:

“it’s very rare that [the voice of the child has] really been at the forefront when the procedures have been developed – they tend to be more of an afterthought, like ‘Well, we’ll invite them along and they can come for the first bit but then we’ll have to ask them to leave.’ Sometimes what that says to the child, if they haven’t been properly informed and prepared, is ‘Right, you can come and say your bit, and now you’ve got to leave because we’re all going to talk about you.’ You can overcome that, but it has to be part, it should be part of the process and procedures so that it’s consistent, so that it’s not the luck of the draw about which professional you’ve got working with you and whether they prepare you – it’s just the same for everybody, and everybody gets a fair opportunity to be supported, prepared and have their voice heard at the meeting, no matter how they want it to be heard. I think that would be very much dependent on each individual area’s process.” *Police CSE representative*

Not only had procedures not been developed to encourage participation from the child or young person, it was stated that at multi-agency meetings parents were sometimes talked about as if they were part of the problem, as might be the case in a more familial child protection case. Victim-blaming of young people was said still to occur amongst professionals at multi-agency meetings. A number of interviewees said that neither parents nor young people were sufficiently made aware in advance of what to expect or how they might participate in multi-agency meetings where cases were discussed. Examples were given of multi-agency meetings where highly inappropriate comments were made and information shared in front of parents and young people:

“The mum and the daughter turned up, didn’t know what they were coming to, and they were sat with several professionals, all looking at them. The Chair actually said, ‘I didn’t know I was meant to be doing this meeting – I was only asked five minutes ago... I don’t know you. The only thing I know from your record is you had a termination last month.’”*

*Given the sensitive nature of this quotation, we have not identified the participant’s professional background.

Some interviewees reported that they worked to 'upskill' parents in relation to CSE, and commented that parents often felt helpless and wanted to do something useful to try and stop the exploitation of their child. Their support should be recognised as a strength and should be valued, but a number of interviewees said that this was not often the case at multi-agency meetings.

“They can sort of ignore the parents, or tell the parents that they don’t understand, or they’ve not assessed that correctly, or they don’t have enough knowledge, that sort of thing. But some areas I have worked with and I’ve trained, especially when I’ve spent a lot of time with them and talking with them around empowering parents as allies, and carers as allies, including residential support workers, because they get a lot of flak as well even though they’re in that carer role; and I’ve said to them, ‘You cannot position yourself as the rescuer, or as the person with the most knowledge on that child, when you’ve got actual parents and carers who are telling you the indicators are completely different, in different situations,’ –for example, when they’re at home, at school, etc. It has to be collaborative.” *CSE trainer*

Suggestions were made for good practice, including limiting the number of professionals working with a child or young person. Rather than having a range of different professionals all working with the child, a less intrusive model is for one professional to take the lead and be the contact person for the child; all of the other professionals work with this single point of contact. Multiple professional involvement in the lives of children and young people was not regarded as helpful:

“Quite often, what a young person needs more than anything is just to feel safe and have some sort of consistency in their life. At the moment nothing we do normally provides them with consistency because of multiple professionals being involved, coming and going in and out of their life – if you look at a lot of children’s life stories, that’s exactly the problem that we’re trying to fix, and we just become another person that goes in and out of their lives.” *Police CSE representative*

Direct work with young people was said to be helpful in explaining to them why adults might be concerned and in helping them to identify risks:

“With the Distance travelled tool (DTT) much more, with the child, with the carer, we’re getting across... in my view of where the risk is, and trust me that the numbers [of risks identified] vary wildly. The child will say, ‘Well, I’m not at risk of that, I’m not at risk of that,’ [and] at the beginning of a piece of work the carer might say, ‘Well okay, I can see that and that,’ and the professional might hold their hands in the air and go, ‘My good god, you are at risk of all of these things so I’m really worried,’ and it’s also a good linking-off point for the worker to talk to the child and parent about how they see the risk. One of the indicators and outcomes for us is at the end of the DTT when a child says, ‘Do you know what, you’re right, when we first started I didn’t see these things as a risk, now I’ve had some direct work I can look at my risk around my internet use and I better understand. Actually, do you know what, I was taking a huge amount of risks at that point and now I’m more aware so therefore I am safer or more risk-averse’” *Manager of a missing service*

Whilst this approach does seem to be more productive, it still focuses very directly on the actions of the young person, rather than on the actions of the perpetrator of exploitation and how they may be ‘pulling’ a young person in their direction. For example, in some of the tools and checklists sent to the research team, a common pathway was to ‘educate to stay safe’ (see Appendix), implying that the responsibility is on the young person to ‘avoid’ CSE. As the LSCB Chair stated during interview, “Any plan should include disruption of the offenders.” The youth justice team leader also expressed concerns about the response being focused on the young person:

“Often their thinking is to remove them from the area, and that’s the ideal thing, but it’s not: you’re moving them from all their support networks, all their friends, and then that’s why these young people go missing from their placements. Or, the perpetrators go and pick them up, because they’re stuck in an area they do not know, with a family they do not know, and it’s a bit of a disaster. So sometimes it’s better to keep them where they are and try and work with them, with the police, to disrupt the behaviour of whoever the perpetrators are.”

3.10. Indicators of risk or actual harm?

As we noted in our EIF report (Brown et al, 2016), many of the indicators used in tools and checklists are indicators of actual harm rather than risk. Since this was assessed in our previous study, we did not assess it again in detail in this study; however, the issue is evident in the tools/checklists we were sent. In one of the tools, for example, two ‘medium level risk indicators’ are ‘receiving a reward for recruiting other peers to CSE’ and ‘reports of involvement in CSE’, while a ‘high level risk indicator’ is ‘child meeting different adults and exchanging or “selling” sexual activity’.

The interviews in this study also revealed that, in many areas, the concepts of ‘risk’ and ‘harm’ are being more widely conflated, with many tools/checklists and processes/policies being used to identify CSE harm rather than risk. In some instances the identification of harm is the focus, despite the terminology of risk being used: in one area, for example, ‘high risk’ means 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.

The risk categories used in the 11 tools sent to us are summarised in the Appendix. One tool has the following ‘serious risk of harm’ category:

‘A child who is entrenched in sexual exploitation, but often does not recognise or self denies the nature of their abuse often in denial, and where coercion/control is implicit.’

Whilst it is clearly important to identify children and young people who are being sexually exploited and abused, and to make immediate referrals when this information comes to light, the conflation of risk and harm is problematic and may mean that children who are at risk are not being identified, or that children who are being exploited are receiving a response aligned to risk reduction rather than an immediate child protection response to safeguard them.

