Appendix D Expert testimony papers

Section A: NCCSC to complete	
Name:	Jasvinder Sanghera
Job title:	Founder of Karma Nirvana
Address:	http://www.karmanirvana.org.uk/
Guidance title:	Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people
Committee:	Guideline committee - Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people, (GC9 – 25 January 2016).
Subject of expert testimony:	You are invited in your capacity as an expert in forced marriage.
Evidence gaps or uncertainties:	We have searched for evidence in relation to recognition, assessment, early help and response to all forms of child abuse and neglect in children and young people under the age of 18. The definition of abuse and neglect we are using includes forced marriage, in line with Working Together 2015. We have found very little evidence in relation forced marriage which meets out criteria for any of our review questions. We would therefore like you to speak on the basis of your expertise in forced marriage with regard to the questions below, which cover the following five broad areas of: Recognition Assessment Early help Response Organisational factors

1. Recognition

Our review questions are:

What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect?

What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect?

The above two broad questions relate to risk factor and indicators that should lead professionals to be concerned about the possibility that abuse or neglect, including forced marriage, is occurring or likely to occur.

For these questions, we have not found any evidence meeting our criteria which relate specifically to risk factors and indicators in relation to forced marriage. What, in

your experience, are the risk factors and indicators relating both to children and their caregivers/families which professionals should be alert to?

What tools support effective recognition of child abuse and neglect, and the taking of proportionate action?

We have not found any evidence meeting our criteria relating to tools or checklists which might help practitioners to recognise when young people are at risk of, or experiencing, forced marriage. Are there any tools (e.g. screening tools, checklists) which can help practitioners to do this? If so, of what quality?

What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action?

We have not found any evidence meeting our criteria in relation to what challenges and barriers there may be in terms of professionals who work with children and young people (e.g. teachers, social workers, health professionals) recognising where forced marriages are taking place. What, in your experience, are the barriers and challenges to recognising forced marriage?

2. Assessment

What tools support effective assessment of risk and need in relation to child abuse and neglect?

We have not found any evidence relating to tools which may support professionals to assess risk in need in children who are at risk of, or experiencing, forced marriage. Are there any assessment tools which support professionals in doing this? If so, of what quality? Is 'assessment', either through early help assessment, under the Children Act, or through another means, a common response to young people at risk of or experiencing forced marriage?

What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect?

We have not found any evidence relating to challenges and barriers in assessing risk and needs of young people at risk of or experiencing forced marriage. What, in your experience, are the barriers and challenges to conducting good quality assessment in cases of forced marriage? Is 'assessment', either through early help assessment, under the Children Act, or through another means, a common response to young people at risk of or experiencing forced marriage?

3. Early help

Early help was defined in Working Together to Safeguard Children (2013), on which the scope for this guideline was based, as support provided 'as soon as a problem emerges'. In the context of abuse and neglect, this means when 'showing early signs of abuse and/or neglect'.

Is the concept of 'early help' – ie responding to risk or early signs - one which is used in relation to forced marriage?

What is the impact of interventions aiming to provide early help to children and young people identified as at risk of forced marriage? (Prevention of occurrence)

We did not find any evidence meeting our criteria about interventions which could provide early help to prevent forced marriage. Are you aware of any effective interventions? What are their components, and what is the evidence of their effectiveness?

What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect?

We did not find any evidence meeting our criteria about aspects of professional practice and ways of working support and hinder the effective early help of children and young people identified as at risk of child abuse and neglect. Our definition of 'ways of working' includes issues such as case management; communication and engagement with children, young people and families; building trust with families and co-working across disciplines. What ways of working, in your experience, support and hinder effective early help to young people at risk of forced marriage?

4. Response

Our definition of 'response' related specifically to interventions provided after a young person has experienced abuse, including forced marriage, with the purpose of preventing psychological or other types of harm, or reducing the extent of harm. We did not find any evidence meeting our criteria about effective interventions that had been offered to young people who have experienced forced marriage.

What is the impact of social and psychological interventions responding to forced marriage? (Prevention of impairment)

We did not find any evidence meeting our criteria about interventions provided to prevent or ameliorate harm following forced marriage. Are you aware of any effective interventions? What are their components, and what is the evidence of their effectiveness?

What aspects of professional practice support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect?

We have only found one paper using qualitative evidence about professional practice in relation to forced marriage (Kazimirski et al. 2009). What ways of working, in your experience, support and hinder effective response to young people who have experienced forced marriage?

5. Organisational factors

The objective of this question is to assess what organisational factors support and hinder effective multi-agency working and professional judgement, including in relation to forced marriage. This may include issues such as training and supervision.

What organisational factors support and hinder effective multi-agency working including supporting good professional judgement?

In your experience, are there organisational structures or processes which can support multi-agency working in the context of forced marriage?

Section B: Expert to complete	
Summary testimony:	**[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]**

What ways of working, in your experience, support and hinder effective responses to young people who have experienced forced marriage?

Karma Nirvana is a national charity that supports both men and women experiencing forced marriages and the underlying abuse being honour based violence. The charity host the government funded national helpline which since its inception in 2008 has dealt with over 48,000 UK calls. The most common profile of the victim caller is aged between 13-21 and this remains the most vulnerable age. When victims report their experiences they are often met with a greater lack of understanding, and often dealt with as different and deemed 'cultural.'

This can lead this abuse not being framed as child and/or public protection but often framed as 'cultural' that can and does lead to inappropriate engagement with families that is clearly not a protective factor in these cases. It remains widely evidenced that victims of forced marriages and honour abuse experience these abuses within a family dynamic and therefore they will always have multiple perpetrators. These individuals are most often immediate family members leaving victims extremely isolated and facing greater vulnerabilities. Victims have very few opportunities to access support within the family and therefore any real meaningful engagement remains outside the family. The term 'One Chance Rule' refers to how professionals may only have one chance to get the response right, this term also recognises the immense courage it takes for a victim to report and the a good response is very much dependent on a professionals awareness.

HM Government issued Multi-agency statutory guidelines as a result of The Forced Marriage Civil Protection Act 2007 recognising the challenges faced by both victims and practitioners. This placed a duty on organisations namely those with senior responsibility to ensure that staff receive the appropriate training in order to understand the danger of involving the family and the community in cases of forced marriage. The guidelines help professionals to understand and assess how any type of family involvement will often place the vulnerable young person at greater risk or harm. It is widely evidenced with cases such as Shafilea Ahmed (17) who reported to 6 organisations including an attempted suicide which hospitalised her for 8 weeks that forced marriages and families that operate honour systems can and does lead to significant harm and in the extreme as with this case murder.

These cases are extremely complex and a lack of knowledge and understanding can lead to ineffective assessments or late recognition that someone is at risk. An effective response requires you to risk assess both actual and the perception of risk and to follow government guidelines, sadly a recent government report highlights a lack of implementation with education and health being of primary concern. These settings provide the greatest opportunities for intervention as victim's movements are often monitored and they will only have access support outside the home. It is also noted that victims may also be chaperoned by family members who will insist on being at a medical appointment often using issues related to cultural sensitivities as a means to ensure they are present. This is a means to control and intimidate the victim who will have little or no power to request that they leave. Health has a significant role at this point and also believing the victim is paramount and engaging with the victim's wishes about fears related to the family. An agreement with agencies to recognise the importance of sharing information and any disclosures to family members must be considered at the earliest stage. Young people will be fearful of repercussions haven spoken outside a family dynamic which will deem it shameful speaking to agencies. A clear understanding of the difference between

breaking confidence (involving a vulnerable person's family without consent) and sharing information with other professionals to prevent a vulnerable young person being at risk of significant harm.