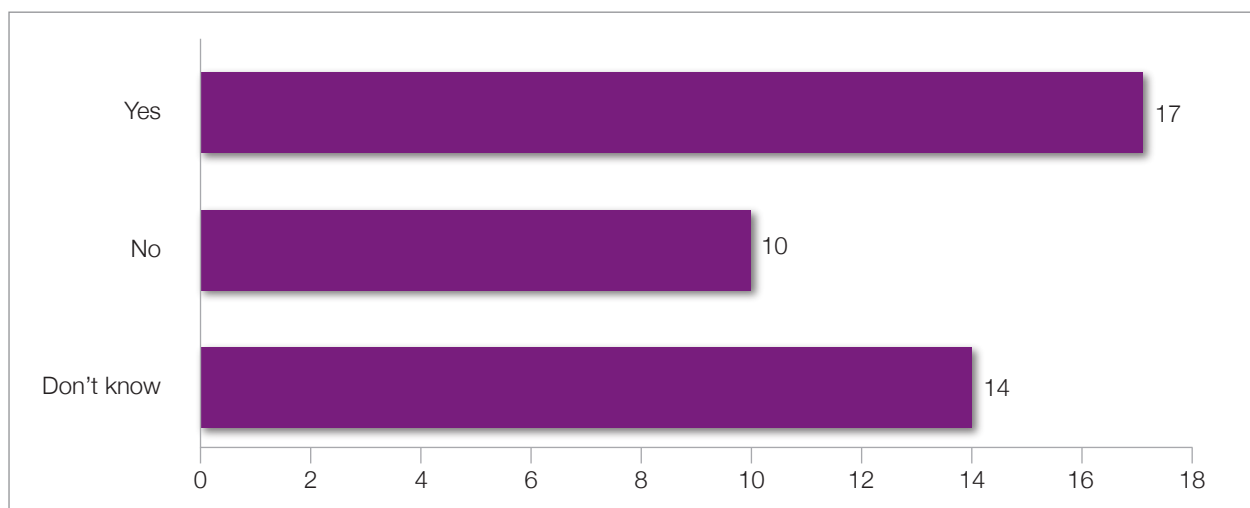
One interviewee suggested that, although it might be difficult to adopt a standard tool or set of tools across England and Wales, having an agreed definition/description of categories such as ‘high risk’ and ‘medium risk’ might be more feasible, as this would enable a shared understanding across services/regions. It would require each tool being used to be mapped on to the agreed ‘standard’ categories. As discussed in more detail later in the report, however, the use of ‘risk’ in relation to victims and potential victims can encourage victim-blaming, and so perhaps it would be better to avoid the use of ‘risk’ categories altogether.

The conflation of risk and harm is not always evident. For example, one tool has four items, including ‘abduction/forced imprisonment’ and ‘child under 13 known/suspected to be having sex’ in a list of ‘critical factors’, in addition to ‘high risk factors’, ‘medium risk factors’ and ‘vulnerabilities. Immediate referral is required if critical factors are identified. Given that the assessment process might be likely to indicate actual harm in many instances, this distinction between harm and risk should be encouraged.

3.11. Missing indicators of risk and harm

The survey revealed mixed opinions about whether there were other indicators of risk or harm not included on the tools or checklists (see Figure 5), while the interviewees who had a lot of experience of CSE identified gaps and raised issues regarding what was included on the tools.

Figure 5. Are there other indicators of risk or harm not included on the tools or checklists?



Source: online survey.

Survey respondents identified the following indicators missing from the tools and checklists they used:

- grooming/online grooming/cyber exploitation
- disability
- drug and/or gang involvement

- deprivation/poverty
- sexual interests and attitudes
- child's health/mental health needs
- history of domestic violence
- sex work in a family
- persistent absence from school.

Interviews provided an opportunity for professionals to draw attention to other issues not captured in the responses of the survey. The interviewees raised concerns in particular about whether the tools worked well for both genders:

“It doesn't really work ... I mean, how does a boy dress inappropriate for his age, almost.” CSE service manager

Some risk factors felt to be more relevant for boys (e.g. online gaming) were considered by interviewees to need more inclusion/prominence. In addition, the designated nurse identified gaps in tools being used in frontline services such as A&E or with GPs, who might miss indicators such as repeated urinary tract infections, abdominal pain, repeat gastro-infections or very visible signs such as branding of gang logos on a child or young person's body.

Concerns were also raised as to whether the tools/checklists should be used for younger children:

“Any child under the age of 13 that you thought was being exploited, you wouldn't sit and do a screening tool on, in my view.” CSE coordinator

Some interviewees raised the question of whether a more general vulnerability assessment would be suitable for younger children.

Several interview participants shared their concern that not enough attention was given to the issues that disabled children might experience, and whether professionals across agencies were aware of the increased risk of CSE for disabled children or had an understanding of how risk impacted upon the lives of young people with, for example, learning disabilities:

“[Regarding] learning difficulties and learning disability, I think still there's a huge amount of work – I don't think we've got anybody on the database in [the local authority] currently that's at risk that's known by Disabled Children's Services.” CSE service manager

“Learning difficulties would be the other area. I think that's a group that's hugely vulnerable and again when I've looked at young people coming... we're looking at about a quarter of those young people having support through special needs and education or they've got a statement for a learning disability, so high numbers but I don't think they've told us enough to capture that group.” CSE service manager

“The only issue we had with the SERAF really is children with learning difficulties or additional needs... It actually doesn’t record learning difficulties appropriately, but we do add a score for a child that’s got a diagnosis, and when you read through it does link in – it’s perhaps just not as overt as we would like.” *Manager of a missing service*

These concerns are not without foundation: Brown et al (2016) identified that, although there is currently a lack of good-quality research evidence on the indicators of risk of CSE, there is evidence to indicate that being disabled increases risk. The Department for Education recognises that, while any child may be at risk of CSE, disabled children may be particularly vulnerable (DfE, 2017), and evidence is increasing that children with learning disabilities are at increased risk of CSE (Smeaton, 2009; Beckett, 2011; Brodie and Pearce, 2012; Berelowitz et al, 2013; Franklin et al, 2015; Franklin and Smeaton, 2017).

Understanding of a child’s history and the impact of trauma was not felt to take prominence during the identification of CSE risk indicators:

“So we never really look at the story, it becomes accepted that 20 foster placements is just part of a young person’s past – no, it’s not. We need to look into that more in terms of how has that actually impacted on that young person, how has it impacted on the sense of whether they know who they are, their sense of grounding and belonging, their sense of forming attachments and how they feel about attachments. It’s so much more complicated than just sitting and ticking a box, like ‘Do they go missing’, yes, ‘Do they use drugs and alcohol’, yes, ‘Do they associate with other young people that may be CSE victims’, yes, ‘Do they get into cars of unknown’, you know – that might tell us what’s going on for that young person but those are just the presenting factors, they’re not the cause of it.” *Police CSE representative*

“It’s about having social workers who know about the dynamics of CSE, so why children will defend their abusers, trauma bonds, all those sorts of things, whereas the training’s all been about signs and indicators.” *LSCB Chair*

Victim-blaming was said to be inherent in the wording of some of the indicators:

“Some of the risk indicators need to be looked at: it is victim-blaming, we are making it that every child’s vulnerable. We are still making it that a child with two parents who go to work is not vulnerable, but a child from a low-income family with people who might be on social income is vulnerable. There are still things like that that really need to be challenged... [In] all the local authorities that I’ve trained at, everybody has pretty much got a copy-and-pasted version, but the indicators are always a contentious issue because people will always come from their own value systems. So, everyone has got a different impression of what low, medium and high mean.” *Manager of a missing service*

In addition, tools/checklists varied in their ability to assess change, with many tools including mostly 'static' factors (which do not change, or take a long time to change) rather than 'dynamic' factors. Some tools, for example, ask assessors to indicate whether an indicator is present within the last six months, so it is difficult to assess whether risk has been reduced over a period of two to three months.

The importance of taking into account factors other than those related to individual young people was also raised. The sharing of intelligence regarding 'hot spots' and offender profiles for geographical areas, as well as victim profiles, was needed to support assessment of risk for young people, helping to inform practice. The recent research by Kelly and Karsna (2017) reveals a wide variation in prevalence of CSE cases and a paucity of consistent data. In particular, the lack of data on the context, frequency and scale of abuse, and about perpetrators, makes it difficult to establish the number of current victims and the contexts and circumstances in which CSE takes place. Professionals are encouraged to see the behaviour of young people as being the focus of the problem, unless that focus is widened.

The tools/checklists generally included indicators of risk only, with no inclusion of protective factors. Some interviewees thought that there should be more emphasis on safety factors and positives. Research is needed, however, to identify appropriate protective and safety factors that should be included, also noting the previously discussed issue in respect of victim-blaming.

3.12. Assessment decisions/scoring

The responses from the survey and interview participants, and the tools that were emailed to the study team, all reveal that there are a range of ways in which the information in the tools is combined or added in order to aid decision-making. As discussed previously, this was an issue that was also raised in our previous study (Brown et al, 2016).

Of the 11 tools sent to the study team (see Appendix), eight ask the assessor to tick a box to indicate if risk indicators are present, and one requires indicating 'yes', 'no' or 'possible' for each indicator; six of them employ a method of assessment based on the number of boxes ticked, with some allowing the inclusion of written comments while others have little space to add information.

The ways in which the number of indicators is used to determine the overall risk category varies across the tools. In some it is not clear from the tool alone how this is done, while in others it is very specific: for example, in one tool the indicators are separated into critical/immediate referral, high risk, medium risk and vulnerability factors, and specific actions are directed based on the number of indicators identified in each of these areas.

As we identified in our previous study, this range of approaches is problematic in that a child/young person might be identified at a certain level of risk on one tool and not another, and the specificity of the scoring in some tools is not in keeping with the limited evidence base for the link between indicators and risk.

The way in which overall decisions are reached is closely related to the extent to which tools encourage the use of professional judgement, which is discussed in more detail in section 3.11. However, as has been discussed above, some of the criticisms of the tools raised by survey participants related to the tick-box and scoring approaches often used in these tools. The issue was also raised during interviews.

“I’ve seen... tools where in areas ‘not known’ got a ‘zero’, so five ‘not knowns’ brings the score down... ‘Not known’ needs further investigation... but if you’re going to have a methodical add-up at the end and it’ll get to this position... there is no empirical evidence about how that score has been allocated, but it gave a sense of security, I think to practitioners, managers and senior leaders.” *LSCB Chair*

“I had one the other day, which I looked at just by default, where there were about four reds and somebody had put there was no evidence of CSE. I had to write back to them and say, ‘Can you explain to me how there’s no evidence when you’ve ticked these four?’ That is the professional judgement bit, really.” *CSE coordinator*

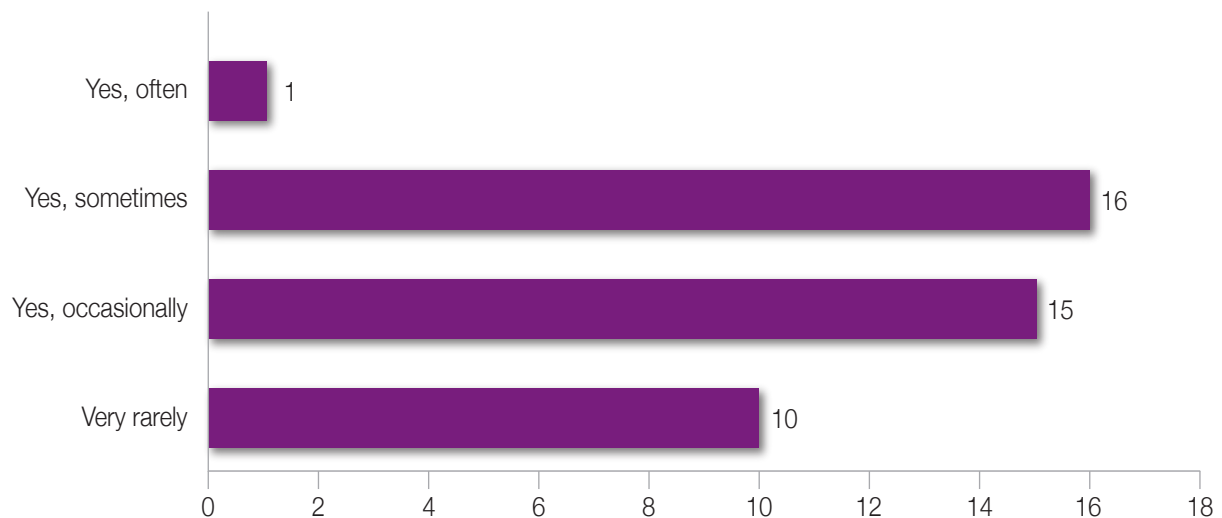
In cases where indicators of risk are identified, but the tool or checklist does not indicate that the threshold of harm or serious risk has been reached, the interviewees reported having additional meetings, gathering more information, being more cautious and using professional judgement. The survey participants described a range of responses:

- Discuss in a team and have a professional view (i.e., in a professionals’ meeting).
- Professional judgement used (tool not the deciding factor in some responses).
- Referred to senior staff/practitioners for professional judgement/refer to social worker.
- Multi-agency input (seek advice from GP, safeguarding teams, social workers, local authority etc.).
- Look at historical and current information.
- If in doubt, err on the side of caution.
- Case would not continue under CSE protocol, referred to child protection/safeguarding policies and protocols.
- Overrule threshold and emphasise the outstanding and important needs.
- Continue working with the child/young person but flag up the concerns.

3.13. Professional judgement

Asked whether the tools allowed them to use their professional judgement sufficiently, a large majority of the survey participants (n=33) felt that they did, with only nine feeling otherwise; these nine came from across social care, police and health services. However, 32 participants reported that tensions arise often, sometimes or occasionally between professional judgement and the use of the tools (see Figure 6).

Figure 6. Are there tensions between professional judgement and the use of these tools?



Source: online survey.