Forced marriage is now a criminal offence 2014 but very few professionals and young people know a law exists to protect them. Forced Marriage Civil Protection Orders are an additional safeguarding tool which can be implemented quickly whilst a child protection inquiry is taking place. According to the Ministry of Justice the majority of these orders have been issued to protect those under the age of 18 as young as 5 years old. Assessments should be informed knowledge of risk informed by the guidelines that has high regard for monitoring the young person not only outside settings but when at home. There is a need to ensure practitioners are aware and supported so they have access to what exists to support assessments and ensure victims receive immediate emotional support and understands how to keep themselves safe, this in my opinion reduces the risk and empowers victims to access safer choices. Today there is a wealth of information and resources for practitioners including a national helpline, it is important for practitioners to know where and how to refer as well as what to and not to do in these cases.

References (if applicable):

Karma Nirvana- Police Training Handbook/Risk Assessment Tool 2016

HM Government Multi-agency Practice Guidelines: Handling cases of Forced Marriage

True Story, Shame- Forced into marriage, rejected by those she loved 2016: Jasvinder Sanghera

Section A: NCCSC to complete	
Name:	Jenny Pearce
Job title:	Professor of Young People and Public Policy Joint Director of The International Centre: researching child sexual exploitation, violence and trafficking
Address:	University of Bedfordshire University Square Luton Bedfordshire LU1 3JU
Guidance title:	Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people
Committee:	Guideline committee - Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people, GC11.
Subject of expert testimony:	You are invited in your capacity as an expert in child sexual exploitation.
Evidence gaps or uncertainties:	We have searched for evidence in relation to recognition, assessment, early help and response to all forms of child abuse and neglect in children and young people under the age of 18. The definition of abuse and neglect we are using includes child sexual exploitation, in line with Working Together 2015. We have found very little evidence in relation to child sexual exploitation which meets the criteria for any of our review questions, although we have found some evidence relating to child sexual abuse more generally. We would therefore like you to speak on the basis of your expertise in child sexual exploitation with regard to the questions below, which cover the following five broad areas of: Recognition Assessment Early help Response Organisational factors. It would also be helpful if you could advise the GC whether evidence relating to general child sexual abuse is transferable to child sexual exploitation for any of the above areas.

1. Recognition

Our review questions are:

What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect?

What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect?

The above two broad questions relate to risk factors and indicators that should lead professionals to be concerned about the possibility that abuse or neglect, including child sexual exploitation, is occurring or likely to occur.

For these questions, we have not found any evidence meeting our criteria which relates specifically to risk factors and indicators for child sexual exploitation. What, in your experience, are the risk factors and indicators relating both to children and their caregivers/families to which professionals should be alert?

What tools support effective recognition of child abuse and neglect, and the taking of proportionate action?

We have not found any evidence meeting our criteria relating to tools or checklists which might help practitioners to recognise when young people are at risk of, or experiencing, child sexual exploitation. Are there any tools (e.g. screening tools, checklists) which can help practitioners to do this? If so, of what quality?

What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action?

We have found little evidence regarding what helps and hinders professionals (e.g. teachers, social workers, health professionals) in recognising when child sexual exploitation is taking place or likely to take place. What, in your experience, are the barriers and challenges to recognising child sexual exploitation?

2. Assessment

Our review questions are:

What tools support effective assessment of risk and need in relation to child abuse and neglect?

We have not found any evidence which meets our criteria relating to tools which may support professionals to assess risk in need in children who are at risk of, or experiencing, child sexual exploitation. Are there any assessment tools which support professionals in doing this? If so, of what quality? Is 'assessment', whether through early help assessment, under the Children Act, or another means, a common response to young people at risk of or experiencing child sexual exploitation?

What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect?

We have not found any evidence relating to challenges and barriers in assessing risk and needs of young people at risk of or experiencing child sexual exploitation. What, in your experience, are the barriers and challenges to conducting good quality assessment in cases of child sexual exploitation? Is 'assessment', either through early help assessment, under the Children Act, or through another means, a common response to young people at risk of or experiencing child sexual exploitation?

3. Early help

Early help was defined in Working Together to Safeguard Children (2013), on which the scope for this guideline was based, as support provided 'as soon as a problem emerges'. In the context of abuse and neglect, this means when 'showing early signs of abuse and/or neglect'. We have conceptualised this as being similar to targeted, as opposed to universal, prevention of abuse and neglect.

Is the concept of 'early help' – ie responding to risk or early signs - one which is used in relation to child sexual exploitation?

What is the impact of interventions aiming to provide early help to children and young people identified as at risk of child sexual exploitation? (Prevention of occurrence)

We did not find any evidence meeting our criteria about targeted interventions which could provide early help to prevent child sexual exploitation. Are you aware of any effective interventions? What are their components, and what is the evidence of their effectiveness?

What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect?

We did not find any evidence meeting our criteria about aspects of professional practice and ways of working which support and hinder the effective early help of children and young people identified as at risk of child sexual exploitation. Our definition of 'ways of working' includes issues such as case management; communication and engagement with children, young people and families; building trust with families and co-working across disciplines. What ways of working, in your experience, support and hinder effective early help to young people at risk of child sexual exploitation?

4. Response

Our definition of 'response' related specifically to interventions provided after a young person has experienced abuse, including child sexual exploitation, with the purpose of preventing psychological or other types of harm, or reducing the extent of harm.

What is the impact of social and psychological interventions responding to child sexual exploitation? (Prevention of impairment)

We did not find any evidence meeting our criteria about interventions provided to prevent or ameliorate harm following child sexual exploitation specifically, although we did find evidence relating to effective interventions following sexual abuse (including cognitive behavioural therapy, individual psychoanalytic therapy and prolonged exposure therapy).

Are you aware of any effective interventions specific to child sexual exploitation? What are their components, and what is the evidence of their effectiveness? To what extent can the evidence base relating to interventions for general sexual abuse be applied to child sexual exploitation?

What aspects of professional practice support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect?

We have found little evidence regarding aspects of professional practice in response to child sexual exploitation. What ways of working, in your experience, support and hinder effective response to young people who have experienced child sexual exploitation?

5. Organisational factors

The objective of this question is to assess what organisational factors support and hinder effective multi-agency working and professional judgement, including in relation to child sexual exploitation. This may include issues such as training and supervision.

What organisational factors support and hinder effective multi-agency working including supporting good professional judgement?

In your experience, are there organisational structures or processes which can support multi-agency working in the context of child sexual exploitation?	
Section B: Expert to complete	
Summary testimony:	[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]

Recognition

It is now established that child sexual exploitation is a form of child sexual abuse, with guidance changing from that focused on 'children involved in prostitution' (DH 2000) to the current focus on children sexually exploited (DfE 2015). Indeed, the current government has identified CSE as a form of CSA to be one of three national threats, with the Strategic Policing Requirement to promote it as a priority in every force in England and Wales (HM Government, 2015). This shift from child prostitution to child sexual exploitation has come from campaign work of lead NGOs, in particular Barnardos, NSPCC and The Children's Society, from research evidence into children's experiences of CSE (Beckett 2011, Melrose and Pearce 2013, Brayley et al 2014, Cockbain et al 2014, Dodsworth, 2014) and from young people's own voices and representations (Becket et al 2013, Warrington 2013). Following the Jay (2014) report, statutory authorities have taken a stronger role in understanding the importance of recognition of CSE

Despite this, recognition of cases of CSE is poor (OFSTED 2015) and children continue to report feeling blamed and responsible for the abuse they experience (Melrose 2013, Beckett and Warrington 2015). There is continued assumption that CSE is perpetrated by specific communities rather than being a crime that impacts across and within cultural divides (Cockbain 2013); that CSE is organised crime by male adults , as opposed to recognising that approximately 25% of cases are perpetrated by peers, who may themselves also be victims of sexual violence, gang violence or abuse within their home and communities (Becket et al 2014, Firmin 2013, Alnock 2015) and that consent to sexual activity is a conscious decision, irrespective of external pressures and constraints (Pearce 2013, Coy 2013). It is recognised that more work is needed to focus on professional's identification of the problem rather than resting on a dependence on children to disclose (Cossar et al 2013); on multi agency information sharing to ensure joined up services between children missing strategies, gang and gun and knife strategies , work on teenage intimate partner violence (Shuker 2013, Barter et al 2011, Firmin 2013),'on line' abuse prevention work (Kloess 2014) and local approaches to child and adolescent mental health (AYPH 2013, McClelland 2013)

Assessment and early help

Research and inquiry reports have identified both risk factors making children and young people more vulnerable to sexual exploitation and protective factors that can help divert children from harm (OCC 2013). There are a number of different and diverse risk assessment tools (see SERAF: Barnardos, RCGP and NSPCC safeguarding children toolkit and London Borough of Camden, Leicestershire, Plymouth CSE risk assessment tools for examples). A comprehensive evaluation of the use and impact of such tools is badly needed (Clutton and Coles 2007). Research suggests that assessment of children's needs is too focused on the individual child rather than incorporating an assessment of the impact of the environment on the child (Firmin 2015), does not reach into marginalised groups of children, including children with disabilities and children from BME groups without specialist targeted intervention (D'Arcy et al 2015); that assessment happens at too high a threshold of risk, preventing early intervention strategies from diverting children from harm and that referrals for support are invariably rejected on the grounds that CSE affected children fail to meet child protection thresholds, themselves designed more with the needs of younger children as opposed to teenagers in mind (Franklin et al 2015)

Response and Organisational factors

There is increasing evidence that multi agency working, information sharing, early intervention strategies and co-location of teams of practitioners working on safeguarding older children from CSE is needed (Jay 2015, DfE2015, Jago et al 2011, Berelowitz et al 2014, OFSTED 2015). This established work means ensuring community profiling assesses dangers for children outside, as well as inside, the home and family, that sexual health, mental health, police and children's services, school nurses and pastoral care staff and PRU staff regularly share information about risk assessed and vulnerable individuals, communities and peer groups under 18.

Challenges for the future are about ensuring that resources are directed towards facilitating multi agency working, that children's voices become part of the establishment and monitoring of interventions designed to protect them, that on and off line child protection strategies share information; and that training and supervision regarding the nature and impact of CSE as a form of CSA is embedded in day to day practice. One of the essential requirements is that CSA and CSE is included in specific training delivered to UG and PG social work students, that further efforts are placed on evaluating interventions, risk assessment tools and that early help strategies link with longer term therapeutic support to ensure that prevention includes addressing the risk of re-victimisation of children and young people

Jenny Pearce , April 2016

References (if applicable):

AYPH (2016) *Be Healthy*. Available at: http://www.ayph-behealthy.org.uk/.

Beckett H. (2011) Not a World Away: The sexual exploitation of children and young people in Northern Ireland. London: Barnardo's.

Beckett H and Warrington C. (2015) Making Justice Work: Experiences of criminal justice for children and young people affected by sexual exploitation as victims and witnesses. Luton: University of Bedfordshire.

Be Healthy Health Advocates (2013) You Get Me? A guide to help young people and professionals work together. Available at: http://www.ayph-behealthy.org.uk/.

Berelowitz, S (2014) *If Only Someone Had Listened Office of the Children's commissioner for England Inquiry into Child Sexual Exploitation in Gangs and Groups* Final report. London : OCC http://www.childrenscommissioner.gov.uk/force_download.php?fp=%2Fclient_assets%2Fcp%2Fpublication%2F743%2FIf_only_someone_had_listened_Office_of_the_Childrens_Commissioners_Inquiry_into_Child_Sexual_Exploitation_in_Gangs_and_Groups.pdf

Brodie, I (2016 forthcoming) Literature review: the participation of children and young people in child sexual exploitation services. Luton. University of Bedfordshire

Cockbain, E., Brayley, H., Ashby, M.(2014) *Not just a Girl thing : a large scale comparison of male and female users of child sexual exploitation services in the UK* UCL (University College London), Department of Security and Crime Science in partnership with Barnarods and Nat Cen

Cockbain (2013) Grooming and the 'Asian sex gang predator': the construction of a racial crime threat Race and Class April-June 2013 vol. 54no. 4 22-32

Clutton S and Coles J. (2007) Sexual Exploitation Risk Assessement Framework: a pilot study. Cardiff: Barnardo's Cymru.

Coffey A. (2014) Real Voices: child sexual exploitation in Greater Manchester. Manchester: Greater Manchester Police Force.

Cossar, J, Brandon, M Bailey , S, Belderson, P, Biggart, L (2013) 'It takes a lot to build trust' Recognition and Telling: Developing earlier routes to help for children and young people Report for the Office of the Children's Commissioner for England : London

Coy, M; Kelly, L; Elvines, F; Garner, M and Kanyeredzi, A. (2013) Sex without consent, I suppose that is rape. How young people in England understand sexual consent London: London Metropolitan University

D'Arcy K, Dhaliwal S, Thomas R, et al. (2015) Families and Communities against sexual explotiation (FCASE) Final evaluation report. Luton: University of Bedfordshire.

Dodsworth J. (2014) Sexual Exploitation, Selling and Swapping Sex: Victimhood and Agency. *Child Abuse Review* 23: 185-199.

Department for Children, Schools, and Families (DCSF)(2009) *Safeguarding Children and Young People from Sexual Exploitation: supplementary guidance to working together to safeguard children,* London: HMSO

Firmin, C. (2013) 'Something old or something new: do pre-existing conceptualisations of abuse enable a sufficient response to abuse in young people's relationships and peer groups?' in Melrose, M., and Pearce.J.(eds) *Critical Perspectives on Child Sexual Exploitation and Related trafficking* Basingstoke: Palgrave Macmillan pp 38-52

Firmin C. (2015) Practitioner Briefing #2: Auditing your local response to peer-on-peer abuse MsUnderstood Partnership available on www.beds.ac.uk/intcent

Firmin C. and Curtis G. (2015) Practitioner Briefing #1: What is peer-on-peer abuse?

MsUnderstood Partnership available n www.beds.ac.uk/intcent

HMSO (2015) *Tackling Child Sexual Exploitation* London: HMSO www.gov.uk/government/publications

HMSO (2015) Working together to safeguard children HMSO www.gov.uk/government/publications

Franklin, A. Raws, P. and Smeaton, E. (2015) Unprotected, Overprotected: Meeting the needs of young people with learning disabilities who experience, or are at risk of, sexual exploitation. Barkingside: Barnardo's

Gilligan P. (2015) Turning It Around: What do young women say helps them to move on from child sexual exploitation. *Child Abuse Review*.

Hallett S. (2015) 'An Uncomfortable Comfortableness' 'Care', and Child Sexual Exploitaiton. *British Journal of Social Work* 1 - 16.

Her Majesty's Inspectorate of Constabulary (HMIC) (2015) Online and on the edge: real risks in a virtual world: an inspection into how forces deal with the online sexual exploitation of children. [London]: Her Majesty's Inspectorate of Constabulary (HMIC).

Jago, S; Arocha, L; Brodie, I; Melrose, M; Pearce, J and Warrington, C (2011) What's going on to safeguard children and young people from sexual exploitation? How local partnerships respond to child sexual exploitation Luton: University of Bedfordshire

Jago, S. (2010) 'Safeguarding future generations: Challenging and prosecuting perpetrators' in Youth and Policy Vol 104 p.48-61

Jay, A. (2014) *Independent inquiry into child sexual exploitation in Rotherham 1997-2013* Rotherham https://www.rotherham.gov.uk

Kloess, J, Beech, A and Harkins, L (2014) 'Online child sexual exploitation: prevalence, process and offender characteristics' in Trauma, Violence and Abuse Vol.15(2)

McClelland, G. T. and Newell, R. (2013) 'Youth Sexual Exploitation (United Kingdom) Managing Health Needs, Alongside Criminal Justice Interventions' in Journal of Psychological Issues in Organizational Culture Vol 3(1), p. 247-275

Melrose, M. (2013) 'Twenty-first century party people:Young people and sexual exploitation in the new millenium' in Child Abuse Review, Vol 22 p.155-168

OFSED (2014) Sexual exploitation of children: Ofsted thematic report: The sexual exploitation of children: it couldn't happen here, could it? OFSTED : London

Pearce J and Jago S. (2008) Gathering evidence of the sexual explotiation of children and young people: a scoping exercise. Luton: University of Bedfordshire.