As described above, 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 [...] what we were finding was that people were using the tool and there were 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*

However, not all interviewees felt that professional judgement was encouraged enough, and in some cases it appeared that it was positively discouraged:

“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, blah-blah-blah.’ They’re getting emails back saying, ‘Do not write on this tool, I’ve taken off your comments.’” *CSE trainer*

“I think we train professionals to listen to their gut feelings, and then we say, ‘Now, go and put those gut feelings into a screening tool.’ But your gut feelings don’t translate into a tick box. I think what we did with our screening tool is we added an extra box and said, ‘And then, as a professional, tell us how you feel.’... And I think people who go into this field, they do know children, they do know families, and we have to respect that something doesn’t feel quite right. But how that translates into a screen or a risk assessment, I can’t help you.” *Manager of a missing service*

The survey respondents noted 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:

- Professional judgement used/experience/instinct – tools and checklists are only there to aid professional judgement (n=9; health care, police, social care, voluntary organisation)
- Discussion/meeting held to raise concerns by professionals/agencies involved (n=7; CAMS, health care, police, social care, voluntary organisation, youth justice)
- Gather more/clarify information (n=4; social care, voluntary organisation) Social care staff are able to challenge scoring they don't agree with (n=1; social care)
- Concerns discussed with managers/safeguarding teams/CSE specialist nurse (n=2; social care, voluntary organisation)
- If in doubt, treat as high risk until further information has been assessed (n=1; voluntary organisation)
- Family, as well as professionals, needs to be involved with discussions too (n=1; social care).

Some participants said they had no experience of conflict or it rarely happened (n=3; health care, social care, voluntary organisation).

However, this was not without its challenges: some professionals interviewed were concerned that inexperience and/or an over-reliance on tick boxes impinged upon the use of professional judgement.

“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 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, 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*

One interviewee had particular concerns about how a possible lack of understanding of CSE combined with the use of professional judgement might leave children at risk, or in situations of sexual exploitation.

“The GP screening tool is really interesting because it goes through all of the... and then they'll ask questions: 'Is the child Gillick competent?'"* I've argued for a long time, how can you have a tool that then asks if a child is Gillick competent? Because the doctor may then instantly tick that and then think, 'Well, actually they're competent,' so everything else there pales to insignificance in some way. So the GP tool is a real concern.”
CSE service manager

*A term used in medical law to decide whether a child under 16 years of age is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

3.14. Actions following use of tools and checklists

All survey and interview participants described that the tools and checklists were used to determine the type of action, level and type of services/support provided to the child/young person and their family. For example:

“Decisions are made based on the risk level:

- Mild – educate to keep safe and monitor.
- Moderate – agencies obligated to educate YP and family to keep safe, monitor situation and call for initial CSE strategy meeting.
- High/significant – Strategy meeting held, safeguarding plan generated, decisions concerning implementation made. Review strategy meeting set.
- Decision for the level of intervention required.” *CSE practitioner.*

“The tool is used to identify risk level. Depending on the level of risk a child is identified as, different services are offered, e.g. low risk = voluntary sector, medium/high = allocated a social worker. In my experience, it is very difficult to reach the threshold for intervention for Children’s Services in cases of CSE.” *CSE trainer*

These two examples, and the range of action pathways for categories of risk found in the tools sent to the study team (see Appendix), reveal a wide variability in the types of responses/services allocated across regions/services/authorities, although the general principle is that more support/services and/or more agencies are involved in cases deemed to be of high risk than those of lower risk.

In some areas, young people who screened ‘low’ would be rescreened at a later date if it was felt their risk was increasing. Some professionals raised concern that young people who were scored ‘low’ were not always getting a relevant service:

“Sometimes we’re hearing the names of moderate-risk children when they may be 12 or 13, and then they’re coming into service when they’re 15 or 16, by which time they’re actually at significant risk or are being exploited. So I think this is something about we’re missing children at an earlier point.” *CSE service manager*

A ‘medium’ or ‘high’ screening score would often lead to a referral to a specialist provider and/or the CSE team, but some raised concerns that it was difficult to get the appropriate support/services:

“Thresholds are so high, trying to get a CSE referral through the door is nigh impossible because you hardly ever work with a disclosure, so you’re writing things like ‘Goes missing’ or ‘Seen in unusual car’, that compared with someone who’s writing in and saying, ‘I’ve seen them smack their child’ isn’t going to be a priority.” *Social worker*

“And then, obviously, the application of resources: if colleagues are saying, ‘Actually this is high risk, what are we going to do,’ and we don’t have the resources... what are we going to do with a child that’s 17½ and doesn’t want to do what we want them to do to be safe? They are able to make those decisions and choices, and sometimes we are limited on resources... although we do try with every child.” *Manager of a missing service*

Reference was made to the increased role that schools could and should play in identifying when something is occurring in the life of a young person. School staff spend a lot of time with young people and may notice changes; also, young people may trust them and be able to signal when things are not quite right. With schools on board as well as all other agencies, one participant described this kind of multi-agency response as ‘the dream team’. A school PSHE lead described the response from Multi-Agency Support when a school concern is referred in. They take it, assess it, refer to Children’s Services or CAF or:

“They’ll just say, ‘It’s not a prominent enough issue at the moment, you can deal with it internally’... Then it’s about us trying to build up more evidence to try and get it up onto a higher level... With some of our pupils and some of the issues they face, time is really against them in some cases – you kind of have to get things done quite efficiently, otherwise they can get worse quite quickly.” *Head of PSHE (secondary school)*

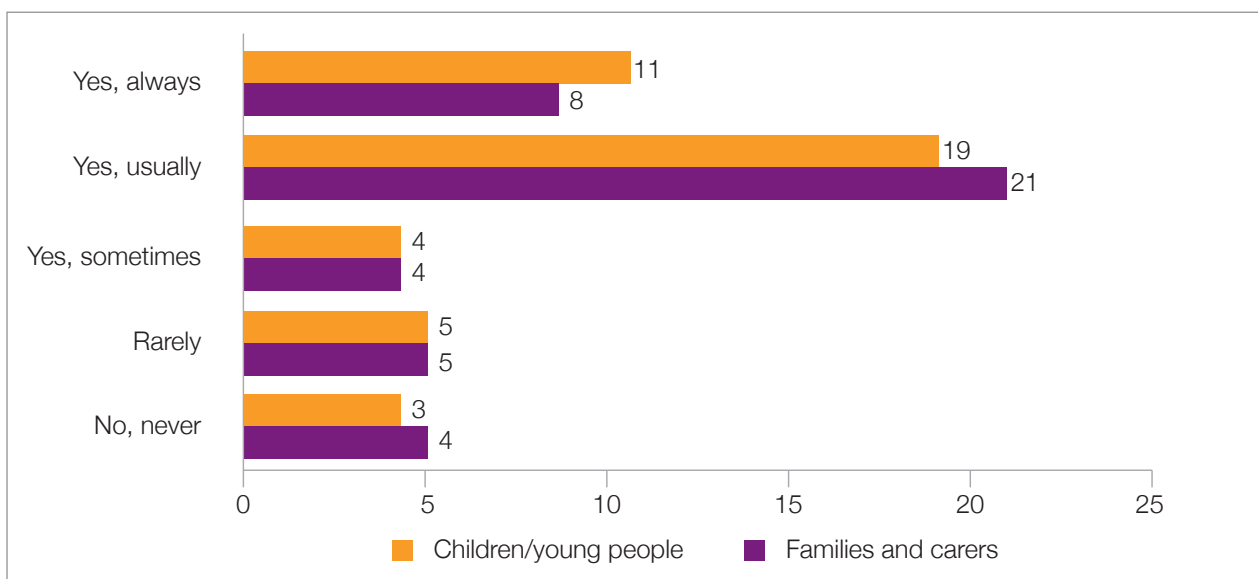
More PSHE and more preventative work was said to be needed, particularly around teaching about healthy relationships. Some staff were prepared to undertake preventative and protective work (delivered in a variety of ways, including through play) with pupils who have emotional difficulties and harmful sexual behaviours, but they experienced difficulties too:

“A lot of our challenges are in getting people in and getting the services that we need... The strain on services is one of the bigger things that we have problem with: I mean, you try and do things in-house but sometimes you need a professional.” *Head of PSHE (secondary school)*

3.15. Reviewing of cases

In the majority of cases, it is the standard procedure or practice to review and repeat (e.g. after a particular time period or in specific circumstances) the CSE risk assessment tools/checklists, as shown in Figure 7.

Figure 7. Are the assessments using the CSE risk assessment tools/checklists reviewed and repeated?



Source: online survey.

Across the survey and interviews, there was a great deal of variety in how the cases were reviewed, by whom, and the frequency and outcome of these processes. Although there were generally clear procedures for reviewing cases, some difficulties were identified:

“People will downgrade them and then within weeks they’ve upgraded again... I don’t know whether we need [the review period] to be more six months, but it is three months... Sometimes there’s over-optimism because we know the details of what’s going on, and we’re meeting them – you know, it’s almost like they go from high and then because there’s a bit of protection around them we sort of mark them down to medium whereas actually they’re still high. I think that’s one thing that we’ve really learnt about, and we’ve seen children go very up and down between the levels.” *CSE coordinator*

As noted above, reassessments were often noted as challenging, particularly given the limited ability of the tools and checklists to monitor change.

“The tool relies on static factors which will never change, so in terms of using the tool to measure shift, it’s not that great because a lot of those factors will never change for this child – the sexual abuse, the physical abuse – so that his life experiences will remain. And again there’s not a focus on protective factors, so I think in terms of my discussions with xxxx it will definitely be ‘Can we also focus on protective factors?’ Because while we know some children have very high SERAF scores, if things like their accommodation are improved, their access to supportive adults, their more appropriate social relationships or development of better problem-solving skills, actually those protective factors can really reduce risk – but if we were to use the tool to measure shift, those protective factors or dynamic protective factors are not included. So I would definitely like to see some more of that.” *CSE service manager*

“CSE toolkits are not humanistic enough, and they’re not holistic enough – they don’t see the child as a person, they see the child as an issue or a risk. So they miss underpinning issues, and they miss wider broader issues because the child is seen like a CSE dichotomy: Is CSE happening? Yes/No.” *CSE trainer*

3.16. Child Protection procedures versus specialist CSE procedures

During interviews, some professionals questioned whether a special CSE procedure is actually needed. Specialist teams who regularly use risk assessment tools are often seen as the experts and can support other workers to use the tools in the most appropriate way. A few specialist CSE workers reported that some social workers may struggle to complete them, and that scores do not always reflect the situation:

“For a long time, social services haven’t been the experts, and it’s probably a bit of an uncomfortable position for them to be in.” *CSE worker*

Opinion was divided on whether prevention of CSE does or does not sit easily within Child Protection procedures. Some said the Child Protection system does not work for children at risk of sexual exploitation, as it is more appropriate for familial abuse and for younger children. Others said that the standard initial assessment carried out within Child Protection procedures is a process that is suitable for identifying CSE, as it is a form of child abuse.

“It is as though we are saying this is a type of abuse that social workers cannot identify in the same way they can identify all the other types of abuse that they’ve been trained to identify and have been identifying for years.”

Social worker

Some interviewees indicated that what needed to happen was the development of practice and the system to be able to mainstream a response to CSE which is a safeguarding response but outside the traditional safeguarding system.

“If you are worried a child is being sexually abused in the home, do you need a checklist as long as your arm, with a load of different levels and scores etc.? No, we just do needs assessment, or we look and we do what we’d do for any form of abuse or neglect. And I’m saying to them, ‘Why is CSE just not in that? Why has CSE been siloed off? Why is it special, it’s just a form of abuse?’ CSE trainer

The specialisation has led to separate teams of CSE experts being created. Whilst CSE specialists were positive about this development, some participants were uncomfortable with the way the teams then worked with other professionals. It was noted in one area that having a separate room with a key card access within Children’s Services was already creating a barrier so that conversation such as ‘This name has come up, have you heard of him before?’ would be less likely to occur naturally. It was stated that the key to challenging CSE was to share information, notwithstanding confidential information regarding police investigations which understandably could not be disclosed until a certain point.

3.17. Accountability

Missing out on an overview of all risk and vulnerability was a big concern. Sharing information centrally was said to more appropriately inform a course of action. As this is a single agency response, the manager of a missing service noted, “you are only putting information that you have got on that day into the MASH”. Yet sharing information was also felt not to be enough:

“Multi-agency meetings should result in actions for individual workers that need to be monitored so that the question ‘Has the risk been reduced?’ can be asked at any follow-up meeting. Ticking a box to say a referral to a service has been made is not enough.” Social worker

The suggestion was made that the LSCB should be sitting on or leading CSE strategy meetings, to ensure that policies and procedures are being followed, regularly reviewed and updated. Agencies should share information wherever possible. With the police, information-sharing is more difficult and confidentiality is important when investigations are taking place:

“But the police do need to be a bit more proactive in letting the professionals know that they are doing something... because sometimes you just feel like you’re feeding information into a black hole and you feel that you’re the only person in the world that cares... There’s got to be some reciprocity, even if it is the police just saying, ‘We are working on this.’ *Social worker*

In addition, quality assurance was of concern to some. When there was a discrepancy in the judgement of risk, through the use of the tool or written comments, some professionals would have liked a senior manager to look at each case. Pathways in terms of interventions are not that structured or developed, and the recording of information on databases can become muddled. For example, issues of CSE can be mixed with missing children and gang-related activity, although often issues are not discrete and do overlap.

4. Future steps for practice and research

The aim of this research was to explore the use of screening and assessment tools and checklists used across England and Wales. The study revealed that a wide range of tools are used across England, with a single tool and policy being used across Wales. Moreover, there are a wide range of practices and processes in terms of who completes the tools, how they are used and the decisions that are taken based on them. This raises a number of concerns in terms of children and young people being assessed differently depending on the tools and processes being used, and the difficulties for professionals who work across jurisdictions or areas so are required to use a number of different tools and processes.