Purple Monsters Streetsafe Lancashire. (2014) Standing tall after feeling small. Preston: The Children's Society

Shuker L. (2012) The Barnardo's Safe Accommodation Project: Consultaiton with young people. Luton: University of Bedfordshire.

Shuker L. (2013) Evaluation of Barnardo's Safe Accommodation Project for Sexually Exploited and Trafficked Young People. London: Barnardo's.

Smeaton E. (2013) Running from hate to what you think is love: the relationship between running away and child sexual exploitation. Ilford: Barnardo's.

Warrington, C. (2013) 'Partners in care? Sexually exploited young people's inclusion and exclusion from decision making about safeguarding.' in Melrose, M. and Pearce, J. (eds.) Critical Perspectives on Child Sexual Exploitation and Trafficking. (pp. 110 – 124) Basingstoke. Palgrave Macmillan

Warrington C. (2013) 'Helping me find my own way': Sexually exploited young people's involvement in decision-making about their care. (Doctoral Thesis) *Institute of Applied Social Research.* Luton: University of Bedfordshire, 259.

Section A: NCCSC to complete	
Name:	Meg Fassam-Wright
Job title:	Implementation Manager
Address:	National FGM Centre
Guidance title:	Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people
Committee:	Guideline committee - Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people, GC13.
Subject of expert testimony:	You are invited in your capacity as an expert in female genital mutilation (FGM).
Evidence gaps or uncertainties:	We have searched for evidence in relation to recognition, assessment, early help and response to all forms of child abuse and neglect in children and young people under the age of 18. The definition of abuse and neglect we are using includes FGM, in line with Working Together 2015. We have found very little evidence in relation FGM which meets out criteria for any of our review questions. We would therefore like you to speak on the basis of your expertise in FGM with regard to the questions below, which cover the following five broad areas of: Recognition Assessment Early help Response Organisational factors.

1. Recognition

Our review questions are:

What emotional, behavioural and social (non-clinical) indicators relating to children and young people should alert practitioners to the possibility of abuse and neglect?

What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect?

The above two broad questions relate to risk factors and indicators that should lead professionals to be concerned about the possibility that abuse or neglect, including FGM, has occurred or is likely to occur. In this section we are particularly thinking about signs such as behaviour or emotional state, rather than clinical diagnosis of FGM.

FGM affects an estimated 200 million women worldwide. The practice is endemic in 29 African countries and in areas of the Middle East, Asia and Latin America. With migration, FGM has spread around the world and instances of the practice being copied by individuals who do not belong in affected communities have been recorded as a means of controlling the sexuality of girls. In the UK, the practice of genital piercing is also classified as FGM and is illegal under the FGM act. In the UK, it is

estimated that at least 137,000 women live with the consequences of the practice and up to 66,000 girls may be at risk. It is important for professionals to familiarise themselves with the prevalence of FGM worldwide to be able to identify girls who may be at increased risk from the practice. However, professionals should also be aware of the world-wide scale of the practice and exercise their personal judgement when faced with the signs and indicators of FGM.

The statutory multi-agency guidelines on female genital mutilation published by the Home Office in 2016 provide a list of signs and risk factors for FGM:

The most significant factor to consider when deciding whether a girl or woman may be at risk of FGM is whether her family has a history of practising FGM. In addition, it is important to consider whether FGM is known to be practised in her community or country of origin. The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, at marriage or during a first pregnancy. Given the hidden nature of FGM, individuals from communities where it takes place may not be aware of the practice. Women and girls who have undergone FGM may not fully understand what FGM is, what the consequences are, or that they themselves have had FGM. Given this context, discussions about FGM should always be undertaken with appropriate care and sensitivity. It is believed that FGM may happen to girls in the UK as well as overseas. Girls of school age who are subjected to FGM overseas are likely to be taken abroad (often to the family's country of origin) at the start of the school holidays, particularly in the summer, in order for there to be sufficient time for her to recover before returning to school. There are a number of factors in addition to a girl's or woman's community, country of origin and family history that could indicate she is at risk of being subjected to FGM. Potential risk factors may include:

- a female child is born to a woman who has undergone FGM;
- a female child has an older sibling or cousin who has undergone FGM;
- a female child's father comes from a community known to practise FGM;
- the family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;
- a woman/family believe FGM is integral to cultural or religious identity;
- a girl/family has limited level of integration within UK community;
- parents have limited access to information about FGM and do not know about the harmful effects of FGM or UK law;
- a girl confides to a professional that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'
- a girl talks about a long holiday to her country of origin or another country where the practice is prevalent;
- parents state that they or a relative will take the girl out of the country for a prolonged period;
- a parent or family member expresses concern that FGM may be carried out on the girl;
- a family is not engaging with professionals (health, education or other);
- a family is already known to social care in relation to other safeguarding issues;
- a girl requests help from a teacher or another adult because she is aware or suspects that she is at immediate risk of FGM;

- a girl talks about FGM in conversation, for example, a girl may tell other children about it (it is important to take into account the context of the discussion);
- a girl from a practising community is withdrawn from Personal, Social, Health and Economic (PSHE) education or its equivalent;
- a girl is unexpectedly absent from school;
- sections are missing from a girl's Red book; and/or
- a girl has attended a travel clinic or equivalent for vaccinations / anti-malarials.

There are a number of indications that a girl or woman has already been subjected to FGM:

- a girl confides in a professional that FGM has taken place;
- a mother/family member discloses that female child has had FGM;
- a family/child from an FGM affected community is already known to social services in relation to other safeguarding issues;
- a girl or woman has difficulty walking, sitting or standing or looks uncomfortable;
- a girl or woman finds it hard to sit still for long periods of time, and this was not a problem previously;
- a girl or woman spends longer than normal in the bathroom or toilet due to difficulties urinating;
- a girl spends long periods of time away from a classroom during the day with bladder or menstrual problems;
- a girl or woman has frequent urinary, menstrual or stomach problems;
- a girl avoids physical exercise or requires to be excused from physical education (PE) lessons without a GP's letter;
- there are prolonged or repeated absences from school or college;
- increased emotional and psychological needs, for example withdrawal or depression, or significant change in behaviour;
- a girl or woman is reluctant to undergo any medical examinations;
- a girl or woman asks for help, but is not be explicit about the problem; and/or
- a girl talks about pain or discomfort between her legs.

For a full list of countries where FGM is endemic, access the National FGM Centre Knowledge Hub.

What tools support effective recognition of child abuse and neglect, and the taking of proportionate action?

We have not found any evidence meeting our criteria relating to tools or checklists which might help practitioners to recognise when young people are at risk of, or have experienced FGM. Are there any tools (e.g. screening tools, checklists) which can help practitioners to do this? If so, of what quality?

Practitioners should refer to the statutory multi-agency guidelines on female genital mutilation published in 2016. Currently, the most comprehensive risk assessment tool in publication is the "Female Genital Mutilation Risk and Safeguarding Guidance

for Professionals" published by the Department of Health (last updated May 2016). Although the guidance is tailored to health professionals, it contains transferable information. Professionals can also seek accredited training by the National FGM Centre on FGM, including recognising and assessing risk.

Further to that, e-Learning courses exist, including the e-Learning course to improve awareness and understanding of FGM risk produced by NHS England:

http://www.e-lfh.org.uk/programmes/female-genital-mutilation

The National FGM Centre has just produced a comprehensive risk assessment tool for social care professionals that is being piloted in selected local authorities. The tool will be available for wider use following the review of the pilot in 2017.

What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action?

We have not found any evidence about what challenges and barriers there may be for professionals who work with children and young people (e.g. teachers, social workers, health professionals) recognising that FGM may, or has, taken place. What, in your experience, are the barriers and challenges to recognising that a child may be at risk of, or have experienced, FGM?