Professionals taking part in the research highlighted the complexity of screening and assessment which involve a focus on the behaviour of children and young people and other wider factors, not necessarily within the control of children and young people.

4.1. Limitations of the research

There are a number of limitations to this exploratory study. The research took place over a short period, with the online survey being available over the period 3–22 March 2017. We aimed to reach a wide range of organisations through email, social media and the NWG network; participants were self-selecting. The participants in face-to-face and telephone interviews were purposively selected to represent the key sectors with a remit for safeguarding and protecting children and young people – CSE specialist workers, managers and trainers; children's social care; police; youth justice; health; education – across statutory and third-sector organisations. More participants than responded within the timeframe were approached to be interviewed. Participants were asked to provide a sample of the screening and risk assessment tool that they generally used; these were then included in the review. A review of peer and grey literature was not part of this study, although we support the commissioning of a review which would complement and contextualise this research.

A number of additional questions and issues were raised about processes and procedures related to safeguarding children and young people from CSE, which are beyond the scope of this short research report: for example, the acceptance of the social and media construction of CSE which has led to a focus of identification of risk in young people's behaviour and a focus on particular forms of CSE, such as that involving networked groups and grooming.

The study did not focus specifically on Wales, and there would be valuable lessons from a specific focus on the Welsh context. Wales uses one tool, the SERAF and also has guidance in place for its use across Wales. A review of the SERAF in Wales was taking place at the same time as this study. That review and its development could inform wider learning and might also benefit from understanding derived from this study.

4.2. Process and purpose of screening and assessment of young people

Currently **a vast number of different processes, tools and checklists, and patterns of scoring and decision-making, exist**. This leads to differences in practice and responses across local authorities and services, meaning that a child might meet a certain threshold within one local authority/region or service but not another. In addition, the use of tools for screening purposes or to complete detailed assessments is often conflated or not clearly specified.

- **Greater clarity** needs to be developed as to whether tools are to be completed for **screening** – e.g. to identify those who are potentially at risk and for whom further assessment or support is required – or for **assessment**. In some instances, tools were used to aid interventions with young people. It is not clear if a single tool should be developed for all these purposes, or if separate tools are needed. Some services/ areas had adapted tools (for example, for screening by health professionals), which further raises questions as to whether different tools are needed for different professional groups. One way of determining this would be to test a preferred tool in practice, evaluate it and provide some level of ‘quality assurance’ as to whether it worked consistently. It is important that everyone involved in assessing and providing support to a child has a shared understanding and language, as far as that is possible given different roles and responsibilities.
- A standard CSE tool would deliver more consistent assessment and practice; however, given the investment and training that services and areas have committed to the development of the tools they use, the point made above, and the associated training and expertise developed in using these tools, this may be difficult to achieve in practice.
- Previous research (Brown et al. 2016) has found a lack of research evidence on the reliability and validity of CSE tools; this was also discussed by participants in the current study. This means that a level of scepticism should be retained and tools should be used to guide and underpin, rather than determine, decision-making. Professionals in this study highlighted a number of limitations of a rigid scoring approach and the use of a limited number of ‘risk’ categories which do not reflect the needs of the children and young people concerned, and which also encourage victim-blaming.
- In completing any screening or risk assessment tool, professionals should keep in mind that it is part of a wider context. Greater clarity is needed as to **how situational, environmental and perpetrator or potential perpetrator factors are included in CSE risk assessment and prevention strategies**. Less focus on the ‘risk’ of a young person and more consideration of the wider causes of any presenting behaviour are welcome. A focus on factors external to the child or young person is crucial to understanding CSE as part of a wider issue and to gathering information about those who are exploiting others, and the contexts and circumstances within which exploitation takes place. Without this wider view, scrutiny will remain on the young person; sometimes, inadvertently, the message given is that they are responsible for protecting themselves and avoiding harm, rather than the responsibility lying with those who wish to exploit children and young people.

- **Care is needed to avoid victim-blaming** and placing all the emphasis for preventing CSE on young people and their families. Increased understanding of the push and pull factors around CSE would help to ensure that this was addressed. Victim-blaming is apparent in the language and terminology reportedly used by some professionals, and is also present in some of the screening and assessment tools. For example, using the phrase ‘putting herself at risk’ or referring to a child as ‘high risk’ rather than a vulnerable young person.
- The importance of **appropriately involving children, young people and their parents in the assessment process** should be stressed. Parents and carers’ active involvement in care and safety planning may enhance the likelihood of success. The inclusion of children and young people and their families requires care and attention to ensure that the process is not disempowering. McNeish and Scott’s (2017) report on supporting parents of sexually exploited young people contains additional information.
- It is very important that **‘harm’ and ‘risk’ are not conflated**, and that a distinction is made between identifying children and young people who are being sexually exploited and abused, and identifying those who are at a potential risk of being abused and exploited.

4.3. Tools in current use

A number of risk indicators were identified that are generally not included in tools, or are missing from some tools in particular: for example, risk indicators for boys, disabled children and online communication are often missing. The threshold for being identified at risk is high in some tools, and many of the medium and high risk categories used are indicative of exploitation or high risk of harm: this means that strategies are lacking to prevent risk early in those that are low risk, or young children who are likely to be at risk as they move into adolescence. There were some examples where professionals said the tools were used to assign resources rather than identify vulnerabilities. Hence **tools should be reviewed and researched to ensure that they include appropriate risk indicators**.

Scoring and the overuse of ‘tick boxes’ was generally not favoured by participants. Tools requiring assessors to provide details of the indicators that they have identified have the most support.

- **Scoring should be discouraged** as it does not reflect the fact that in some instances a single factor (e.g. the development of a ‘relationship’ online) could increase risk considerably without the need for any other indicators of risk to be present, while in other instances a range of indicators might combine to increase risk.
- **Indicators of harm should be distinguished from indicators of risk**, with appropriate action pathways for each.
- **The use of ‘risk’ categories should be reviewed**, firstly so that risk is not conflated with harm but also to discourage victim-blaming terminology and practice.
- Consideration should be given to **ensuring that young and/or vulnerable children and young people are being identified early**, as it is likely that prevention strategies can be more effective at an earlier stage of intervention.

- **The development of tools to prevent CSE seems to have occurred in isolation from the expertise and knowledge developed in relation to the assessment of perpetrators' risk of harm.** Much can be learnt from tools which have been developed to assess risk from research carried with perpetrators: for example, an approach that does not score risk (Douglas et al 2013). This approach takes into consideration that a single factor could be crucial in increasing one individual's risk, while particular combinations of factors combine to increase risk for others; many of the participants in this study indicated that the tools they used did not always allow for such consideration. It also clearly links the risk factors identified to the risk management plan – another area that is lacking in the CSE tools. Although the evidence base is much less developed in relation to risk of CSE, much could be learned from this approach that could strengthen CSE risk tools and practice. Tools and checklists should be based on the available evidence and include indicators of risk identified in this report (and elsewhere) as being missing, such as dynamic variables and protective indicators.
- Screening and assessment tools play a role in the protection of children and young people, but they cannot present the whole picture. They should **be used by professionals as a point of discussion of the needs of a child or young person.**

4.4. Training

The use of any tool is reliant on professionals having appropriate knowledge, training and a shared definition and understanding of CSE, harm and risk. Many participants raised concerns that some professional groups, or those who were recently qualified or new to work in this area, would find using these tools more difficult than experienced professionals, or CSE specialists.

- **Training and guidance should go hand in hand** and always be provided around the use of tools for assessing the needs of young people, including any risk or harm, focused on recognition of CSE and other harms and appropriate responses.
- Different training approaches and resources such as guidance/toolkits to support the use of tools are likely to be needed for different groups of professionals and those with varying levels of CSE expertise and knowledge. **The usefulness of multi-disciplinary training was particularly highlighted, and the opportunity for discussion valued.** All training should include exploration of the push and pull factors in CSE, and the reasons why young people become involved or are targeted, rather than just the presenting behaviours and signs to be aware of. The story behind each young person's experience is just as important.
- **Guidance on how to complete screening and assessment** is also important, helping practitioners to understand the dynamics of CSE and the decisions that are likely to follow in response to their screening or assessment.
- **Training needs to be ongoing and embedded**, part of continuing professional development, particularly given the rapidly changing policy and practice landscape.

4.5. Research

There are a number of ways in which practice in this area could benefit from additional research, as listed below. It should also be noted, however, that a great deal of research has already been conducted in relation to child sexual abuse, risk assessment and sexual aggression more generally, that is relevant to CSE. This fact has tended to have been overlooked in practice developments in England and Wales in respect of CSE to date, and **more attention should be paid to this wider body of research evidence.**

- There is limited research evidence on which to identify the indicators (risk and protective factors) that should be included in the tools. **Research is needed to identify and validate both risk and protective indicators in respect of CSE**, including indicators in young children, disabled children, boys and those at early stages in the pathway towards CSE victimisation.
- Although professional judgement was generally favoured, and a number of limitations and difficulties were identified with the use of 'scored' tools, no research in this area has been conducted, and expertise in the broader forensic risk assessment research/practitioner knowledge and experience has not been used to assess or evaluate the best approach(es) to use in identifying potential victims. **Existing and newly developed tools require evaluation, alongside practice including the use of tools, to identify best practice in strategies to encourage professional judgement.**
- Taking account of the findings of the forthcoming report in respect of the SERAF and practice in Wales, research is required to assess whether a **single tool or set of tools** (e.g., one for screening and one for assessment, or tools/checklists tailored for specific professional groups) can and should be adopted across England and Wales. This should include research on tools that would be suitable for professions where there is a need for swift screening evaluations (e.g. in healthcare).
- Research is required to **assess the effectiveness of support and intervention pathways** for children and young people (along with their families) who are at different levels of risk of CSE or who have been sexually exploited, and to identify and share current best practice.

4.6. Final reflection

The professionals who contributed to this research have a range of knowledge and experience to draw on; the interview participants, with considerable experience, have been reflecting on their practice in this field, to varying degrees, over time. Any move to improve practice should draw on this wealth of expertise amongst frontline workers, managers of services, and those responsible for safeguarding children at a local and regional level. Priorities for improving responses to children and young people should combine this experiential and professional knowledge with research evidence of what is known about risk and sexual exploitation, to work towards effective and meaningful practice that centres on responding to the needs of children and young people.

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Appendix: Scoring methods, risk categories and actions pathways of the tools and checklists received

Tool 1

How risk is assessed

Write a level of risk against each of the 14 risk indicators. One tick in a high risk box, or several in low risk, may indicate a serious risk of sexual exploitation; alternatively, this might be an indication of other concerns that require addressing via the child's overall plan, or by accessing other appropriate services. At the end, write an overall analysis.

Risk categories

- No risk** Whilst there may be concerns for the welfare of the child/young person, which may involve the requirement of service provision for other assessed risks, the assessment indicates that there is no current risk of the child/young person being at risk of or experiencing sexual exploitation.
- Low risk** The indicators and assessment raise some concerns that the child/young person is at risk of sexual exploitation, and/or places him/herself at risk. Concern that the child/young person is at risk of being targeted or groomed, but there are positive protective factors in the child/young person's life.
- Medium risk** The assessment indicates that the child/young person is vulnerable to being sexually exploited, but that there are no immediate/urgent safeguarding concerns. There is evidence the child/young person may be at risk of opportunistic abuse, or is being targeted/groomed. The child/young person may experience protective factors, but circumstances and/or behaviours place him/her at risk of sexual exploitation.
- High risk** Indicators/assessment/evidence/disclosure suggests that the child/young person is assessed to be engaged in high-risk situations/relationships/risk-taking behaviour, and is at immediate risk of or experiencing sexual exploitation. (They may not recognise this.)

Action pathways

Please use this tool in line with local LSCB Procedures. Consider ALL of the 14 risk indicators and record a level of risk against each, before proceeding according to local procedures.

Tool 2

How risk is assessed

Tick boxes in each section. If a certain number of boxes are ticked in each section, there is an action to take.

Risk categories and action pathways

<i>Risk category</i>	<i>Action pathway</i>
Critical Factors	Immediate referral
High Risk Factors [two or more are present]	Contact Children's Social Care/Police.
Medium Risk Factors [five or more are present, or two or more plus a high risk factor]	Contact Children's Social Care/Police.
Vulnerabilities [five or more are present, in combination with two or more medium risk factors and/or one high risk factor]	Contact Children's Social Care/Police.

Tool 3

How risk is assessed

Tick boxes if indicators are present. Can also write comments alongside each indicator. Summarise concerns and make a professional judgement on whether to take action.

Risk categories

Risk levels are not used.

Action pathways

- No further action required.
- Discussion with the Safeguarding Team.
- Discussion with social worker/health visitor/school nurse.
- Completion of a referral to Children's Social Care and a copy to be sent to the Safeguarding Children Team.

Tool 4

How risk is assessed

Tick boxes if 'serious risk indicators', 'risk indicators' or 'vulnerability factors' are present; use professional judgement to determine the risk level and explain the reasons for this.

Risk categories

Category 1: Low – at risk of harm

A child who is at risk of being groomed for sexual exploitation.

Category 2: Medium – significant risk of harm

A child who is targeted for abuse through exchange of sex for affection, drugs, accommodation and goods etc. The likelihood of coercion and control is significant.

Category 3: Significant – serious risk of harm

A child who is entrenched in sexual exploitation, but often does not recognise or self denies the nature of their abuse, often in denial, and where coercion/control is implicit.

Action pathways

The presence of one significant risk indicator necessitates action as set out in LSCB procedures.

Category 1 Delivered as a single agency or integrated into existing multi-agency plan. Educate to stay safe. Work with children, young people and families to develop an awareness of the risks that can lead to a situation in which they may be exposed to sexual exploitation. Ongoing review of risk required, particularly if there are significant changes in circumstances. Inform CSE coordinator of young person considered to be at risk of CSE so this can be captured by LSCB. Use the police information report form to share information on victim's or perpetrators.