Unlike other types of abuse, the risk of FGM or signs that FGM has occurred is not as obvious (for example, there are no physical signs of abuse or signs of neglect present). Furthermore, FGM often happens within families with no prior history of safeguarding concerns because parents genuinely believe that the practice is in the best interest of their daughter. In our experience, professionals often lack sufficient training to be able to recognise the signs of FGM risk or to identify indicators that the practice has taken place. The National FGM Centre has provided accredited training on FGM to over 500 frontline professionals in the past year, of whom nearly two thirds stated that they have never had training on FGM before. Prior to training, nearly half of professionals stated that they did not feel confident in recognising and responding to FGM risk and that they did not feel confident in bringing up the subject of FGM with girls or families at risk. Confidence levels rose to over 90% post training provision.

Even in cases where professionals recognise there is potential risk, they lack the confidence to ask questions and to gather more information for fear of causing offence. As a result, even when professionals make referrals to social care, these lack the level of detail to meet the risk threshold for social services and are not investigated further. The National FGM Centre regularly receives referrals of FGM cases that would not normally meet the risk threshold because they contain insufficient information (for example, we receive referrals of girls from FGM affected communities being taken for holidays abroad with no further information). Although the Centre's specialist Social Workers invest the time and effort to further investigate these referrals, other safeguarding teams that lack the expertise and resources to process such referrals would not investigate further.

2. Assessment

What tools support effective assessment of risk and need in relation to child abuse and neglect?

We have not found any evidence relating to tools which may support professionals to assess need in children who are at risk of, or have experienced FGM, particularly relating to social and psychological needs. Are there any assessment tools which support professionals in doing this? If so, of what quality? Is 'assessment', whether through early help assessment, under the Children Act, or through another means, a common response to young people at risk of or who have experienced FGM?

Please see Q1 for risk assessment guidance. Professionals can access the National FGM Centre Knowledge Hub for a comprehensive library of quality-assured resources and tools on FGM:

https://barnardosfgm.custhelp.com/app/home

What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect?

We have not found any evidence relating to challenges and barriers in assessing the needs of young people at risk of or who have experienced FGM. What, in your experience, are the barriers and challenges to conducting good quality assessment in cases of FGM?

A significant barrier to assessing the needs of young people at risk or who have experienced FGM is the reluctance of young people to request help for fear of their parents being prosecuted. As mentioned above, FGM in atypical type of abuse in that it often happens within loving families with no prior history of safeguarding concerns. As a result, girls are less likely to seek help or report FGM and professionals are less likely to identify families as being at risk ("statutory multi-agency guidance on female genital mutilation", Home Office 2016).

At the same time, FGM is linked to a culture of silence; it is considered a taboo issue not to be spoken about outside the family home, or after it has taken place. Often, victims may fear retributions from their wider family network or their communities for speaking out while in some cases FGM is linked to witchcraft and victims may be bound to silence by superstitious fear (e.g. Sierra Leone). This further hinders the ability of girls affected to seek help and express their needs. The above is supported by PEER research conducted by the FGM Centre in 2016, the findings of which will be published later this year.

Professionals often fear being branded 'racist' and express reluctance in bringing up the subject of FGM with girls or families from FGM affected communities. On the other end of the spectrum, some professionals with insufficient training on FGM are prone to over-reacting, or using aggressive language and measures to address perceived FGM risk (for example, the National FGM Centre has received social care referrals for FGM for parents who took their children to Disneyland simply because they were from an FGM-affected community).

Because of the above, professionals need the expertise to balance cultural sensitivity with safeguarding responsibilities when it comes to assessing the needs of girls affected by the practice and the potential risk of FGM. The Home Office statutory

multi-agency guidance on FGM includes guidance on speaking to individuals and families, as does the FGM Safeguarding Guidance for Professionals published by the Department of Health. However, in the experience of the National FGM Centre, professionals with no familiarity of working with FGM affected communities require more in-depth training to understand how to conduct sensitive conversations and how to assess risk.

3. Early help

Early help was defined in Working Together to Safeguard Children (2013), on which the scope for this guideline was based, as support provided 'as soon as a problem emerges'. In the context of abuse and neglect, this means when 'showing early signs of abuse and/or neglect'.

Is the concept of 'early help' – i.e. responding to risk or early signs - one which is used in relation to FGM?

What is the impact of interventions aiming to provide early help to children and young people identified as at risk of FGM? (Prevention of occurrence)

We did not find any evidence meeting our criteria about interventions which could provide early help to prevent FGM. Are you aware of any effective interventions? What are their components, and what is the evidence of their effectiveness?

FGM is a harmful practice that has been carried out for thousands of years and is deeply ingrained amongst communities that practice it. FGM is practiced in 29 African countries, in parts of the Middle East, Asia and South America and it is estimated that 200 million women and girls worldwide are currently living with the consequences. In the UK it is estimated that over 130,000 have undergone FGM and as many as 66,000 girls might be at risk. Unlike other forms of abuse, FGM is deeply rooted in the cultural practices and identities of the communities affected. As such, legislation and safeguarding practices alone are not enough to eradicate it. Prevention strategies require long-term work with affected communities to change attitudes to FGM and to reconceptualise the practice as harmful. The National FGM Centre has been working with FGM affected communities in our pilot sites. Successful interventions include:

Providing counselling or other forms of psychotherapeutic support to women and girls affected by FGM. Women and girls who have undergone FGM often do not link the harmful health consequences they are experiencing to the practice of FGM. At the same time, some women and girls are surprised to find out the Type and severity of their FGM during medical examinations and suffer emotional harm or damaged relationships with their families that they hold responsible. Psychotherapeutic interventions can help victims understand the harmful consequences of the practice, empower women and girls to better cope with the trauma they have endured and help them break the cycle of FGM within their families. Further information about providing psychotherapeutic interventions can be found in the "WHO guidelines on the management of health complications from female genital mutilation" published in 2016. In the UK, organisations that deliver specialist psychotherapeutic interventions to women and girls affected by FGM include the Maya Centre in London, Nestac in Manchester and the UCLH paediatric clinic in London.

Providing awareness-raising and prevention programmes on FGM to communities

affected by the practice. PEER research conducted by the National FGM Centre and Forward in 2016 revealed that members of FGM affected communities who had attended community-based awareness raising programmes were more likely to be aware of the law on FGM, understand the health consequences of the practice and less likely to express support for FGM. A number of interventions have been developed to raise awareness of the negative consequences of FGM and change community attitudes both in the UK and internationally with varying degrees of success. These include recruiting and training members of FGM affected communities as Community Champions against the practice, working with religious and community leaders, partnering with health professionals, delivering awareness raising programmes in a range of settings including community meeting places (e.g. community organisations, tea houses, mosques and churches), as part of traditional ceremonies (such as naming ceremonies or Henna nights), in maternity settings, parent and toddler groups etc. For a review of the effectiveness of different interventions, the following resources are useful:

"What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation" Johansen R.E.B. et al 2013, Obstetrics and Gynecology International Vol. 2013

"*Tackling FGM in the UK: What works in Community Based Prevention*" Hemmings, J. and Brown, E., Options Consultancy 2013

Delivering quality-assured and age appropriate lesson plans in schools. Because FGM is a taboo issue, girls are unlikely to discuss it outside the context of the family home and are often not aware of their rights or the consequences of the practice. Quality-assured lesson plans can empower girls affected or at risk from the practice to come forward and seek help and support around FGM. At the same time, girls at risk from the practice are more likely to speak to their friends about issues that concern them. Delivering lesson plans to the whole classroom ensures that all students are able to understand the consequences of the practice, their rights, and make disclosures either for themselves or their friends. Lesson plans on FGM can be delivered in the wider context of PSHE and Sex and Relationship Education. For a list of quality assured lesson plans, visit the National FGM Centre's Knowledge Hub:

https://barnardosfgm.custhelp.com/app/answers/list/kw/lesson%20plans/search/1

What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect?