Category 2 A multi-agency approach is likely to be needed. A multi-agency referral form should be completed along with a screening tool. Follow local procedures e.g. CAF or LSCB Safeguarding Procedures for Children at Risk of Sexual Exploitation (Section 34). Inform CSE coordinator of the young person considered to be at risk of CSE so this can be captured by LSCB. Discuss with Police missing episodes and Barnardo's, and referral for return home visits to be completed. Work on risk awareness and staying safe should be undertaken with children and young people. A planned programme to raise awareness of sexual exploitation and to provide tools for children and young people to self-protect is required. Ongoing review of risk required, particularly if there are significant changes in circumstances. MASE (Multi Agency Sexual Exploitation) will be convened and risk assessment form completed.

Category 3 Follow the LSCB Safeguarding Procedures for Children at Risk of Sexual Exploitation. A referral will be needed and a multi-agency strategy meeting should be convened in relation to children and young people assessed as at 'significant risk'. Participants of the meeting should agree a protection plan and action to include long-term intensive direct work with the individual child or young person. Risk should be closely monitored and regularly reassessed as part of the risk reduction process. The Plan to include actions in relation to perpetrators. MASE meeting will be convened and risk assessment form completed. Joint investigation between police and Children's Services. Inform CSE coordinator of young person considered to be at risk of CSE so this can be captured by LSCB. Intervention by Barnardo's who will conduct return interviews and assessments and work proactively with parents/carers and families.

Tool 5

How risk is assessed

Tick boxes if low, medium or high risk indicators are present.

Risk categories and action pathways

<i>Risk category</i>	<i>Actions</i>
Lower risk level [one or more low risk <i>indicators</i> identified]	<ul style="list-style-type: none"> • Educate to stay safe • Make links with One Point • Ongoing review of risk
Medium risk level [any of the low risk indicators and one or more medium risk indicators identified]	<ul style="list-style-type: none"> • Regarded as a Child In Need • Consider multi-agency planning meeting to agree a prevention plan to address risk and a disruption plan for offender(s) • Regular CIN until child/young person exits CSE
High risk level [any of the low/medium risk factors and one or more high risk indicators identified]	<ul style="list-style-type: none"> • Immediate police and Children's Care joint investigation required for all high risk cases. • Multi-agency meeting for prevention plan/disruption plan. • Consider need for Initial Child Protection Case conference.

Tool 6

How risk is assessed

Written answers to questions regarding six areas of the child's life, then a professional analysis to identify any indicators of CSE.

Risk categories

Risk levels are not used.

Action pathways

If you have identified risks or concerns, please discuss with CSE/Safeguarding Lead and follow your own child protection policy and procedure.

Tool 7

How risk is assessed

Tick boxes and give a total score, with the option to write additional relevant information.

Risk categories

0–5 = Category 1: Not at risk	A child or young person who may be ‘in need’ but who is not currently at risk of being groomed for sexual exploitation.
6–10 = Category 2: Mild (Standard) risk	A vulnerable child or young person who may be at risk of being groomed for sexual exploitation.
11–15 = Category 3: Moderate (Medium) risk	A child or young person who may be targeted for opportunistic abuse through exchange of sex for drugs, accommodation (overnight stays) and goods etc.
16+ = Category 4: Significant (High) risk	Indication that a child or young person is at significant risk of or is already being sexually exploited. Sexual exploitation is likely to be habitual, often self-denied and coercion/control is implicit.

Action pathways

Category 1	Educate to stay safe. Review risk following any significant change in circumstances.
Category 2	Work on risk awareness and staying safe should be undertaken with this child/young person. Review risk following any significant change in circumstances.
Category 3	Convene multi-agency meeting under local protocol for sexually exploited children and young people to ensure effective exchange of information with multi-agency colleagues and agree protection plan. At least one review meeting to be convened. Work should be undertaken with this child/young person around risk reduction and keeping safe.
Category 4	Convene multi-agency meeting under local protocols for sexually exploited children and young people to ensure effective exchange of information with multi-agency colleagues and agree protection plan, including regular review meetings. Protection plan should include long-term intensive direct work with the child/young person.

Tool 8

How risk is assessed

Tick boxes to show vulnerabilities and risk indicators that are present, then make a written professional judgement.

Risk categories

Risk levels not used.

Action pathways

Having considered the vulnerabilities and risk indicators above, in your opinion is this child/young person at risk or suffering child sexual exploitation? If so, why?

Having answered this question, talk to your Safeguarding Lead within one working day, about what action you should now take. This may include internal monitoring through use of the Early Help Assessment or where you believe this child meets Level 3 or 4 of the [local authority] guidance.

Tool 9

How risk is assessed

Write yes/no/possible for each domain of risk indicators and then write a risk analysis after each domain. Total the number of high/medium/low risk indicators that have been marked and then give an overall risk score.

Risk categories

If you have ticked any indicators, refer to the behaviour chart to support your decision-making about the level of risk this indicates. Then complete Part B, risk assessment section, agreeing the risk level with your manager or lead CP safeguarding lead.

Action pathways

The tool is to assist you in assessing the possibility of sexual exploitation; it is not intended to be a referral form.

If you have not identified CSE concerns in the screening tool but remain worried about the child's safety, refer to MASH.

Tool 10

How risk is assessed

Tick boxes if risk indicators are present and rate how high the risk level is in each case. A few details can be written beneath each indicator.

Risk categories

High Risk Screening and risk assessment indicates evidence that the child is actively being sexually abused. Should be level 4 on continuum of need and will require a children's social care intervention.

Medium Risk Screening and risk assessment indicates evidence that the child may be being sexually abused or at significant risk of exploitation. Level 3 or 4 on the continuum of need requiring a social worker or named lead professional.

Low risk Screening and risk assessment indicates evidence that the child may be vulnerable to exploitation and sexual abuse. Level 3 or 2 on the continuum of need and will need a named lead professional.

Action pathways

Proceed according to local procedures.

Tool 11

How risk is assessed

Provide written answers for identifying risks. The 'Explanations and Conclusions' section involves a number of ratings and scores.

Risk categories

Risk levels are not used.

Action pathways

- Intervention Indicators including Scaled Approach and recording of other plans in place.
- Key areas of intervention where priorities are identified under five key outcomes areas:
 1. Goals and life opportunities
 2. Not Offending
 3. Not hurting others
 4. Keeping safe
 5. Repairing harm
- Resources and Proposals to record areas for further action and referrals
- Tailoring Interventions including considerations of learning styles and suitability for interventions
- Our Intervention Plan:
 - o Targets/actions needed to achieve the outcomes
 - o Other actions to be taken by parents/carers and staff/agency (for example, referrals, information sharing or disclosure)
 - o Additional controls
- Mobility and ROTL (for custodial cases only)
- Dealing with changing circumstances



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