We did not find any evidence meeting our criteria about aspects of professional practice and ways of working that support and hinder the effective early help of children and young people identified as at risk of FGM. Our definition of 'ways of working' includes issues such as case management; communication and engagement with children, young people and families; building trust with families and co-working across disciplines. What ways of working, in your experience, support and hinder effective early help to young people at risk of FGM?

All professionals with a safeguarding duty are expected to be familiar with the Home Office's "Statutory multi-agency guidance on Female Genital Mutilation" published in 2016. The guidelines outline good practice standards for different professionals and

principles of effective multi-agency working. Professionals are also encouraged to undertake quality-assured training to increase their understanding of upholding their safeguarding responsibilities around the sensitive issue of FGM. The National FGM Centre can provide accredited training course for all professionals. E-learning courses by the Home Office and the Department of Health have also been produced and are available to access online.

4. Response

Our definition of 'response' related specifically to interventions provided after a young person has experienced abuse, including FGM, with the purpose of preventing psychological or other types of harm, or reducing the extent of harm. We are not looking at clinical treatment of the physical consequences of FGM.

What is the impact of social and psychological interventions responding to FGM? (Prevention of impairment)

We did not find any evidence meeting our criteria about interventions provided to prevent or ameliorate psychological harm following FGM. Are you aware of any effective interventions? What are their components, and what is the evidence of their effectiveness?

The availability of specialist psychotherapeutic interventions to address the needs of women and girls affected by FGM is crucial in ameliorating the psychological harm of the practice and in breaking the cycle of FGM in families. A number of interventions have been developed and delivered to support women and girls affected, including Cognitive Behavioural Therapy, group counselling and 1-to-1 counselling. Psychotherapeutic interventions can also help address the damage in relationships between daughters and mothers, as girls who have been subjected to FGM often experience a break in trust with those closest to them, expressing feelings of betrayal alongside the physical and psychological impact of the practice. In the UK, such services are successfully being provided by the UCLH paediatric clinic, the Maya Centre in London and Nestac in Manchester. Unfortunately, psychotherapeutic interventions for women and girls affected by FGM are not widely available in the UK, and services for girls are particularly limited. The WHO has published guidance on the management of health complications from FGM that suggests the delivery of a range of psychotherapeutic interventions:

"WHO guidelines on the management of health complications from Female Genital Mutilation" 2016.

The following article also reviews the effectiveness of some psychotherapeutic interventions and explores the role of mental health nurses:

"Crossing borders: Discussing the evidence relating to the mental health needs of women exposed to female genital mutilation," Mulongo, P. et al 2014, International Journal of Mental Health Nursing

What aspects of professional practice support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect?

What ways of working, in your experience, support and hinder effective response to young people who have experienced FGM?

5. Organisational factors

The objective of this question is to assess what organisational factors support and hinder effective multi-agency working and professional judgement, including in relation to FGM. This may include issues such as training and supervision.

What organisational factors support and hinder effective multi-agency working including supporting good professional judgement?

In your experience, are there organisational structures or processes which can support multi-agency working in the context of FGM?

All organisations should ensure that professionals with a safeguarding responsibility are expected to be familiar with the statutory multi-agency guidelines on FGM.

Organisations should ensure they have:

- suitable policies and procedures on FGM in place
- FGM embedded in key strategy documents e.g. Children and young people's plan; LA's violence against women and girls strategy
- trained staff and a designated lead
- clear lines of accountability
- effective inter-agency working and information sharing
- a girl-centred approach
- established links with support services to signpost girls & women affected by FGM
- effective monitoring & evaluation practices
- effective multi-agency practice arrangements and
- effective risk-assessment frameworks.

Section B: Expert to complete

Summary testimony:	**[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]**

The World Health Organisation defines female genital mutilation (FGM) as: "Any procedure which involves the partial or complete removal of the external female genitalia or other injury to the female genital organs for non-medical reasons".

FGM violates the rights and dignity of women and girls and is illegal regardless of the age of the female on which it is performed.

FGM is a harmful practice that has been carried out for thousands of years and is deeply ingrained amongst communities that practice it. FGM is practiced in 29 African countries, in parts of the Middle East, Asia and South America and it is estimated that 200 million women and girls worldwide are currently living with the consequences. In the UK it is estimated that over 130,000 have undergone FGM and as many as 66,000 girls might be at risk.

There are many variations of FGM that broadly come under four types:

Type 1: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy) Type 2: Partial or total removal of the clitoris and the labia minora with or without excision of the labia majora (excision)

Type 3: Narrowing of the vaginal orifice with creation of a covering seal by cutting and bringing together (sewing) the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)

Type 4: All other types of harmful traditional practices that mutilate the female genitalia, including pricking, cutting, piercing, incising, scraping and cauterisation

Short term health implications include:

- death
- severe pain and shock
- broken limbs from being held down
- injury to adjacent tissues
- urine retention
- increased risk of HIV and AIDS

Long term health implications include:

- uterus, vaginal and pelvic infections
- cysts and neuromas
- infertility
- increased risk of fistula
- complications in childbirth
- depression and post-natal depression
- psychosexual problems
- pregnancy and child birth complications
- sexual dysfunction
- difficulties in menstruation
- trauma and flashbacks

Signs that a girl could be at risk of FGM

- One or both of a girl's parents come from a community affected by FGM
- A girl is born to a woman who has undergone FGM
- Mother has requested re-infibulation following childbirth
- A girl has an older sibling or cousin who has undergone FGM
- One or both parents or elder family members consider FGM integral to their cultural or religious identity
- The family indicate that there are strong levels of influence held by elders and/ or elders who are involved in bringing up female children
- A girl/family has limited level of integration within UK community
- A girl from a practising community is withdrawn from PSHE and/or Sex and Relationship Education or its equivalent may be at risk as a result of her parents wishing to keep her uninformed about her body, FGM and her rights Signs that a girl could be at immediate risk of FGM
- If a female family elder is present, particularly when she is visiting from a country of origin, and taking a more active / influential role in the family

• If there are references to FGM in conversation, for example a girl may tell other children about it

• A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'

• A girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk

• Parents state that they or a relative will take the child out of the country for a prolonged period

• A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent

• A girl is taken abroad to a country with high prevalence of FGM, especially during the summer holidays which is known as the 'cutting season'

Signs that FGM has occurred

• prolonged absence from schools

• frequent need to go to the toilet

• long break to urinate

• urinary tract infections

FGM is child abuse and professionals are required to uphold their safeguarding responsibilities to protect girls at risk or affected by the practice. Professionals are expected to be familiar with the legislation on FGM and the changes introduced by the Serious Crime Act 2015. Professionals must also be familiar with relevant statutory guidance including the statutory multi-agency guidance on female genital mutilation 2016 and other relevant guidance including the mandatory recording of FGM in healthcare.

Organisations should ensure they have:

- suitable policies and procedures on FGM in place

- FGM embedded in key strategy documents e.g. Children and young people's plan; LA's violence against women and girls strategy

- trained staff and a designated lead

- clear lines of accountability

- effective inter-agency working and information sharing

- a girl-centred approach

- established links with support services to signpost girls & women affected by FGM

- effective monitoring & evaluation practices

- effective multi-agency practice arrangements and

- effective risk-assessment frameworks.

Unlike other forms of abuse, FGM is deeply rooted in the cultural practices and identities of the communities affected. As such, legislation and safeguarding practices alone are not enough to eradicate it. Prevention strategies require long-term work with affected communities to change attitudes to FGM and to reconceptualise the practice as harmful. Organisations should investigate good practice in working with communities to raise awareness and change attitudes to FGM at a local level. Recommended interventions include working with quality assured local community organisations, recruiting and training Community Champions from within local communities affected by the practice, working with community and religious leaders and delivering quality-assured lesson plans in

schools.

The availability of specialist psychotherapeutic interventions to address the needs of women and girls affected by FGM is crucial in ameliorating the psychological harm of the practice and in breaking the cycle of FGM in families. A number of interventions have been successfully developed and delivered to support women and girls affected, including Cognitive Behavioural Therapy, group counselling and 1-to-1 counselling. A holistic approach to FGM prevention must include psychotherapeutic support for FGM survivors.

References (if applicable):

"Statutory multi-agency guidelines on female genital mutilation," Home Office, 2016

"Female Genital Mutilation Risk and Safeguarding Guidance for Professionals," Department of Health (last updated May 2016).

"Female Genital Mutilation: An Overview" National FGM Centre 2015

Serious Crime Act 2015

The FGM Act 2003

"What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation" Johansen R.E.B. et al 2013, Obstetrics and Gynecology International Vol. 2013

"*Tackling FGM in the UK: What works in Community Based Prevention*" Hemmings, J. and Brown, E., Options Consultancy 2013

"Crossing borders: Discussing the evidence relating to the mental health needs of women exposed to female genital mutilation," Mulongo, P. et al 2014, International Journal of Mental Health Nursing

"WHO guidelines on the management of health complications from Female Genital Mutilation" 2016.

For a full list of quality-assured tools, lesson plans, training courses and other resources on FGM please visit the National FGM Centre's Knowledge Hub:

https://barnardosfgm.custhelp.com/app/home

Section A: NCCSC to complete	
Name:	Ravi Kohli
Job title:	Professor of Child Welfare, Institute of Applied Social Research
Address:	University of Bedfordshire University Square Luton Bedfordshire LU1 3JU
Guidance title:	Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people
Committee:	Guideline committee - Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people, GC11.
Subject of expert testimony:	You are invited in your capacity as an expert in child trafficking.
Evidence gaps or uncertainties:	We have searched for evidence in relation to recognition, assessment, early help and response to all forms of child abuse and neglect in children and young people under the age of 18. The definition of abuse and neglect we are using includes child trafficking, in line with Working Together 2015. The remit of the guidance is to influence practice in England (and Wales?). For our questions about recognition of, and early help for children at risk of trafficking, we have therefore focused on children at risk of internal trafficking within England. We have not been able to include interventions for children at risk of being trafficked from other countries in to England. We have found very little evidence in relation to child trafficking which meets the criteria for any of our review questions. We would therefore like you to speak on the basis of your expertise in child trafficking with regard to the questions below, which cover the following five broad areas of: Recognition Assessment Early help Response Organisational factors. It would also be helpful if you could advise the GC whether evidence relating to general child sexual abuse is transferable to child trafficking for any of the above areas.
1. Recognition Our review questions are: What emotional, behavioural and social (non-clinical) indicators relating to children	

and young people should alert practitioners to the possibility of abuse and neglect?

What emotional, behavioural and social (non-clinical) indicators relating to caregivers and families should alert practitioners to the possibility of abuse and neglect?

The above two broad questions relate to risk factors and indicators that should lead professionals to be concerned about the possibility that abuse or neglect, including that a child may have been a victim of trafficking.

For these questions, we have not found any evidence meeting our criteria which relates specifically to risk factors and indicators for child trafficking. What, in your experience, are the risk factors and indicators relating both to children and their caregivers/families to which professionals should be alert?

What tools support effective recognition of child abuse and neglect, and the taking of proportionate action?

What aspects of professional practice support and hinder recognition of child abuse and neglect, and the taking of proportionate action?

We have found one monitoring report relating to the use of the London Safeguarding Trafficked Children guidance and toolkit (London Safeguarding Children Board, 2011), which aims to support identification and assessment of trafficked children. This does not demonstrate effectiveness of the toolkit, but does gather stakeholder perceptions of its usefulness.

Do you know of any other tools for recognising/identifying children who may have been trafficked which have been shown to be effective?

We have found little other evidence regarding what helps and hinders professionals (e.g. teachers, social workers, health professionals) in recognising when child trafficking is taking place or likely to take place. What, in your experience, are the barriers and challenges to recognising children who have been trafficked?

2. Assessment

Our review questions are:

What tools support effective assessment of risk and need in relation to child abuse and neglect?

What aspects of professional practice support and hinder effective assessment of risk and need in relation to child abuse and neglect?

We have found one monitoring report relating to the use of the London Safeguarding Trafficked Children guidance and toolkit (London Safeguarding Children Board, 2011), which aims to support identification and assessment of trafficked children. This does not demonstrate effectiveness of the toolkit, but does gather stakeholder perceptions of its usefulness.

Do you know of any other tools for assessing children who may have been trafficked which have been shown to be effective?

We have found little other evidence regarding what helps and hinders professionals (e.g. teachers, social workers, health professionals) in assessing children who may

have been trafficked. What, in your experience supports and hinders assessment of children who have been/are suspected to have been trafficked.

3. Early help

Early help was defined in Working Together to Safeguard Children (2013), on which the scope for this guideline was based, as support provided 'as soon as a problem emerges'. In the context of abuse and neglect, this means when 'showing early signs of abuse and/or neglect'. We have conceptualised this as being similar to targeted, as opposed to universal, prevention of abuse and neglect.

Is the concept of 'early help' – ie responding to risk or early signs - one which is used in relation to child trafficking?

What is the impact of interventions aiming to provide early help to children and young people identified as at risk of child trafficking? (Prevention of occurrence)

We did not find any evidence meeting our criteria about targeted interventions which could provide early help to prevent child trafficking. Are you aware of any effective interventions? What are their components, and what is the evidence of their effectiveness?

What aspects of professional practice and ways of working support and hinder the effective early help of children and young people at risk of child abuse and neglect?

We did not find any evidence meeting our criteria about aspects of professional practice and ways of working which support and hinder the effective early help of children and young people identified as at risk of child trafficking. Our definition of 'ways of working' includes issues such as case management; communication and engagement with children, young people and families; building trust with families and co-working across disciplines. What ways of working, in your experience, support and hinder effective early help to young people at risk of child trafficking?

4. Response

Our definition of 'response' related specifically to interventions provided after a young person has experienced abuse, including child trafficking, with the purpose of preventing psychological or other types of harm, or reducing the extent of harm.

What is the impact of social and psychological interventions responding to child trafficking? (Prevention of impairment)

We did not find any evidence meeting our criteria about interventions provided to prevent or ameliorate harm following child trafficking specifically. Are you aware of any effective interventions specific to responding to child trafficking? What are their components, and what is the evidence of their effectiveness?

What aspects of professional practice support and hinder effective response to children and young people who are experiencing, or have experienced, child abuse and neglect?

We have found little evidence regarding aspects of professional practice in response to child trafficking. What ways of working, in your experience, support and hinder effective response to young people who have experienced child trafficking?

5. Organisational factors

The objective of this question is to assess what organisational factors support and hinder effective multi-agency working and professional judgement, including in relation to child trafficking. This may include issues such as training and supervision.

What organisational factors support and hinder effective multi-agency working including supporting good professional judgement?

In your experience, are there organisational structures or processes which can support multi-agency working in the context of child trafficking?

Section B: Expert to complete

Summary testimony:	**[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]**

I find the focus of the enquiry to be too narrow in relation to trafficked children in England and Wales. Children trafficked from outside the EU constitute a major grouping in the UK. Our recent study on Independent Child Trafficking Advocates (ICTAs) (Kohli *et al*, 2015) shows that 70% of children who were referred to public authorities as trafficked or potentially trafficked, came from countries outside the EU. UK citizen children constituted 17.7% of the whole cohort of children, and were predominantly referred in relation to sexual exploitation. Therefore I would caution against working within a narrow scope, when the lived experiences of children and practitioners is broad.

A briefing paper by ECPAT (2010) offers a succinct definition of child trafficking:

Child trafficking can be … defined as the movement of a child for the purpose of exploitation or financial gain or benefit of another

Categories of exploitation include sexual, criminal, and labour exploitation. Children are sometimes subject to multiple exploitation across such categories. It should be noted that the categories themselves are subject to interpretations based on the judgement of a decision maker at the time of the categorisation, within the context of their understanding of child trafficking. Some categories may exist (temporarily or permanently) as sub-types within larger categories. Also, children may be re-categorised over time, as details of a case are understood. For example, a young child trafficked for the purposes of domestic servitude or benefit fraud may later be sexually exploited. Similarly the children of trafficked women may also be at risk of illegal adoption, sexual exploitation or being groomed to beg and take part in street crime on behalf of a trafficking gang. Overall, therefore, it is important to note a landscape of categories that move, and that children may be subject to categorisation multiple times during the life of a case.

Risk Factors

In my view, the risk factors relevant to trafficked children are shared with all children subject to different types of abuse, neglect and exploitation, including circumstances of deprivation and poverty. A focus on risks to the child, should also consider needs, many of which are deep and broad, related to the contexts from which trafficked children emerge. Risks should be understood within an ecological frame (Rigby and Whyte, 2015). On those occasions where facts associated with movement, exploitation and gain are clear and categorical, risks are easier to establish. However, risks can also be malleable – more liquid than solid – when such facts are

occluded, and hemmed in by suppositions or concerns. Risks change over time. They modulate. They are tidal, and their movements are governed by facts, as well as the gaze of public authorities. 'Risk factors' can appear as black and white features in a trafficked child's fast moving and kaleidoscopic world.

Tools for recognising/identifying children who may have been trafficked which have been shown to be effective

Indicators for the recognition of potential child trafficking are widely available – see, for example, in the UK https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-trafficking/signs-symptoms-effects/ and in the US https://polarisproject.org/recognize-signs

The SERAF framework developed by Barnardo's for children subject to sexual exploitation (Clutton and Coles, 2007) is widely cited as a good tool.

Also the referral form to the National Referral Mechanism for children who are trafficked contains a useful checklist of indicators. It is available here:

NRM referral form, children (England and Wales)

Further information about the NRM is available here:

UKHTC - National Referral Mechanism

However, in my view the lists of features contained in such tools are seldom exhaustive. Nor are they diagnostically certain, either as single or cumulative features. They require users to interpret the meaning of categories. They also contain features that may be present in the lives of children who are vulnerable, but not trafficked. So they need to be used in a disciplined and bespoke manner for each child over time as factual evidence begins to accrue. Also, recognition tools in themselves are seldom effective in the identification of trafficked children unless a measure is also taken of the ways those tools are used skilfully. So far as I am aware, there are no studies in the UK that have measured the skilful usage of such tools with children who are trafficked. Effectiveness is therefore occluded in relation to the beneficial impact on the lives of children who may be trafficked.

Recognition, including barriers and challenges to seeing trafficked children

Seeing a child who is trafficked costs extra time, money and effort. In contexts of austerity, it is perhaps unsurprising that blind spots remain, when seeing trafficked children carries further financial liabilities. Also, concerns that could be picked up can be dismissed – for example if a child refers to a trafficker in affectionate terms, or is aggressive and secretive when offered professional assistance, or indeed refuses to be wrapped in what they consider to be someone else's moral blanket. Our study (Kohli *et al*, 2015) showed that having an independent and dedicated nation wide service for trafficked children helped some public authorities to up-skill their workforce with sustained and specialist knowledge from expert advocates for children. The study also confirms that public authorities tend to respond to such specialisms in at least two ways. Firstly, as dismissing them as over-zealous and interfering interlopers. Secondly, as facilitative and collaborative relief bringers. In such instances senior mangers within statutory agencies acted as fulcrums for effective or defensive practices. One of the key lessons for advocates in these contrasting contexts was to endure in the face of non-collaboration by children and public authorities, and offer a rugged continuity of service, to ensure that threads

were not dropped, and actions were calibrated that fitted with the known facts.

Effective assessment tools used with children who have been trafficked

See my response to the question of recognition above. The LSCB report that you refer to above was related to separated children coming to the UK, and appears to lie outside your focus on UK citizen children. Again, I am unsure whether you are referring to the existence of assessment tools, or their known effectiveness via empirical research. As far as I am aware, the LSCB report was not intended to look at the effectiveness (however defined) of the toolkit but to monitor its use and roll out. The toolkit was designed to help workers to identify (potentially) trafficked children and young people alongside the Integrated Assessment Framework, and replicated some of the IAF factors – understandable in one way, but a cause of aggravation for practitioners who felt it made them repeat data captured elsewhere. Also, so far as I know, no resources have been dedicated to measuring effectiveness of such assessment tools. In all, the myriad risk matrices and indicator frameworks can be used to contain organisational anxieties via a taxonomic frenzy – with no sustained commitment to evaluation of effectiveness. The overall impact is like trying to catch water with a sieve. However, the following reports from Scotland provide a good benchmark for thoughtful considerations of how to see, and what to do about trafficked children in the UK context:

Rigby *et al* (2012) Child trafficking in Glasgow - the journey so far

Scottish Government (2013) Inter-Agency Guidance for Child Trafficking

'Early help', targeted interventions, and barriers to 'early help'

For trafficked children, one way 'early help' was measured in our study (Kohli et al, 2015: 16-17) was to see how quickly a (potentially) trafficked child was referred to the ICTA Service, to secure the assistance of an advocate. There was general agreement between the Home Office and the 23 Local authorities taking part in the trial that the first 2 hours were critical in stabilising the child's situation, and making sure they were in safe accommodation where their presence could be monitored. Only 19% of cases hit the 2-hour threshold, for a variety of reasons, including referrers who were busy, or where information took a long time to filter through labyrinthine local authority systems. Some children – primarily non-UK nationals - went permanently missing in the gaps between noting the referral and communicating with the ICTA Service (Kohli et al, 2015: 29-31). On the basis of our report we can say that, trafficked children who have liquid trajectories require 'early help'. However, we cannot say that in England and Wales we have effective systems and resources in place to provide such help as yet.

Effective interventions

Traffickers tend to organise and evolve their systems of exploitation at speed. Public authorities tend to be bulky and slower to respond to these movements. It is as if in turbulent waters, traffickers have speedboats, and public authorities have oil tankers. They move differently, reacting and responding in ways that coincide haphazardly. On that basis, we have recommended to Government that a national ICTA service is rolled out to provide:

'…clarity, coherence and continuity for the child, as well as for other services responsible for the child, over time and across contexts (Kohli et al, 2015:39)

A specialist independent, well informed, well-organised service for trafficked children can flow into the gaps of understanding between public authorities. It can devote time to children to build relationships that are sustaining, particularly in contexts of distrust. Overall, we found good evidence that such a service offered the following benefits:

Assisted in keeping trafficked children safely visible once they started working with them;

Sought and made relationships of trust and credibility with the children and other stakeholders;

Shared developing expertise in trafficking and case specific information in purposeful ways;

By working across immigration, criminal justice and social care systems, helped trafficked children to orientate to and navigate their ways through complex circumstances;

Spoke up for the children when necessary;

Maintained a momentum in a case that was suitable to the child's needs, including planning for a sustainable future; and

Improved the quality of decision-making.

However, the Government is not yet willing to commit to rolling out such a service – see Report on the trial of independent child trafficking advocates and next steps

I am happy to discuss this further with the Committee.

Ravi KS Kohli, April 2016

References (if applicable):

Clutton S and Coles J. (2007) Sexual Exploitation Risk Assessment Framework: a pilot study. Cardiff: Barnardo's Cymru

ECPAT (2010) Child trafficking – begging and organised crime. ECPAT UK.

Kohli, RKS, Hynes, P, Connolly, H, Thurnham, A, Westlake, D, D'Arcy, K (2015) Evaluation of Independent Child Trafficking Advocates trial. Research Report 86. Home Office. December 2015

Rigby, P and Whyte, B (2015) Children's Narrative within a Multi-Centred, Dynamic Ecological Framework of Assessment and Planning for Child Trafficking. British Journal of Social Work 45:34-51